

**(In)Voluntary:
How Long-Acting Reversible Contraceptives
Became Mechanisms of Reproductive Control in
the Volunteer State**

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DEDICATION

For Leonore Madeline and Patsy Jean, without whom.

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ABSTRACT

Historically, the most vulnerable members of United States society—Black, indigenous, criminalized, disabled, and poor people—have been systematically subjected to reproductive control by the state. This control continues to take new, complex forms with important local and regional variation, setting national precedents. Tennessee is an exemplary case of “voluntary” sterilization through the implementation of new coercive programming. Through an ethnographic case study of long-acting reversible contraceptives (LARCs) in Tennessee, this dissertation addresses four primary questions: 1) How did long-acting reversible contraceptives become the primary mechanism of reproductive control in East Tennessee? 2) How do criminal justice system actors, health care providers, non-profit organizations, and community organizers work together to influence reproductive control? 3) What is the role of long-acting reversible contraceptives in the carceral state? 4) How are long-acting reversible contraceptives structured through the intersections of race, class, and gender? Drawing upon 33 in-depth interviews, 18 months of participant observation, and archival data, I argue LARCs became mechanisms of reproductive control through the influx of private dollars into public infrastructures which targeted Black, immigrant, undocumented, and poor women. Expanding upon the theoretical frameworks of Reproductive Justice and mass surveillance, I argue the spaces of reproductive control are, simultaneously, spaces of resistance and transformation. Exploring the dialectic experience of LARCs as mechanisms of

reproductive control and as mechanisms of reproductive autonomy, I elucidate the interlocking webs of oppression in Tennessee to enable organized resistance as an emergent pathway of reproductive liberation.

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CHAPTER ONE

THE VOLUNTEER STATE

Located in the American southeast, Tennessee shares borders with eight states—Kentucky, Virginia, North Carolina, Georgia, Alabama, Mississippi, Arkansas, and Missouri. Codifying the natural, topographic borders created by rivers and mountains, the land occupied by the state of Tennessee is divided into three Grand Divisions—West, Middle, and East Tennessee—represented by three stars on the state flag. The three Grand Divisions reflect the complexity and nuance of the geographic, economic, political, and cultural divergence across the state as borders are not simply “spatial fact(s) with sociological consequences, but [rather] sociological fact(s) [which] form [borders] spatially” (Simmel, 1997: 142).

Although borders are established to define space, this juncture of two spaces creates a third place—the Borderlands. To view borders only as geopolitical dividing lines obfuscates the psychological and sexual Borderlands¹ “present wherever two or more cultures edge each other, where people of different races occupy the same territory, where under, lower, middle, and upper classes touch, where the space between two individuals shrinks with intimacy” (Anzaldua, 1987, preface). Within the Borderlands, the embodied experience is a space of constant negotiation and transition as those who exist within the

¹ In Anzaldua's work, geopolitical borders are written using a lowercase letter b while ideological Borderlands are written using a capital letter B. For consistency with Anzaldua's work, I also utilize these capitalization patterns when referencing borders (geopolitical divisions)/Borderlands (ideological constructions).

Borderlands are those who persist in spite of their divergence from the hegemonic ideals of a place. Sara Ahmed (2019) describes this divergent existence as an identity often defined by what one is not—not man, not white, not cis, not able-bodied. Legitimacy and citizenship are only granted to “those in power, the whites, and those who align themselves with whites” (Anzaldúa, 1987, pg. 3-4).

It is in this space of the Borderlands where bodies are “raped, maimed, strangled, gassed, [and] shot” (pg. 3)—places fraught with ambivalence, unrest, and where “death is no stranger” (pg. 4). Demands and intrusions from legitimized actors are, then, acted upon and extracted from the bodies of those in the Borderlands. Particularly for those who can become pregnant, acts of violence within the Borderlands have centered on systematic reproductive control through coercive sterilization, forced births, mandated parenthood, or involuntary removal of children. In response to the systematic oppression of reproductive autonomy, Black women have challenged the white, cisgendered focus on reproductive rights—particularly, abortion access—through the integration of a social justice framework into the intersectional theory and praxis of Reproductive Justice (Nelson, 2003).

This dissertation elucidates the convergence of factors whereby a seemingly benign form of birth control—long-acting reversible contraceptives (LARCs)—promises autonomy through a highly effective, healthcare provider mediated contraceptive device. Long-acting reversible contraceptives include

three types of contraceptive devices: chemical subdermal implant, copper intrauterine device, and hormonal intrauterine device. Long acting reversible contraceptives have gained the reputation of being a form of pregnancy prevention that requires no action on the part of the user. Once a LARC has been inserted by medical professional, the user experiences a pregnancy rate comparable to those who have been sterilized through tubal ligations. In other words, LARCs are tremendously effective at preventing pregnancy without requiring the user to do anything other than receive an implant or an IUD. Additionally, depending on the LARC inserted, pregnancy prevention will last between 3 years (the implant, Skyla and Liletta hormonal IUDs), 5 years (Mirena hormonal IUD), and 10 years (copper IUD). Although most forms of non-barrier contraceptives are mediated through a medical provider, the implant and IUDs are unique in that they require a provider to insert and remove the device safely. Access, insertion, and safe removal of implants and IUDs require a healthcare provider; thereby, providing rates of pregnancy prevention equal to that of tubal ligations solely through the discretion of healthcare providers.

Echoing the coercion and violence of the past, long-acting reversible contraceptives have emerged and become entrenched as mechanisms of reproductive control of “the nots” in Tennessee. Specifically, the restricted access of contraception through LARC-only programming for those who are not white, not documented, not citizens, not sober, not free, and not wealthy reflect the strategic and systematic targeted reduction of reproduction among those who

exist in the Borderlands. Focusing on the emergence and entrenchment of LARCs in Tennessee, there are four primary questions which drive this research:

- 1) How did long-acting reversible contraceptives become the primary mechanism of reproductive control in East Tennessee? Following this shift, how did LARCs enter Tennessee jails?*
- 2) How do criminal justice system actors, health care providers, non-profit organizations, and community organizers work together to influence reproductive control?*
- 3) What is the role of long-acting reversible contraceptives in the carceral state?*
- 4) How are long-acting reversible contraceptives structured through the intersections of race, class, and gender?*

To understand LARCs in their contemporary form, we must turn to geography, law, and policy. LARCs originate in Tennessee in a complex juridical landscape where the desire to prohibit pregnancies among people who use drugs—and subsequently, reduce the number of neonatal abstinence syndrome (NAS) diagnoses—led to two policy strategies. First, the Tennessee Department of Health in East Tennessee developed a pilot program which focused on increased access to contraceptives to curtail the number of NAS diagnoses in Tennessee through a reduction of pregnancies by substance users. However, because the pilot program was based in the county jails, the only form of contraception those who were incarcerated could receive was a LARC. Nearly

simultaneously, a non-profit organization in West Tennessee emerged with a separate LARC-only program which was designed to prevent pregnancies as a solution to move women out of poverty by encouraging women to pursue educations and careers before raising a family.

I wanted to understand how two programs in the same state with dissimilar goals—educational attainment/career success and reduction in pregnancies among substance users—became fixated on LARCs as the solution to distinct social issues. The claims of success by both programs has made Tennessee a model state for LARC-only programming in jails as well as LARC-only programming as a tool of female empowerment. As such, agencies and organizations from other states have traveled to Tennessee as the first step in replicating the respective programs in other states. To explore this emergence and entrenchment of LARCs, I traveled the state of Tennessee interviewing key stakeholders in criminal justice, healthcare, non-profit, and activist/organizing spaces; attending conferences, presentations of research, recruitment and education events, resistance strategy meetings, and trainings; and collecting ephemera and archival data as a cartographical plotting of LARCs across the state. To understand these developments requires a sense of the long history of the region, including its foundations in conquest, extraction, and settler colonialism.

Bordered by the Mississippi River to the west and the Tennessee River to the east, West Tennessee became part of the state in 1818 following the

Chickasaw Indian Nation cession of their tribal land to the United States for \$300,000 (Kleber 1997). The rural, flat land and rich soil enabled the expansion of antebellum cotton farming before the shift to corn and soybean farming, as a largely agricultural-based economy. In the 2018 Senate and Gubernatorial elections, the counties of West Tennessee were mostly red, reflecting a majority of votes for Republican candidates. The only exceptions were Shelby and Haywood counties, which were blue, reflecting a majority of votes for Democratic candidates. Shelby and Haywood counties are the only two remaining majority-Black counties in the state. Although West Tennessee is rural, the dominant narratives from Middle and East Tennesseans about Western Tennessee focus on Memphis, the second largest city in the state, as a representation of the entire division.

Middle Tennessee, the largest division of the state, is encompassed by the Nashville Basin and the Highland Rim, which produce the rich, rolling hills of the geography in the central region. With this topography less conducive to the large-scale, crop-based farming of West Tennessee, the Middle Tennessee agriculture economy is based on livestock—including beef, poultry, and pork. Nashville—the largest metropolitan area in the state—is also the capital. With the exception of Davidson county, where Nashville is located, the remaining 40 counties voted overwhelmingly for Republican candidates. Likely related to the presence of Nashville and the influx of transplants to the region, Middle Tennessee is perceived as being the most progressive and liberal portion of the

state. With rapidly expanding population growth, an estimated 100 people moved to Nashville each day during 2017 (Reicher 2019).

Situated entirely within the Appalachian Mountain region, the land of East Tennessee moves between fertile river valleys, dense forests, and the tallest mountains in the state. It is from this topography which yields one of the most significant economies within the region—tourism. With more than 11 million visitors, the Great Smoky Mountains National Park, located at the borders of Tennessee, North Carolina, and Georgia, is the most visited National Park in the U.S. (National Park Service, 2020). Unlike the other two grand divisions, manufacturing and mining have a long history in East Tennessee. Specifically, the region is known for iron, coal, and pyrite mining. Additionally, East Tennessee has been central to the history of power innovation. Between the Tennessee Valley Authority's hydroelectric power initiatives and Oak Ridge National Lab's work on nuclear power, the East Tennessee division has made significant contributions that have gone largely unrecognized. Of the three divisions, East Tennessee has the most distinct political history. The region is one of the oldest Republican strongholds in the United States, and houses two districts which have been Republican controlled since 1859 and 1855, respectively. In fact, the congressmen from these two districts were the only two who did not resign following Tennessee's vote to secede from the Union.

The Grand Divisions go beyond organizational distinctions, and are, in fact, legally distinct. The 1835 Acts of Tennessee mandate the Supreme Court

should meet once per year in each division—West Tennessee, in Jackson; Middle Tennessee, in Nashville; and East Tennessee in Knoxville (Tennessee State Library and Archives, 2018). Codifying the three divisions into the state constitution reflecting the long-standing historical tensions within the state. Historical tensions which shape the development and implementation of state-wide policies and procedures.

Moving beyond the overview of the Volunteer State, this introductory chapter highlights the specific contexts, which when taken together, establish Tennessee as the model state for the emergence and entrenchment of LARCs as the primary mechanism for reproductive control. The public narrative of the opioid crisis focused, almost exclusively, on claims to mitigate the negative impact of maternal substance use on infants and children in a state which utilizes austerity-based politics. These conditions have converged to create the conditions whereby LARCs function as a new form of coercive sterilization, what I conceptualize as soft sterilization (Winters and McLaughlin, 2020).

Opioid Crisis

Across the U.S., the use and misuse of opioids have been at the center of criminal justice and public health conversations. Often focused on prescription opioid medications—hydrocodone, oxycodone, oxymorphone, fentanyl—and heroin, communities have struggled to implement strategies which reduce substance abuse, and have instead, relied on punitive policies which contribute to higher levels of incarceration. Not only increasing incarceration among groups

typically targeted by criminal justice policies—Black women, poor women—punitive responses to substance use have also increased incarceration among groups with historically low levels of confinement—specifically, white women. The public outcry surrounding opioid use is poised to surpass other recent substance use moral panics—methamphetamines and crack—as there is an assumed narrative of the opioid user as a sympathetic victim.

The face of the opioid crisis is constructed as young, white, and privileged. Through this lens the opioid abuser is an accidental addict, someone whose addiction is the byproduct of external forces as opposed to internal failings. This narrative falls in line with various forms of carceral feminism (Richie, 2012), whereby cries for recognition of disproportionate victimization among women simultaneously exclude the nuances of race, sexuality, and class within gendered victimization. As a result, carceral feminism centers the experiences of privileged white women while neglecting the harm experienced by Black women and women of color as a direct result of the punitive policies which claimed to protect them. Through this lens, the act of whitewashing opioid use, and the punishments associated with opioid use, obfuscates the precarity and violence of utilizing the criminal justice system as a replacement for healthcare. There is a long, complicated racialized history to this practice in the U.S., with various actors vying for forms of regulatory control, much like in the present moment.

Historically, there has been a reluctance to prescribe opioids to patients in need of pain relief. Early in medical professionalization, pain was perceived to

inevitable, an unsolvable problem. However, cocaine and morphine were used regularly throughout the U.S. as a method of home-based pain management. Initially unregulated, newspapers claimed an increase in crimes committed by Chinese and Black men against white women as being tied to cocaine and opioid use. There was, however, no evidence to substantiate these claims. In fact, there was far more evidence to support widespread cocaine and opioid abuse among whites (Helmer and Vietorisz, 1974) as there is now (National Institute on Drug Abuse, 2017). In the wake of racialized alarmism about street heroin and morphine dependence, the U.S. passed the Harrison Narcotic Control Act of 1914 (Jones et. al 2018). Critical to this legislation was the ability to prosecute physicians who prescribed opioids to patients with substance use disorder.

This racialized, punitive shift contributed to a significant reduction and reluctance of physicians to prescribe opioids from the 1920s until the late 1990s (Jones et. al 2018). Controversy surrounding the use of opioids in pain management for cancer patients and for patients suffering from chronic pain led to a keynote by the World Health Organization (1986) encouraging doctors to prescribe opioids for pain management. Simultaneously, medical researchers claimed patients receiving opioids for non-cancer pain management rarely became addicted (Max, 1990). Unfortunately, within the context of chronic pain, the assumptions about opioid use and addiction were unfounded. Only two studies reported the non-addictive use of opioids for pain management, one of which was not peer-reviewed (Jones et. al 2018). The conflation between

addiction levels of non-cancer induced chronic pain and cancer induced pain proved to be deadly.

Emerging in the mid-1990s, the American Pain Society launched a campaign to establish pain as the fifth vital sign (Campbell 1995). This initiative sought to add a patient's self-reported pain rating into the essential vital signs—temperature, blood pressure, respiratory rate, and heart rate—taken at each medical appointment. With more than 80% of patients seeking medical care reporting acute pain, prioritizing patient reported pain became an important requirement of patient-centered care (Wallid et al 2008). By 1999, pain as the fifth vital sign initiative had been adopted by the Veteran's Health Administration. To support this new form of patient-centered care, the Joint Commission developed and issued standards for pain management. Additionally, the Federation of State Medical Boards and the Drug Enforcement Agency agreed to reduce scrutiny of opioid prescribers as a mechanism to increase willingness of prescribers to treat patient pain with opioids. In this way, we see how contemporary reproductive justice issues are established through historical forms of institutional control around pain, health care, substance use at the intersections of race, class, and gender.

Following the Joint Commission standards, hospital administrators feared a loss in federal funding for non-compliance with the new pain management regulations. As a result, prescribers relied heavily on opioids to manage patient pain. Hospital administrators were correct: increased use of opioids led to

increased satisfaction rates among patients regarding their care. In fact, medical providers who refused to prescribe opioids were labeled as inhumane (Jones et. al 2018). For providers in pain medicine, specifically, the previous concerns about opioid use leading to addiction were replaced with a reliance on opioids as the most effective pain management treatment. In fact, providers now faced legal challenges from patients who argued the practice of not prescribing or under-prescribing opioids in pain treatment could constitute malpractice (Tucker 2004). Therefore, the incentives within the healthcare system to prescribe opioids outweighed previous concerns about possible patient addiction as a result of pain treatment.

Simultaneously, prescription opioid manufacturers were creating new formulations of existing medications. Specifically, extended release oxycodone was marketed as a safe alternative to traditional opioid medications. Pharmaceutical companies were aggressively marketing extended release opioids as having the benefit of high levels of pain relief with a built-in protection against medication abuse due to the time release. However, the assumptions of a safer, addiction-resistant medication were wrong. Between 1997 and 2002, prescriptions for extended release oxycodone increased from 670,000 to 6.2 million (Hwang et. al 2018). Prescribers, then, flooded communities with opioids through legal mechanisms. To combat the perceived misuse of opioids, Tennessee began to pass punitive legislation targeting substance users as the primary strategy to address the opioid crisis. Here, race and class converge

through processes of healthcare access and criminalization, leading to an emergent form of carceral feminism and soft sterilization. A carceral policy became the singular official response.

“Save the babies!”

Some of the earliest state policies designed to address public concerns surrounding opioid abuse in Tennessee targeted substance using mothers under the guise of mitigating the harms of substance use on infants and children. In 2013, Tennessee became the first state in the nation to mandate all hospitals report babies diagnosed with neonatal abstinence syndrome (NAS) to the Tennessee Department of Health. Following the passage of this legislation, an additional five states—Kentucky, Virginia, Georgia, Florida, and Arizona—have implemented mandated reporting by hospital staff for NAS diagnoses as well. NAS diagnoses are determined through a cluster of symptoms—excessive crying; tremors; trouble sleeping; sensitivity to light, touch, and sound; fever; sweating; vomiting; and diarrhea—along with reported or suspected opioid use by the mother. To confirm opioid use among mothers in delivery, hospitals perform drug tests on urine samples collected during labor through the general consent form signed by mothers upon admission to the hospital. Unsurprisingly, the creation of a mandated reporting protocol for NAS-symptomatic babies led to an increase in NAS diagnoses across the state.

In response, the Tennessee Department of Health piloted a program where women who were incarcerated in two county jails could receive a long-

acting reversible contraceptive for free to strategically reduce the number of babies born with NAS. With more than 80 percent of women with substance use disorders reporting an unintended pregnancy, healthcare providers characterize unintended pregnancies among substance users as a public health concern (McNeely, 2019). Targeting incarcerated women specifically reflects the demonization of criminalized and substance using women as more than 72 percent of babies diagnosed with NAS have mothers with prescriptions for the substances which cause NAS (Kid Central Tennessee, 2017). That is, although NAS can be caused through legal or illegal use of opioids, initiatives claiming to protect babies from opioid exposure primarily target women who are currently or previously criminal justice system involved.

The Tennessee Department of Health's system for administering long-acting reversible contraceptives was largely invisible until the summer of 2017 when a central Tennessee judge issued an official order to reduce jail sentences by 30 days for incarcerated women who volunteered to receive a Nexplanon subdermal contraceptive implant. This order was justified as necessary in order to "break a vicious cycle of repeat drug offenders with children" (Hawkins, 2017). The unprecedented order was the first in the nation to offer a reduction in jail time in exchange for receiving a LARC. The national controversy that emerged in response to the news coverage of the sentence reduction offer led the judge to rescind the order by July 2017 (Adams, 2018) . However, during the two months the order was in effect, more than 32 women signed up for the program and one

incarcerated woman, reportedly, cut a Nexplanon implant from her arm using a razorblade (Hawkins, 2017).

By 2018, Tennessee Governor Bill Haslam signed TN Together, the \$30 million plan to target Tennessee's opioid epidemic focusing on prevention, treatment, and law enforcement. The prevention component of TN Together "identifies women of childbearing age who are chronic opioid users and provides targeted outreach about risks, contraception and treatment in order to aid in the prevention of Neonatal Abstinence Syndrome (NAS) births" (Tennessee State Government, 2018, p. 1). Best practices developed by the Department of Mental Health and Substance Abuse Services (2016), explicitly highlight the recommendation of the Tennessee Department of Health to promote long-acting reversible contraceptives (LARCs) to women of childbearing potential who have a history of opioid use. Once again, this measure is just the latest intervention claiming to mitigate the negative effects of substance use on infants and children through the explicit control of women's reproduction by the state of Tennessee, further replicating the history of reproductive violence exercised through the convergences of geography, law, and policy against those who exist in the Borderlands.

Austerity as Usual

The seemingly contradictory legislation leading to the punishment of mothers who use opioids while not increasing resources for treatment of substance use disorder follow widespread practices of government austerity—

policies and practices which claim to promote growth by cutting the state's budgets (Blyth, 2015). Those in favor of austerity politics argue an economy in crisis will become balanced through an increase in private spending, reflecting confidence in the economy by the business class, as a result of the reduction of public spending (Blyth, 2015). Specifically, concerns on the ever-expanding state deficits and fiscal crises have positioned the sole solution to be austerity measures which make drastic cuts to social welfare programs; thus, disproportionately harming poor people (Abramovitz, 2006; Wong, 2018). At the same time, municipalities and states have increased funding earmarked for policing and security, even during times of fiscal crisis (Vargas and McHarris, 2016). Tennessee, like the rest of the states in American southeast—North Carolina, South Carolina, Georgia, Florida, Alabama, and Mississippi—did not adopt the Medicaid expansion, a decision in line with previous austerity-based solutions in the state (Shaffer, 2018).

Tennessee-based researcher Jonathan Metzl (2019) argued that people who lived in “Trump country felt the burden of centuries of history that charged the idea of government intervention in general, and into health care specifically, with race and class politics—often accompanied by overt xenophobia and racism” (pg. 123). This perspective was evident in Metzl's interviews where one participant, a 41-year old uninsured white man living in Tennessee, explained his resistance to the Affordable Care Act (ACA): “Ain't no way I would ever support Obamacare or sign up for it. I would rather die. We don't need any more

government in our lives. And in any case, no way I want my tax dollars pay for Mexicans or welfare queens” (pg. 3). This participant—who was disabled due to years of manual labor and advanced, untreated hepatitis C—admitted he would rather die than expand healthcare services to those he felt were undeserving, in spite of the deadly consequences this ideology would have in his own life.

The dogmatic allegiance of removing interference from the state in healthcare access were reflected primarily in discussions of financial cost. Given the required, intensive post-natal care, often including a stay in the neonatal intensive care unit (NICU), local medical professionals and state legislatures often center the concerns of NAS treatment on the number of resources used by the mothers who use opioids while pregnant and the babies who are exposed to opioids in utero. Despite narratives which claim substance abuse and NAS are public health crises, the discussions of the crises are less focused on diagnosis or treatment, and are instead, situated around financial costs. In East Tennessee—a region of the state with NAS rates four times the national average—the state Medicaid program spent \$53 million dollars on the care provided to NAS-symptomatic babies (McNeely et al. 2019). In 2013, in the face of these high rates of NAS—and the related high costs associated with NAS treatment—Tennessee committed to the prevention of pregnancy among substance using women through reproductive control as the primary mechanism of cost reduction.

Chapter Summary

This chapter introduces the study by elucidating the confluence of factors necessary for Tennessee to become the “model” state for reproductive control through the use of long-acting reversible contraceptives (LARCs). Chapter 2 outlines the theoretical frameworks which serve as the foundation of this research. Bringing Reproductive Justice and mass surveillance into conversation, I expand the field of mass surveillance by shifting away from the typical construction of the impact of the carceral on the neutral subject to the impact of the carceral through the interlocking oppressive systems of criminalization, class, and race in relation to reproductive autonomy. In chapter 3, I outline the data collection process and the use of Situational Analysis as the primary method of data analysis.

Chapter 4 explores the inextricable connections between the public and private spheres. Specifically, LARCs would not have become enshrined as the primary device for reproductive control without the influx of private funding through public infrastructures. In Tennessee, three policy structures—the rejection of the Medicaid expansion and a potential shift to a block grant system, reduced funding for Title X partnered with the implementation of the Gag rule, and the state mandate for abstinence-only education—converge to produce barriers to healthcare which can only be overcome with the infusion of private funding sources. Chapter 5 addresses the nuanced ways in which the barriers of reproductive healthcare access, as detailed in the previous chapter, are encoded

in the systematic identification and targeting of oppressed populations at the complex intersections of criminalization, class, and race. Elucidating the ways in which seemingly separate key stakeholders—criminal justice system actors, non-profit organizations, and state agencies—work together to form invisible webs of oppression along lines privilege and disadvantage. In chapter 6, I explore the response and resistance to reproductive control by community members, activists, and organizers. By highlighting the work of collectives, the impact of mutual aid, and the reconceptualization of borders, I challenge the hegemonic narratives about the community strategies designed to support bodily autonomy. Finally, chapter 7 concludes the dissertation by positioning my work within a larger conversation of reproductive liberation. With insight into the process formation of reproductive control through LARCs, I argue for a reconceptualization of LARCs within mainstream narratives and of resistance strategies to ensure reproductive autonomy for all.

CHAPTER TWO

(RE)THINKING REPRODUCTIVE CONTROL

The stories of reproductive control in the United States are myriad. I integrate the frameworks of Reproductive Justice and mass surveillance to elucidate the process through which long-acting reversible contraceptives became mechanisms of reproductive control in Tennessee, Reproductive Justice expands the concept of surveillance beyond the carceral supervision of incarceration, probation, or parole to the prevalence of carceral logics in spaces not typically understood as carceral spaces—schools, non-profit organizations, and healthcare providers. Through this integration of Reproductive Justice and mass surveillance, I challenge previous constructions of reproductive control as forced sterilizations and forced births by identifying the logics and processes of systematically preventing births among “undesirable” groups through coercive LARC programming as a new form of reproductive control.

History of Reproductive Control

To examine the current context, a historical understanding of the practices of reproductive control in the United States is essential. Throughout the second half of the 19th century, a movement to sterilize people who would produce “undesirable” children emerged. Supported by physicians, social workers, social scientists, lawyers, social reformers, women’s groups, and politicians, the eugenics movement provided the foundation for five decades of involuntary, legal sterilization in the United States (Alzate, 2009; Cahn, 2007; Largent, 2007;

Lombardo, 2011). Characterizing poverty, sexual promiscuity, substance use, criminality, mental illness, and disabilities as social and moral ills, nearly two-thirds of states passed laws classifying more than 63,000 people to be involuntarily sterilized. The 1907 Indiana Eugenics Law became the first sterilization law in the United States. The timing of sterilization laws corresponded with the emergence of surgical sterilization procedures—vasectomies and tubal ligations—deemed less radical and safer than previous methods of sterilization through castration or hysterectomy (O'Hara & Sanks, 1956). However, the Indiana Eugenics Law legalized the already present practices of sterilizing people who were incarcerated (Reilly, 1991; Lombardo, 2011).

Over the next four years, more than 14 states enacted involuntary sterilization laws. The eugenic-based sterilization laws did not go unchallenged. Prior to the enactment of the 1907 Indiana law, the first pieces of sterilization legislation—an 1897 Michigan bill and a 1905 Pennsylvania bill—passed in both the state Senates and state Houses before being vetoed by the states' respective governors. From 1912-1921, eight eugenic laws—including Indiana—faced constitutional challenges with seven of the eight challenges successfully overturning the enacted legislation (Reilly, 1991). Although the overturned laws were, at times, replaced by additional sterilization legislation, the subsequent laws had more constraints than previous legislation including limitations on

sterilizing people who were incarcerated or prohibiting sterilization procedures as punitive measures.

In 1924, Carrie Buck, a then 18-year-old woman, who had recently birthed a child out of wedlock was committed to a state facility due to her alleged intellectual disability. Fearing a pattern of additional “illegitimate” births of children with intellectual disabilities, the superintendent of the state facility petitioned and received approval for Carrie’s sterilization (Largent, 2007; Solinger, 2005). R.G. Shelton—Buck’s attorney—immediately appealed the sterilization decision to the Circuit Court of Amherst County, Virginia. With the circuit court’s decision to uphold Buck’s sterilization without dissent, Shelton appealed Carrie’s case to the United States Supreme Court. Ultimately, in an 8 to 1 decision, the Supreme Court upheld the involuntary sterilization law in Virginia. Following the Supreme Court decision in *Buck v. Bell*, the number of states with involuntary sterilization laws increased from seventeen to thirty. Thus, *Buck v. Bell* facilitated the enactment and implementation of involuntary sterilization programs (Lombardo, 2011).

By 1932, the number of women sterilized under the involuntary sterilization policies exceeded the sterilizations of their male counterparts. Sterilizations of women in 1929—2,362 completed operations—exceeded the completed sterilizations of women in 1927 and 1928 combined. Subsequently, the number of sterilizations increased each year until the operations peaked in 1932 when 3,921 sterilization operations were completed. Reilly (1991)

speculates that the economic constraints of the Depression prohibited states from building additional institutions to manage growing populations with “undesirable” traits.

In the South, the pathway to state-sanctioned reproductive control through eugenics-based logics was more challenging due to the lack of public infrastructures. Political coalitions—which had conspired to successfully overthrow the post-Civil War Reconstruction and to maintain white supremacy—systematically destroyed high-quality healthcare providers by denying federal funding until closure of public hospitals and education by dismantling the public school systems. Strategies designed to limit public healthcare and education disproportionately harmed Black and poor communities in the South. The lack of medical care coupled with the public disdain for government interference served as significant barriers for eugenicists in the South (Lombardo, 2011). Thus, by the time the South adopted “progressive” sterilization legislation in the late 1930s, the sterilization legislations were perceived to be outdated (Larson, 1991). States developed strategies to institutionalize cases deemed to be most severe, while sterilizing and paroling those characterized as less severe. For the people who were institutionalized who understood the sterilization for parole exchange option, parole was a powerful incentive to consent to sterilization operations.

By 1935, physicians in the American Association for Mental Deficiency argued that “all defective women in their reproductive years should be sterilized” (Reilly, 1991, p. 93). Focused on the connection between undesirable genetic

traits and a “deprived early home life” as the foundation for developmental issues in young children, eugenicists appealed to the economically constrained state budgets with “progressive” sterilization policies by calling for the involuntary sterilization of women of reproductive age with undesirable traits—especially if that woman had already been labeled a “bad mother” (Reilly, 1991; Kluchin, 2009). Involuntary sterilization came to represent a mechanism of state reproductive control that limited the proliferation of less desirable traits under the guise of state fiscal responsibility. The state could claim reducing the number of children who were identified as a drain on the system—those who would need more resources due to an assumed future of poverty, disability, or criminality—would ensure more resources for children who were identified as being deserving of resources—those who were assumed to be contributing financially, able-bodied, and non-criminal justice system involved. That is, state financial decisions, then, reflected larger social values rooted in white supremacy, heteropatriarchy, and capitalism.

In 1974, state sterilization programs were halted due to a hold on federal funds for involuntary sterilization pending a review by the United States Department of Health, Education, and Welfare. In spite of the moratorium of sterilization procedures without newly developed precautions to prevent deceptive or coerced sterilization, the ACLU reported rampant non-compliance with the policies designed to preserve the rights of vulnerable populations (Kruse, 2014). The non-compliance was targeted by local, grassroots anti-involuntary

sterilization organizations. As a result of legislative successes, regional activist organizations were able to demand government compliance of approved voluntary sterilization procedures (Kruse, 2014).

Too often, this brief history of reproductive control in the U.S. is discussed as an atrocity of the past—a horror we have moved beyond as a culture.

Particularly in the wake of the landmark Supreme Court case, *Roe v. Wade*, many white feminists claimed victory over state sanctioned reproductive control in the name of progressive politics. Missing from the mainstream understanding of reproductive control in the U.S. is an awareness of the ways in which self-identified “progressive” narratives are often the result of policies and legislation systematically designed to increase births among “desirable” populations—white, wealthy families—and to decrease births among “undesirable” populations—Black, brown, poor, disabled, and queer families (Wu et al., 2017; Zampas & Lamačková, 2011).

Reproductive Justice

Using an intersectional analysis to challenge the processes reproductive control, Reproductive Justice emerged as a convergence of reproductive rights and social justice. Reproductive justice is a theory, praxis, and movement created and developed by Black women in 1994 as an analysis tool that builds upon the work of Black feminist thought and Black feminist theory to explore the racial, economic, and social inequalities that impact and shape lived experiences. Reproductive justice is “purposefully controversial in that it disrupts the

dehumanizing status quo of reproductive politics” (Ross, 2017, p. 11).

Foundationally, there are three human rights at the core of reproductive justice:

1) the right to have a child under the conditions of one’s choosing; 2) the right not to have a child using birth control, abortion, or abstinence; and 3) the right to parent children in a safe and healthy environment free from violence by individuals or the state (Ross, 2017). To fulfill each of these human rights for all would necessitate reproductive autonomy and reproductive emancipation, and thus, represent a standard against which reproductive healthcare and legal rights can be compared.

Reproductive justice echoes the assertion from the 1977 Combahee River Collective statement that: “If Black women were free, it would mean that everyone else would have to be free since our freedom would necessitate the destruction of all systems of oppression” (Eisenstein 1978: 215). Essential, then, to the work of reproductive justice is the reorganization of reproductive politics around an intersectional framework. Intersectionality—which emerged from the tradition of Black feminist thought before being enshrined by Crenshaw (1989)—is a lens through which the collision and intersection of power in interlocking identities is made apparent. Collins (1990) furthered understandings of the ways in which the systems of race, gender, and class are organized, and shape lived experiences through her development of the matrix of domination. An intersectional perspective is essential to understand current politics and policies

of reproductive control as histories of reproductive oppression are inextricably connected to the intersecting identities.

Standing in contrast to the fight for reproductive autonomy and liberation is the traditional reproductive rights movement. Centered on the legal rights of reproductive choice that have, historically, focused on the right *not* to have children through access to birth control and the right to terminate a pregnancy, reproductive rights have largely represented the interests of middle class and wealthy white women. Conversely, reproductive justice utilizes a human rights paradigm to integrate the legal rights of recognition and access to comprehensive reproductive healthcare. Centering social justice through the work of grassroots organizing and direct action targets social inequalities to generate transformation of the lived experience for the most vulnerable communities. Reproductive justice is “an amplifying organizing concept to shed light on the intersectional forms of oppression that threaten Black women’s bodily integrity” (Ross, 2017, p. 291).

The histories of reproductive oppression are inextricably connected to the intersecting identities of the subject. In the U.S., the reproductive control of indigenous and enslaved black women reflected a divergence of tactics—sterilization versus forced reproduction—in a convergence of politics—reproductive and population control—motivated to maintain the structures of white supremacy, patriarchy, and capitalism (Ross and Solinger 2017). I argue the coercive administration of long-acting reversible contraceptives reflect a

continuation of reproductive control as an updated mechanism designed to maintain and reproduce white supremacy and heteropatriarchy. Broadly constructed, reproductive control through the utilization of LARCs includes limited, coerced, deceptive, or forced insertion.

Although mainstream awareness of reproductive control coincided with the emergence of the reproductive rights movement in the 1960s, the history of reproductive control is the very foundation of U.S. history. With advances in medicine, policies regulating reproduction converged with emergent technologies as early as the 1907 Indiana Eugenics Law, where the governor of Indiana mandated sterilization for “certain individuals in state custody” with “criminality, mental problems, and pauperism” assumed to be hereditary (Indiana Historical Bureau 2017). The contentiousness of state sanctioned reproductive control was apparent through the shifting legislation— where the 1907 Indiana Eugenics Law was ruled unconstitutional in 1921, reinstated in 1927 on appeal, and abolished in 1974 as part of a mass repeal of sterilization laws in Indiana.

However, Indiana was not alone nor in the minority in the implementation of sterilization laws, policies, and programs. In 30 states across the U.S., laws targeted the “insane, feeble-minded, dependent, and the diseased” as unable to manage their own reproductive decisions as a justification of state-sanctioned sterilization programs (Kruse 2014). The state sterilization programs were halted as a result of the 1974 hold on federal funds for involuntary sterilization pending a review by the U.S. Department of Health, Education, and Welfare. In spite of

the moratorium of sterilization procedures without newly developed precautions to prevent deceptive or coerced sterilization, the ACLU reported rampant non-compliance with the policies designed to preserve the rights of vulnerable populations (Kruse 2014). The non-compliance was targeted by local, grass roots anti- forced sterilization organizations. As a result of legislative successes, regional activist organizations were able to demand government compliance of approved voluntary sterilization procedures (Kruse 2014).

Across the history of state-sanctioned reproductive control, the bodies of black and brown women have routinely been the primary targets. In one of the most notorious cases of targeted sterilization in the United States, thousands of women were sterilized in North Carolina over 40 years. Of the women sterilized in North Carolina, 65 percent of sterilization procedures were committed against Black women, despite Black women only making up 25 percent of the state population (Kruse 2014). At its peak, sterilization was so common among Black and brown women in the south, hysterectomies became known as the “Mississippi appendectomy” (Roberts 2000).

Acts of forced sterilization or sterilization abuses continued throughout the U.S. In the early 1970s, national news outlets reported the widespread performances of unnecessary hysterectomies on Black and brown women by medical residents for training purposes (Roberts 1997). The rhetoric about the perceived increase in Black women using government benefits motivated

legislation to further reproductive control practices as a means to strategically limit the number of children black women could have.

Black women have not been the only targets of systematic sterilization practices. A central feature of the colonial occupation of Puerto Rico by the United States has been the widespread practice of contraceptive testing and sterilization. By 1965, one-third of Puerto Rican mothers of childbearing age had been sterilized making Puerto Rican women 10 times more likely to be sterilized than other women in the United States (Kruse 2014). Legislation and policies implemented in Puerto Rico reflected the focus on population control. Specifically, the population control initiatives did not provide Puerto Rican women with the array of contraceptive options available. Instead, women in Puerto Rico were subjected to coercive sterilization and long-acting reversible contraceptives reflecting the primary goal of the U.S. government to systemic, targeted depopulation of specific, identified racial groups.

For indigenous women in the United States, the implementation of health services provided by the Indian Health Service led to the integration of widespread use of sterilization procedures. From the beginning, IHS family planning initiatives in 1965 through the 1970s, an estimated 25 percent of Indigenous American women had been sterilized (Kruse 2014). As a demonstration of the routine nature of involuntary sterilization procedures, the IHS sterilized two Indigenous girls who had been admitted for emergency appendectomies without consent of the girls or their parents.

The ability to reproduce new tribal members through heredity is critical to perpetuating tribal lines. As Kruse (2014) highlights, sterilization abuse serves as a rights violation in addition to the decline in social status and emotional well-being within the tribe. The development of policies and procedures for indigenous people from a Western, white perspective perpetuate a multi-cultural, neoliberal colorblind framework (Richards 2013, Grzanka et al. 2016, Goldberg 2015). That is, through the infantilizing of indigenous people, white Westerners can talk about the importance of maintaining tribal distinctions while simultaneously applying an outsider paradigm without collaboration with indigenous people. These historic parallels described above highlight the myriad ways in which reproductive control has been sanctioned and legalized by the state.

As highlighted above, the first official eugenics legislation—the 1907 Indiana Eugenics Law—included incarcerated, criminalized, and poor women as primary targets of reproductive control through sterilization. Incarcerated women have continued to be targeted with coercive sterilization practices as recently as 2013 in California (Walden, 2013). Despite official abolition of involuntary sterilization practices, historical precedent indicates coercive reproductive control will continue in spite of legislative prohibitions.

In the brief overview of the historical lineages of sterilization abuses of Black women, Puerto Rican women, indigenous women, and criminalized women in the United States, the evidence is clear: reproductive control of “undesirable” populations has never been perpetrated through covertly constructed policies

buried in the minutiae of legislative language (Beckett & Herbert, 2009). Instead, legislation regulating reproductive control were written and implemented to limit and control women's bodies. To assume the abolition of formalized reproductive control policies have been abandoned under the current political and legislative rhetoric reflects an overly simplistic perspective of the ways in which reproductive oppression is currently implemented. The persistence of reproductive control is evidenced by the continued experiences of Black, brown, and criminalized women targeted through public and private long-acting reversible contraceptive initiatives.

The overrepresentation of reproductive control among Black and brown women mirrors the disproportionate targeting of Black and brown women in the criminal justice system as both processes uphold structures of white supremacy, heteropatriarchy, and capitalism. Even among geographic areas where the women targeted for reproductive control were predominantly white—reflecting the regional racial and ethnic demographic characteristics of the state—reproductive justice provides insight into the precarious nature of whiteness with the convergence of intersecting identities—class, sexuality, criminality. That is, disparate treatment—whether criminal and medical—of women continuously shift to preserve white supremacist ideals (Cooper Owens 2017), and the seemingly ever expanding “carceral creep” draws more women under the surveillance by the state (Kim, 2018; Carlton, 2018).

Mass Surveillance

The inability to escape state surveillance and control reflects the proliferation of the carceral state through mass incarceration and mass supervision (Beckett & Murakawa, 2012). Mass incarceration reflects the historically unprecedented number of people—many of whom are disproportionately young, black, and poor—who are incarcerated in the U.S. Originally identified as mass imprisonment, Garland (2001) argued that although we know the cost of imprisonment on the individual we do not yet know the cost of mass imprisonment on society. Tracing state control from mass incarceration to carceral citizenship is critical to understand the way in which the state has been able to infiltrate and regulate the most intimate aspects of our lives—our reproductive decisions.

Mass incarceration is not sufficient to convey the pervasiveness of the criminal justice system. Scholars have, instead, conceptualized the carceral state as an expansion beyond the millions of incarcerated people in prisons and jails to include the “development, operation, and effectiveness of criminal justice institutions (including the police) in the context of US penal expansion and welfare retrenchment” and satellite social service/non-profit agencies (Beckett 2018: 237). That is, the carceral state represents the general expansion of penal institutions within disproportionately poor and disproportionately black communities that shapes the daily lived experience through surveillance and policing. The proliferation of criminalizing logics into non-criminal justice system

institutions—education, healthcare, social welfare—can serve as a barrier preventing those who have had previous contact with the criminal justice system from upward mobility (Beckett & Murakawa, 2012; Bernstein, 2010).

Within the carceral state, crime and criminality are reduced to actuarial assessments of risk and likelihoods (Hannah-Moffat, 1999; Hannah-Moffat, 2005; Hannah-Moffat, Maurutto, & Turnbull, 2010). Werth (2018) reconceptualizes risk assessment as a tool that “not only *influence* penal practices, they *constitute* and *structure* the realm in which they operate and the targets (penal subjects) upon which they report” (pg. 2). Assessments of risk are developed under a presumption that the subject of the assessment is always already a risk.

Therefore, any measure that purports to be descriptive in nature—just reporting percentages or likelihoods of a behavioral response—denies the generative power of risk assessments to create the subject it claims to measure. In other words, the subject of the risk assessment is constructed by the assessment as inherently risky and is prohibited from being classified outside of determined risk. Any subject constructed as risky must then fall under the supervision of the state.

Mass supervision entails the official punitive actions established and employed by the state to manage previously incarcerated people (McNeill and Beyens 2013, Miller and Stuart 2017). Often supervision is conceptualized as the more than 4.5 million people under formal state supervision through probation (3.7 million people) and parole (840,000) (Prison Policy Initiative, “The Whole Pie”, 2018). Mass supervision expands this framework from a focus on probation

and parole to include the ways a criminal conviction creates a carceral citizenship that “changes the nature of one’s interactions with public welfare agencies, the labor and housing market, with their families and in civic life” (Miller and Stuart 2017: 536). However, Loyd (2011) argues that “confinement, in turn, effectively becomes the mark of criminality, regardless of criminal conviction” (pg. 12). In other words, a conviction is not necessary to establish one as a carceral citizen—an alternate citizenship status experienced by the raced, gendered, and classed targets of the criminal justice system.

Carceral citizenship “is produced by crime control practices born in the era of mass incarceration and its community analog, mass supervision” and presumes that one has committed a crime (Miller and Alexander 2016: 296). With these preconditions, the carceral citizen is not denied the enforcement of constitutional rights to citizenship. Instead, the carceral citizen has distinctive rights and claims which can be made against the state that are differentiated from other vulnerable populations. That is, the carceral citizen receives access to services—mental or physical healthcare, for example—that the very poor would not be able to access without involvement with the carceral system. Carceral citizenship, then, allows for the “constitutionally justified forms of exclusion based solely on the presumption of legal guilt at some point in their lifetimes” (Miller and Alexander 2016: 297). The expansion of criminal justice logics into interventionist social welfare policies produced community-based actors and agencies to manage the carceral citizen.

The convergence of non-conviction status and carceral citizenship is apparent in child welfare cases. The Department of Children and Family Services (DCFS) can temporarily or permanently remove children from the home or investigate claims of abuse or neglect without pursuing criminal charges. That is, child welfare cases are adjudicated in civil, not criminal, court. Therefore, parental rights could be terminated without a criminal conviction of any kind; thus, the parent—who is likely to be disproportionately black, poor, and a mother—being investigated by DCFS becomes a carceral citizen without a criminal conviction (Roberts 2007). The status of carceral citizenship provides eligibility for social services—housing assistance, drug and alcohol treatment, or parenting classes—that were likely not previously accessible by the parent being investigated due to structural barriers and are not available to poor, non-system involved parents due to their citizenship status outside of the carceral state.

Although the recognition of the paradox of parenting as a carceral citizen in the carceral state has been detailed, there is no analysis of the distinct implications of mass supervision on reproductive control. I argue LARCs serve as the exemplar mechanism for reproductive control. Taken together, the characteristics of LARC—being highly effective for multiple years, not requiring any action on behalf of the user to be effective, and requiring a medical provider for safe removal—provide a clear pathway to reproductive control of the carceral citizen. It is unsurprising, then, that reproductive healthcare in Tennessee for women who have been, or could be, labeled as criminal—Black women,

undocumented women, incarcerated women, poor women, substance using women—has narrowed to LARC-only contraceptive options. I argue the criminal justice system, reproductive healthcare providers, and non-profit organizations work strategically to stop women who are carceral citizens from having children through the proliferation of LARC-only jail and community services. Trouillot (1995) claimed “the ultimate mark of power may be its invisibility; the ultimate challenge, the exposition of its roots (pg. xix). As a framework, reproductive justice shifts the analysis from the essentialized identity to the “webs of social structures that affect reproductive decision making” generating a position from which the transformative power of reproductive autonomy and emancipation become manifest (Ross 2017:300).

Reproductive control is critical to the foundational colonial project in the United States. Solinger (2005) argues: “from the white settlers’ point of view, population growth among Europeans was crucial for establishing, developing, enlarging, and defending their land claims, their accumulation of wealth, and their political control of the settled territories” (p. 18). Critical to the desired United States expansion of colonization were: the production of white citizenry, the production of labor and laborers through enslaved Black women, and the destruction of indigenous communities and culture through warfare and “civilization” efforts. Free white women were not subjected to same violences of colonization and chattel slavery, reflecting the racialized and gendered

oppression at the very foundation of life in the United States which continues to structure reproductive control today.

Throughout Reconstruction and Jim Crow, when Black reproduction no longer served as a capitalistic investment of chattel slavery, Black fertility was no longer beneficial to the colonial project. Black sexuality, reproduction, and motherhood were characterized as transgressive and, often, the byproduct of poor choices. The emergence of social work and social welfare programs—exemplified by Jane Addams and Edith and Grace Abbott—were designed to address the needs of poor white women. White mothers who represented hegemonic racial, cultural, and moral ideals of the “cult of true womanhood” (Giddings, 1996, p. 47) had access to aid and assistance which further entrenched racialized ideologies of care (Solinger, 2010; Abramovitz, 2006). Black women, through the racialized ideologies of white supremacy, were excluded from narratives and benefits of virtuous womanhood signifying the pervasive and accepted institutionalized white violence (Ross & Solinger, 2017; Ocen, 2012; Ocen, 2013; Ocen 2017).

From the 1930s-1960s, under the guise of expanding “progressive” policies, federal social welfare programs—Aid to Dependent Children (ADC), later Temporary Aid to Needy Families (TANF); Food Stamp Program (FSP), later Supplemental Nutrition Assistance Program (SNAP); and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)—emerged to supplement state funding for the early mothers’ aid laws which had

been passed through the work of pioneering social workers, like Addams and the Abbott sisters. In spite of the intentions of social workers to use this shift to federal funding-based programming as a way to reduce the stigma of single motherhood and of receiving public assistance, the results of the legislation were invasive and demeaning to recipients—states routinely paying significantly less to families than their financial need, policies naming the male partners of single mothers as “stepparents” as a way to reduce monthly payments, and counting ADC payments as income to reduce the amount of SNAP funding each month. Thus, the history of social welfare programming claiming to provide progressive transformation of the lives of poor, Black, brown, and disabled people have often created an illusion of opportunity which only serves to obfuscate structural oppression.

The emergence of programs like Aid to Dependent Children (ADC) claimed to support women in need of financial assistance, while in reality, providing women minimal financial support with no additional resources—such as childcare. With the social “concern” of population growth concentrated on Black women, immigrant women, and poor women, the surveillance required by receiving government assistance allowed the policing of women’s sexual and reproductive behaviors, often criminalizing women who became pregnant while receiving assistance (Ross & Solinger, 2017; Solinger, 2010; Abramovitz, 2006). Punitive actions against mothers on assistance reflected racialized ideologies.

Compelling Black women and women of color to consent to sterilization in exchange for social services—daycare assistance, housing assistance, SNAP, and Medicaid—contributed to their higher rates of sterilization (Blake, 1995). From the 1970s onward, sterilization was the fastest growing method of birth control with most sterilizations performed on women of color (Roberts, 1997). White women, by comparison, faced access barriers to tubal ligations, and were often required to receive clearance from two physicians and a psychiatrist, in addition to meeting a desired formula ($\text{age} \times \text{number of children} > 120$) (Solinger, 2005).

The political fixation on reproductive choice—typically referring to contraceptive and abortion access—exemplifies the non-existent reproductive choices that have always existed for Black women, indigenous women, and women of color. Reproductive history in the United States is a history of reproductive injustices. The lived experiences of women are constrained through race, class, sexuality, and ability in ways that vary with one's positionality. Long-acting reversible contraceptives (LARCs) epitomize this nuance. For privileged white women with access to health insurance and reproductive healthcare, LARCs are highly effective contraceptive devices that require no additional action on the part of the user after insertion. The extremely low-risk of unintended pregnancy with LARCs can be emancipatory for privileged women who are able to have the device removed if that is what they choose to do. For Black women and women of color, who are disproportionately poor and criminalized, LARCs do

not represent the same experiences of emancipation. Lack of access to comprehensive sex education, regular reproductive healthcare providers, transportation, and language translators influence the ways in which Black women and women of color navigate their reproductive health.

Organizations like A Step Ahead, a Tennessee-based non-profit which provides free LARC and transportation to and from the medical appointment to any woman who resides in an area where A Step Ahead operates, and the Colorado Family Planning Initiative, an exemplar state-administered LARC program, focus on populations who are most in need of reproductive healthcare assistance (Hillard, 2013; Tarico, 2017; Turnbull, 2019; Wolk, 2015). These seemingly progressive organizations tout LARC as the solution to the social ills of poverty and low educational attainment by reducing unintended pregnancies. However, it is the positionality of those in need—being poor, undocumented, Black, or disabled—which reproduces rhetorics and patterns of eugenic sterilization. By focusing on the removable nature of the device, non-profit and state-sponsored organizations avoid the stigma of previous involuntary sterilization programs; thereby, allowing for the strategic reduction of pregnancies among Black women, indigenous women, women of color, and poor women through the targeted provisions of LARC.

Chapter Summary

The history of the United States is fraught with policies and procedures of reproductive control motivated by the desire to maintain the structures of white

supremacy, heteropatriarchy, and capitalism (Ross & Solinger, 2017; Harris, 2011). These patterns are then, disproportionately, replicated and enacted in spaces like Tennessee where the historical resistance to, what is perceived as, government interference and an embrace of austerity politics have created a chasm whereby oppressed groups are unable to access the services and resources they need to survive. I have provided an overview of the history of reproductive control in the United States to demonstrate the ways in which disparate state interventions—forced birth, forced sterilization, reduction of welfare support—reflect the ways in which bodies are targeted at the complex intersections of gender, race, class, citizenship status, and ability in the carceral state (Zampas & Lamačková, 2011). I integrate the frameworks of Reproductive Justice and mass surveillance to elucidate the ways in which “progressive” policies which often claim to provide resources as a scaffold to lift families out of poverty are, instead, mechanisms of the ever-expanding reach of the carceral state (Brown & Schept, 2017; Kim 2018; . This reframing identifies the explicit mechanisms of mass surveillance within the Reproductive Justice framework while, simultaneously, expanding the field of mass surveillance to center the embodied experience of surveillance for poor, Black, brown, disabled, and queer people.

CHAPTER THREE

METHODS

My dissertation is an ethnography of long-acting reversible contraceptives (LARCs), with particular focus on the emergence and entrenchment of LARCs in Tennessee as the primary mechanism for reproductive control. Although LARCs are not new contraceptive technology, the cost of the device and the lack of medical professionals trained in insertion and removal had previously relegated LARC use to privileged, white women with access to a regular healthcare provider.

With no other known research tracing the emergence and entrenchment of separate, yet simultaneous, systematic LARC-based reproductive control in county jails and through non-profit organizations, my dissertation is designed to elucidate the empirical construction of this particular instance of reproductive control through Situational Analysis. To reiterate, there are four primary questions driving this inquiry: 1) *How did long-acting reversible contraceptives become the primary mechanism of reproductive control in East Tennessee? Following this shift, how did LARCs enter Tennessee jails?* 2) *How do criminal justice system actors, health care providers, non-profit organizations, and community organizers work together to influence reproductive control?* 3) *What is the role of long-acting reversible contraceptives in the carceral state?* 4) *How are long-acting reversible contraceptives structured through the intersections of race, class, and gender?*

Given the lack of research in this area, I structured my data collection around three qualitative techniques: in-depth interviews, participant observation, and archival analysis. Participant interviews were semi-structured to maintain consistency in conversations between participants while allowing the participant to shape the direction of the interview based upon their perspectives. I utilize a Reproductive justice paradigm, which foundationally, prioritizes the multiplicity and complexity of subject positions, as they exist both with and against dominant narratives of reproduction and sexuality (Ross, 2017). In addition to formal interviews, I completed eighteen months of participant observation across five areas in Tennessee. In addition to the three Grand Divisions of Tennessee—West, Central, and East Tennessee—I have identified South Tennessee (Chattanooga and the surrounding area) and Memphis as distinct spaces which must be considered separately from East and West Tennessee, respectively. East Tennessee—both culturally and geographically—reflects its position within the Appalachian mountain region, while Chattanooga and the surrounding areas are closer to—culturally and geographically—north Georgia. Similarly, West Tennessee—excluding Memphis—reflects the cultural and geography of the Mississippi delta, while Memphis has distinctly urban geographic and cultural characteristics.

I observed organizations and key stakeholders across intellectual spaces—workshops, community meetings, research presentations, public education—and cultural spaces—organization receptions, art shows, fundraising

events, parties—where LARCs are identified, maintained, and resisted as the solution to social ills. To provide additional insight into the shifting narratives surrounding LARC and reproductive control in Tennessee, I drew upon primary sources across organization ephemera, propaganda, speeches, interviews, photographs, and newspapers. Although not comprehensive or distributed equally across key stakeholders, the archive provides insight into the context from which key stakeholders develop their perspectives.

Based on previous research experience in the field and validated by the initial situational map, I have outlined the connections between criminal justice system actors, reproductive health providers, non-profit organizations, and organizers that served as the participants for this project. Criminal justice system actors include judges, prosecutors, defense attorneys, and jail administrators. The LARC program in the East Tennessee county jail system was developed by a local judge—in collaboration with the Tennessee Department of Health—promoted by prosecutors, and granted access to incarcerated women by the county jail administrator. Defense attorneys in Tennessee initiated lawsuits in response to the sentence-reduction judicial orders, and can provide insight into the ways in which their clients have experienced the jail-based LARC program. Although I reached out to several criminal justice system actors, this category had the fewest participants. Despite being state employees, and thus, theoretically mandated to be accountable to the public, many criminal justice system actors responded to my requests for interviews with: “I checked with my

administration, and I am not permitted to share any information about the [LARC] program. I do apologize for the inconvenience” (email response, 10/2/2019). At the time of my interviews, the public outcry in response to the Central Tennessee judge offering LARCs and vasectomies in exchange for time-served was very recent (Davis, 2017; Hawkins, 2017; Lussenhop, 2017), and criminal justice system actors seemed to be much more hesitant to talk about the LARC program in the county jails.

Reproductive healthcare providers include practitioners—doctors, nurses, midwives, doulas—and educators from the Tennessee Department of Health, Knoxville Center for Reproductive Health, and Planned Parenthood.

Reproductive healthcare providers are distinct in their ability to provide comprehensive contraceptive options to clients. However, it is important to note that although a full range of reproductive healthcare services can be provided, I was particularly interested in the ways in which healthcare providers limited comprehensive contraceptive access.

Non-profit organizations include providers who provide LARC-only contraceptive options and the non-profit organizations where the LARC-only programs are promoted. A Step Ahead Foundation is a non-profit organization which seeks to empower women to reach their goals through increased access to long-acting reversible contraceptives. At the core of A Step Ahead Foundation’s mission is that prohibiting unintended pregnancies will allow women to advance their education and career goals. To accomplish this goal, the

Foundation provides free long acting reversible contraceptives only and transportation to and from the LARC insertion appointment. A Step Ahead flyers and brochures have been the only reproductive healthcare advertisements in the waiting rooms of drug treatment programs (Cornerstone, Renaissance Recovery).

Organizers, specifically Black women led organizations centered on reproductive justice, resist reproductive control. As part of their long histories of resistance, organizers have insight into the ways in which the criminal justice system, healthcare providers, and non-profit organizations interact. The reproductive justice centered organizations centered in this project are: SisterReach², a Memphis-based organization which focuses on education, outreach, and legislation as “an advocate for the reproductive autonomy of women and teens of color, poor and rural women, LGBTQ+ and gender non-conforming people” (SisterReach, 2020); SisterSong³ Women of Color Reproductive Justice Collective, an Atlanta-based organization works to support, train, create space, and provide a platform for Reproductive Justice movement work “to strengthen and amplify the collective voices of indigenous women and women of color to achieve reproductive justice by eradicating reproductive oppression and securing human rights” (SisterSong, 2020); New Voices for Reproductive Justice⁴, a Pittsburgh-based organization engages in “leadership

² <https://www.sisterreach.org>

³ <https://www.sistersong.net>

⁴ <http://www.newvoicespittsburgh.org>

development, community organizing, policy advocacy, and cultural change amplifying the voices of Black women, femmes, and girls to advance sexual and reproductive health” (New Voices of Reproductive Justice, 2020); and Healthy and Free Tennessee⁵, a Nashville-based “coalition of agencies, organizations, and individuals working together to promote sexual health and reproductive freedom in the state of Tennessee” through education, policy and legislation advocacy, and connecting relevant organizations and agencies (Healthy and Free Tennessee, 2020).

Data Collection

From January 2019-January 2020, I conducted 33 interviews across five areas—criminal justice system actors, reproductive healthcare providers, non-profit organizations, organizers, and state social services. To identify and recruit participants for the project, I utilized snowball sampling in this study. Having been engaged with the reproductive health community for a year prior to the start of this research, I returned to the connections I made as the foundation from which I built a database listing points of contact for each organization and their contact information. I also performed online searches to identify organizations and key stakeholders engaged in LARC-promotion outside of the networks I established. Drafting field specific recruitment emails—criminal justice, medical, non-profit, state social services, and organizers/activists, respectively—yielded 26

⁵ <https://www.healthyandfreetn.org>

respondents across the 5 fields. An additional 7 participants agreed to an interview after being referred to me from a previous participant. The final sample ranged in age from 23 to 63 years old, and included 27 people who identified as women, 4 people who identified as genderqueer/non-binary/trans, and 2 people who identified as men. Although the majority of participants were white, the sample also included Black and Latina participants, comprised of 4 and 1 participants, respectively.

At the beginning of each interview, the participant was presented with an informed consent document outlining the purpose, risks, and benefits associated with participation in the study. To mitigate risks and to amplify the importance of non-coercive participation, I explicitly reiterated the right of the participant to refuse to answer a question without consequence and to terminate the interview at any time. Additionally, I reviewed the options for identification—with attribution or without attribution. For participants who selected to be identified with attribution, the participant granted permission for their name, occupation, and organization to be listed in the final project. For participants who selected to be identified without attribution, the name, occupation, and demographic characteristics of the participant have been intentionally obscured. In some cases, participants who elected to be listed with attribution were obfuscated to protect either their privacy or the privacy of other participants.

After a respondent indicated an interest in being interviewed, I scheduled in person, phone, or Skype interviews based upon the preference of the

respondent. For phone or Skype interviews, I would provide an electronic version of the informed consent document. The participant would then sign and return the informed consent document prior to the interview date. Although the informed consent document was already signed by the participant at the beginning of a phone or Skype interview, I would reiterate the risks, benefits, voluntariness, and attribution selection prior to the interview. For in person interviews, the informed consent process at the beginning of our meeting provided time for the participant to read the document and reviewed the risks, benefits, voluntariness, and attribution procedure.

The average length of each interview was about an hour; however, some interviews lasted as little as 25 minutes while others lasted as long as 3 hours. I used a voice recording application on my mobile phone and on an iPad to record the interviews. In-person interviews were typically conducted in the office of the participant. However, in some cases, participants requested to meet away from their colleagues at local restaurants or conversation areas at conferences. At the conclusion of the interview, I provided my participant with a brief survey of demographic questions—age, gender, race, level of education. The signed informed consent document and the demographic characteristic survey were assigned two different numbers based on a coding system devised by me as a method to protect participant confidentiality. Following each interview, I recorded my own reaction to the interview in a separate audio file.

The participant observation component of my data collection included a variety of public and private events within the areas of healthcare, non-profit, and organizing. I did not have access to or there were no opportunities for participant observation within the areas of the criminal justice system or with state social services workers. I attended public and semi-public events such as tabling at the women's Marches, women's expos, conferences, lobbying days, lectures, and public education events. I also had access to private events with organizers and non-profit organizations including organizing meetings, presentations of research, and internal strategy meetings.

When engaged in participant observation at public events, I assumed the role of a complete observer. I would sit in an area where I could observe the organization of interest within the context of the larger event, usually taking field notes using a notebook, mobile phone, or laptop, reflecting the appropriateness of device usage in the space. Additionally, I would take photos using my mobile phone as a method of situating the organization I was observing within the physical space of the larger event.

Participant observation at private events required situation-specific methods of data collection. If the organization event was mid-to-large (20 to 80 people in attendance), I was often not introduced to the group, and I acted as an observer only, usually taking handwritten field notes in the back of the event space. For smaller organization events and meetings (fewer than 15 people in attendance), it was typical for me to be introduced as a graduate student and

researcher. In the smaller meetings, I was frequently an active participant in the space, sharing preliminary details, findings, and perspectives on the topics being discussed. It is important to note that often due to the connection between LARC promotion and substance use in Tennessee, the meetings in which I would participate were usually centered on issues related to substance use. Given the intimacy of the private spaces in which I was invited to be a participant observer, I did not take any photographs of these spaces during the meeting.

To further explain the techniques used to document my participant observation, I relied heavily on technology to capture as many details of the observation as possible. I utilized the Music ID application on my mobile phone to identify and track songs played at events or in organization common areas. I used Instagram, Facebook, and Twitter applications to track posts by organizations and key stakeholders to find events and to compare messaging promoted on social media with direct observations in the field. I collected flyers, buttons, stickers, and other ephemera provided by the organizations. I also took photos of organization spaces and presentations to more fully capture moments, in an attempt to move beyond the limitations of relying on written notes alone. As mentioned above, some of the meetings I observed, due to participant privacy concerns, I did not document through audio or visual recordings. Instead, I relied solely on handwritten notes and my own recorded reflections to document these observations.

The collection of archival data included the management of the organizational ephemera I obtained through participant observation as described above; searches through electronic databases of peer reviewed journals and newspaper articles using organization names, key stakeholders, and project titles as keywords; websites and social media run by organizations and key stakeholders; local newspapers; and websites which highlighted the work of organizations or key stakeholders. Although I collected archival data on the organizations and key stakeholders throughout the project, given the impermanent nature of internet-based data, where posts, comments, and photos can be deleted by the organization or the original poster, I was particularly vigilant when posts coincided with events at which I was a participant observer. Temporality of posts was less of a concern with more traditional forms of archival data—newspaper articles, peer reviewed journal articles, or highlights on third party websites. Archival data were saved as digital documents and uploaded into NVivo.

Situational Analysis

Given the diversity of data collected for this project, the lack of established research on the use of LARCs as mechanisms of systematic reproductive control, and the importance of clearly positioning myself within the context of the dissertation, I utilized Situational Analysis as an approach to data analysis which brings together method and methodology. Building from the foundation of Grounded Theory in Sociology (Strauss and Corbin, 1997), Adele Clarke

developed Situational Analysis (SA) not simply to contribute to, but rather, to move beyond the limitations of grounded theory. Specifically, Clarke (2015) built SA to be a “theory/methods package” grounded in the Sociological tradition of symbolic interactionism (p. 87). The formulation of a theory/methods package “becomes a way of knowing and doing *together*” (Clarke 2015: 87). That is, the ontological and the epistemological are inextricably linked. As such, SA enables the integration of the theoretical frameworks of Reproductive Justice and mass surveillance with the qualitative data collected in this dissertation with an understanding of the positionality of the researcher as critical to the analysis and discussion of emergent themes.

The SA theory/methods package emerges from the integrated work of symbolic interactionist theory (Blumer 1969; Reynolds and Herman 2003), constructionist grounded theory (Charmaz 2006, Strauss 1987), and situational analysis (Clarke 2003, 2005). Clarke argues to use SA requires the researcher to learn the foundational theories and practices and the application of this knowledge across time and context. Expanding upon this argument, Clarke highlights the necessity of this knowledge work by the researcher as foundational for moving beyond the limitations of narrowly constructed theory and praxis.

Since the postmodern turn, then, all knowledges
are understood by major segments of scholarly worlds
and beyond as *situated* knowledges (e.g. Haraway,
1991b)—produced and consumed by particular

groups of people, historically and geographically locatable. Claims of universality are considered naïve at best and much more commonly as hegemonic strategies seeking to silence/erase other perspectives (Gramsci 1971). Genealogies of knowledges, their discourses and practices—histories of the present—are routinely undertaken (e.g., Foucault 1972, 1973, 1980). In fact, taking on social analysis of “the hardcases” of knowledge production is what studies of science, technology, and medicine . . . do. (Clarke, 2005, pg. xxv).

Largely in response to critiques of qualitative work from constructivist perspectives as less rigorous, too subjective, or essentially nihilistic, Clarke (2005) developed SA as a method which enables the researcher to confront these challenges and to proceed in spite of them. In other words, the positivist underpinnings of much sociological and criminological research and the, at times, nihilistic conclusions of post-modernist and post-structuralist work are challenged through the development of SA as an empirical method which allows for a complex and multifaceted analysis of a world understood in the wake of constructionist and interpretative shifts.

Situational Analysis, then, uses an iterative, cartographical approach in which the components and the relationship between the components of a

particular situation are mapped; thus “the situation per se becomes the ultimate unit of analysis” (Clarke 2005, pg. xxii). Specifically, SA uses three maps: situational maps, social worlds/arenas maps, and positional maps. Situational maps provide an overview of significant elements in the situation of analysis, including the human, non-human, discursive, historical, symbolic, cultural, or political components. Given the iterative processes within SA, the situational map, when used at the beginning of the research process, guide the researcher through the initial stages of the identifying participants and guiding research questions. However, the researcher can return to the situational map to elucidate and interrogate how significant elements within the situation are connected to one another, often serving to highlight the complexities of the situation.

Social worlds/arenas maps identify and lay out the collective actors, significant non-human elements, and any arenas of commitment or discourses in which actors are engaged in an ongoing negotiation. The social worlds/arenas map, then, highlights the meso-level interpretation of the situation. That is, the ways in which key actors and non-human events are in active process and conversation with the larger context of the situation. Within this map, the researcher cannot assume the directionality of influence, understand boundaries as static, or articulate discourses as consistent. Instead, the social worlds/arenas maps reflect the constant negotiation and endless possibility of the situation of inquiry.

The third, and final, map are positional maps which identify and lay out the central positions taken and not taken as reflected by points of divergence, concern, and controversy surrounding topics and issues within the situation of analysis. The positional map, then, serves as a tool whereby positions are analyzed for patterns within the situation as both distinct from and connected to the situational map. In other words, the positional map reflects many possible discursive positions—which can include multiple or contradictory positions—from people and groups within the situation of inquiry. As such, the positional map attempts to reflect a full range of positions, with equal weight given to the non-human elements—things, technologies, discourses—to the human elements.

Analytic Procedure

Following each interview, I transcribed the interview recordings, and removed information that would identify the participant, or their organization, based upon attribution preferences. Audio reflective memos were also transcribed and labeled to maintain the relationship between the memo and the related interview or event. Transcripts, field notes, photos, and ephemera were uploaded into NVivo to organize and manage the data. However, the coding lists and cartographical maps were done by hand.

Situational Analysis begins with an open coding process of all collected data. It is through the open coding process that the analytical situational maps

are developed. Situational maps⁶ identify the principle components involved in the situation of analysis. Using line-by-line coding, I generated codes which supported the division of the participant groups—criminal justice system actors, reproductive healthcare providers, non-profit organizations, organizers, and state social services. Following initial open coding to identify and sort participants, I used the line-by-line coding to highlight the complexity of the data as reflected by the basic elements of the situation of inquiry—human, non-human, spatial, political, symbolic, historic, and cultural. Given the focus of the dissertation, each code was mapped within the relational context of LARC as a mechanism of reproductive control. Reviewing the codes generated through this process, the most significant codes were grouped within the elements of the situation.

The initial formulation of messy maps (Clarke 2015) connects the codes generated through open and line-by-line coding. In addition to identifying the five social worlds—state, criminal justice system, healthcare, activist/organizing spaces, and non-profits—the discourses and contexts are also elucidated through this process of generating codes. Emergent themes related to the state include: social workers, Tennessee Department of Health, Title X, state/federal funding, gag rule, and connections with the criminal justice system and non-profit organizations. Within the criminal justice system social world, coding identified: jails, probation, substance use legislation, the influence of judges, lawyers, and non-profits, counter responses by activists/organizers and non-profits, and

⁶ The situational map for this project is in Appendix E.

positioning within the larger context of the state. Codes generated related to the healthcare system reflected a significant presence of federally qualified health centers, the role of doctors and healthcare practitioners on non-profit boards and engaged in counter movements with activists and organizers, situated LARC-first promotion as the standard for high quality healthcare, and no pro-criminal justice system actors. The non-profit social world was the most varied and, likely, the most significant with overlapping codes related to federally qualified health centers, the presence of doctors and healthcare practitioners, and the coexistence of counter-movements (A Step Ahead Foundation and Reproductive Justice organizations). The final set of codes generated reflect the world of activists and organizers whereby emergent reimaginings of the future through Borderlands ideologies, mutual aid, harm reduction, and anarchist collectives balanced suspicion and wariness with solution seeking initiatives.

Engaging in the process of iterative data analysis, I compared the original open coding list with the situational map to begin the process of developing the social worlds/arenas maps⁷. In the process, I developed a third list of codes which described the discourses present in the data. It is through the creation of the social worlds/arenas maps which Clarke (2005) argues the “stories to tell” from the data become apparent (pg. 111). The social worlds/arenas maps, then, yielded three dominant narratives—influx of private funding as a result of the failings of public infrastructure (chapter 4), disproportionate use of public

⁷ The social worlds/arenas map for this project is in Appendix F.

infrastructure by oppressed populations (chapter 5), and resistance to reproductive control (chapter 6).

Within the social worlds/arenas maps, the relationships between the codes identified in the situational map are elucidated. Rather than presented as separate or static, the social worlds/arenas maps provides a visual representation of the power within and between the social worlds/arenas which emerge from the iterative coding process. From the codes produced in the development of the situational maps, the criminal justice system is housed within the larger context of the state. The social world/arena of healthcare overlaps with the state—reflecting state-based healthcare providers, policies, health coverage, and legislation—and the criminal justice system—reflecting the healthcare coverage mandated for those who are incarcerated. The healthcare social world/arena also converges with the work of non-profit organizations—where healthcare practitioners serve as board members—and activist and organizing spaces—through counter-movements whereby healthcare practitioners are also advocates and providers to marginalized communities. The social world/arena of activists and organizers converge in the frequent focus on resistance to punitive, unjust actions within the realms of the state—and thus, the criminal justice system—and healthcare as the latter social worlds/arenas are responsible for the necessities of survival—food, safe housing, high-quality healthcare. Activists and organizers often—though, importantly, not always—engage in resistance work through the creation and management of non-profit organizations. Through this

analysis, it is apparent that the final social world/arena—non-profit organizations—was the most significant of all the social worlds as non-profits were present in all the other social worlds/arenas. The context in which non-profits existed varied significantly. In some spaces—healthcare and the state—non-profits often engaged in work to support state structures. However, with activists and organizers or the criminal justice system, non-profits were sites of resistance against state and carceral structures.

Supported by specific discourses and elements reflected in the subsections of each chapter developed through positional maps⁸ which represent the range of positions found in the discourses listed above. It is essential to the process of mapping the range of positions reflect the always already multiplicity and contradictions within the social worlds/arenas identified within the situation of inquiry. As such, an organization or key stakeholder can, and often does, operate within more than one social world/arena.

The positional maps, then, situate the primary discourses, actors, and events within the social worlds/arenas. At the intersection of all five aforementioned social worlds/arenas—state, criminal justice system, healthcare, activists/organizers, and non-profits—are the discourses, experiences, actors, and events of criminalization, poverty, and race. Again, these elements of the situation need not be consistent. In fact, it is at these intersections the nuance and complexity of a situation of inquiry are most apparent. Thus, criminalization

⁸ The positional map for this project is in Appendix G.

reflects the mechanisms, legislation, and logics of the state while simultaneously representing resistance to the process of criminalization. From the intersection of the state, healthcare, non-profits, and activists/organizers emerges the implications and discourses of the Medicaid expansion, the Gag rule, and abstinence-only education. That is, the perpetuation of state-based mechanisms designed to limit comprehensive, affirming healthcare coexists with resistance to these mechanisms and their underlying ideologies.

At the intersection of non-profit organizations and activists/organizers are attempts to work outside of the state and state-based funding through the work of collectives and mutual aid resource distribution. By shifting away from state mechanisms, resistance work challenges prevalent ideologies and moves toward the creation of non-state-based solutions. This was most apparent in the emergence of the concept of the Borderlands, the only codes with emerged from a singular social world/arena—activist/organizing spaces. By locating the situational elements within the social worlds/arenas map, the positional map is a visual representation of the complex, multi-dimensional relationships which are created and co-constituted within the situation of analysis.

Essential to SA and broader commitments to social justice, I understand who I am—at the intersection of history, identity, experience, and temporality—is foundational to my research. As a white, well-educated woman in her 30s, I resembled many of my interview participants, thereby establishing a quick and easy rapport. My participants seemed to assume similarities or sameness in our

perspectives, even when my politics were divergent from my interviewees. As a researcher from the University of Tennessee Knoxville—the flagship university in the state—I experienced a heightened sense of legitimacy. Many of my participants were from Tennessee, had attended the University of Tennessee, or identified themselves as fans of the university’s sports teams. For me, the university connection was a tremendous benefit. Many of my participants asked me about my research and seemed genuinely interested in my findings and work, often asking about my post-graduation and future publishing plans. In this way, the presumption of similarity of our social identities coupled with the legitimacy of my University of Tennessee connection allowed for me to develop a foundation of trust during interviews that enabled my participations to make disclosures that often countered the official or public narratives of the organizations my participants represented.

As a queer, former social worker with close kin who have experienced substance use disorder, incarceration, criminal justice surveillance, and victimization, I am intimately aware of the ways in which the state enacts harm against the most oppressed. My understanding of state mechanisms of harm and my ability to engage in class-based code switching is deepened through my experiences of being born into poverty, gradually moving into the upper middle class through marriage and career changes, before divorce and graduate school led to my return to life below the poverty line. These identities and experiences enabled me to see and hear beyond what my participants presented to me. Even

in situations where interviewees seemed to believe what they were saying—for example, long-acting reversible contraceptives are empowering—this lack of nuance or critique in my participants’ responses reflected their own identities and experiences. As a researcher, my training has developed a practice of engaging in critical reflexivity. That is, identities and experiences alone are insufficient. To understand and account for the impact of my history, identity, and experience within the current moment demands a critical reflexivity of the ways in which I am present in my research. The questions I asked during interviews, the ways in which I asked those questions, and my feelings and responses—intentional or unintentional—communicated to participants through my tone, body language, or word choice influence the data I collect and how the data are analyzed. To mitigate and account for my role within the research, I have relied heavily on the words of participants throughout the subsequent chapters to convey a nuanced perspective of LARCs within Tennessee.

Chapter Summary

Thus, through the iterative mapping process of Situational Analysis, the complex relationships which serve as the foundation of and opportunities within the situation of inquiry are elucidated. I have provided an overview of the data collection and analysis methods used in the creation of situational, social worlds/arenas, and positional maps. The integration of method and methodology in Situational Analysis render this technique ideal for my dissertation as SA allows for a diversity of data to be analyzed in an under-researched topic through

a rigorous approach which necessitates the reflexivity of the researcher in the analysis process.

CHAPTER FOUR

PUBLIC FAILURES/PRIVATE SOLUTIONS

The tires of my car rumble along the brick streets. It is a late-spring day in the South—a breeze gently moves the lush, green trees back and forth in the warmth of the sun on a small liberal arts college campus. Students stroll between the handful of light stone academic buildings like a scene from a college brochure. I am lost. This is the third time I've circled the college looking for the road which leads away from the picturesque college to the, recently repurposed, industrial sector. I pull my car over on one of the side streets next to the college green to reconfigure the map on my phone. With updated turn-by-turn directions, I drive north watching the brick streets and stone buildings disappear in my rear-view mirror.

In less than a minute, the brick streets give way to well-maintained paved roads and colonial houses with large, manicured lawns. An oversized median with grass and trees separate the northbound and southbound lanes. Everything about the neighborhood feels well-established—from the luxury cars in the driveways to the professionally landscaped lawns. The trees in the median and in front of the houses are mature with an encompassing canopy shielding the neighborhood from the sun.

As I continue to drive north, the trees begin to disappear from the median and the colonial style homes are replaced by one-story bungalows in need of repair. These closely nested homes sit just a few feet back from the sidewalk with no professional landscaping in sight. A series of 7 story apartment buildings appear off to my right as I approach the end of the road where a rundown gas station and an abandoned building bookend the street.

Directly in front of me is the building I've been looking for—a former distribution center with a 1920s art deco tower that reminds me of a cathedral. A former center of industrial worship. As my car winds around a narrow bridge, I drive inside a parking garage with a mid-century modern aesthetic. Large, orange signs shaped like motel key tags spell out "YOURS" vertically along the grooved cement.

Off to the right, behind the art deco tower, the expansive building alternates between large windows and brick dividers. As I walk in through the first atrium entrance, I feel a burst of cold air from the air conditioning mixed with the warmth of the sunlight passing through the windows and skylights of the building. The renovated spaces are built around a center windowed column which reaches to the skylight in the rooftop. A green, geometric staircase, with bold gem-tone mobiles dangling beneath, winds down from the fourth floor to the atrium. I stroll across the polished cement floors to find a color coded directory affixed to one of the exposed brick columns noting the combination of non-profit, retail, and health care providers that fill the space.

A neo-soul, light r&b playlist floating through invisible speakers fills the entire space subtly—D’Angelo’s “How does it feel” plays as I start to walk up the concrete staircase. The entire building has a cohesive aesthetic – polished concrete floors, exposed brick, precisely distressed pillars, shared work spaces with geometric seating, glass walls and doors, industrial metal fixtures. A mixture of cold industrialism and warm collaboration.

As I walk up the center stairway, I see the markers of gentrified spaces that have become all too familiar: a cold pressed juice bar, a market with locally sourced produce and meat with an on-site butcher, and a shared art making co-operative occupy spaces in the specter of this urban warehouse. From one of the floor-to-ceiling windows, just barely visible was the edge of working-class neighborhood I had driven through to get here. An abandoned store, a covered bus stop filled with potential riders and loiterers, and parking lots in disrepair littered with trash which seemed to an unofficial employee parking area.

The stairway ended at the fourth floor, and I wandered around the hallways looking at the art for sale, the cafes, the reading areas. A white neon sign against a dark navy wall reading “Today and Always” drew my attention. In a space filled with empty white tables, Tiffany blue plastic chairs, and perfectly distressed white columns, there was nothing about this space that felt timeless or permanent. I felt as though I was wandering around in a carefully curated Instagram photo.

I was feeling self-conscious as I wandered around taking photos of the space. An odd feeling given the space seemed to be created around perfectly curated Instagrammable locations. I went back downstairs to buy a juice from the cold-pressed juice bar before finding an open seat at a stainless-steel table with black wicker cube stools in an indoor/outdoor space. The breathy intro of Whitney Houston’s Heartbreak Hotel played as khaki short and Chaco clad undergraduate students gathered in groups between the scattered flannel shirt and noise cancelling headphone-wearing late millennials working furiously on their laptops.

This was it. After interviewing and observing the regional executive directors of ASAF, I was finally going to interview ASAF’s founder, Claudia. As I walked down the hall, I could see the ASAF office off to my left. Open and modern, the glass door and walls allowed me to look in at a mustard, mid-century sofa and chairs arranged in a horse-shoe. A group of 7 women, Black, brown, and white women ranging in age from early twenties to their fifties were working on the other side of the glass barriers. Transparency. I only hoped Claudia would be as open as the office aesthetic. (Field notes: May 2019)

My fieldwork and data analysis converged with the impending 2020 U.S. Presidential election and in the midst of a global pandemic, where discussions of healthcare are at the center of the Democratic presidential nomination debates while, paradoxically, devoid of nuance. The “single-payer”-“Medicare for all”-“Medicare for those who want it” talking points have become so predictable, political pundits have jokingly referred to the healthcare question and answer section as the “pre-taped portion of the [Democratic] debate” (Pfeiffer, 2020). The repetitive, simplistic political talking points about the U.S. healthcare system do not reflect the complex realities of the policies which regulate the funding structure, and subsequently, the healthcare treatment options of the more than 330 million people living in the United States.

Without ever being explicitly named, long-acting reversible contraceptives (LARCs) have been centered in Democratic Presidential Debates by primary candidate and former Colorado Governor John Hickenlooper’s platform. Mirroring the Colorado Family Planning Initiative (CFPI), Presidential candidate Hickenlooper proposed a \$700 million expansion in federal funding for Title X Family Planning Program to train healthcare providers in LARC insertion and removal, develop and implement a national campaign on the benefits of LARC, and increase access to LARCs for low-income women, with particular attention to women residing in rural areas (Ollstein, 2019; Lunde, 2013). Using the success of the CFPI, Hickenlooper boasts of saving tax-payers nearly \$70 million by providing LARCs to more than 36,000 women across the state of Colorado

(Colorado Department of Public Health and Environment, 2017). Specifically, the state reported birth and abortion rate reductions of 50% among 15-19 year-olds and 20% among 20-24 year-olds as an estimated \$60.6 million savings across four entitlement programs—Medicaid, Temporary Assistance to Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and Women, Infants, and Children (WIC) (Colorado Department of Public Health and Environment, 2017; Budner, 2018; Leins, 2019). The CFPI provided three primary services: training for reproductive healthcare providers, operating assistance for clinics, and funding to purchase LARC devices (Dube, 2015).

What is often neglected in reports celebrating the success of the state managed CFPI is the \$23 million private donation which made the program possible. Although the Colorado Department of Public Health and Environment refuses to confirm, media reports identify the Susan Thompson Buffet Foundation (STBF) as the private donor responsible for the financing. Given STBF's history of donating millions of dollars to support pro-choice reproductive healthcare organizations—Planned Parenthood, National Abortion Federation, NARAL, and the Guttmacher Institute—it seems the news reports identifying STBF as the private donor are likely accurate.

In the wake of increasing austerity politics, the influx of money from the private sector into the public infrastructure has been used as an expedient solution to the failings of often cash-strapped public systems. In this chapter I will highlight how three legislative mandates—refusing the Medicaid expansion,

implementing the gag rule in Title X, and requiring abstinence-only sex education—converge into a failure to provide easy to access, comprehensive contraception for all in Tennessee; thus enabling the inundation of long-acting reversible contraceptives as the only accessible form of contraception through the infusion of private funding, which is not subject to the same stipulations or oversight as public funding.

Rejecting the Medicaid Expansion under Obamacare

Signed into law in March 2010 by President Barack Obama, the Patient Protection and Affordable Care Act (ACA)—often referred to as “Obamacare”—was only passed into law through the Health Care and Education Reconciliation Act of 2010. The highly contentious legislation passed in the Senate on December 24, 2009 in a 60-39 vote, prohibiting the use of the filibuster to prevent the obstruction of the legislature. Just over a month earlier, the House had passed a similar, yet not identical, healthcare bill in a 220-215 vote. At the time, there was no urgency to reconcile the two bills. However, a surprising win by a Republican in a Massachusetts special election meant the Democratic party no longer had the 60 votes required to pass legislation without the possibility of a legislation-ending filibuster. Newly concerned about the viability of the significant healthcare reform, the bill passed by the Senate was brought to the House for a second vote, passing by a similarly narrow margin of 219-212. This second House vote was highly partisan with all 178 Republicans—and 34 Democrats—voting against the bill.

In the wake of the controversial vote, Republicans “invoked Thomas Jefferson’s observation that ‘great innovations should not be forced on a slender majority—or enacted without broad support’” (Price and Norbeck, 2014, para. 9), and have repeatedly called for the repeal of the ACA since the passage of the bill (BBC News, 2019; Davis, 2019; Bacon, 2018). Reflecting the continued partisan split, Republican President Donald Trump said during the signing of an executive order:

I had a decision to make. Do we do a good job with Obamacare—a remnant of Obamacare? Or do we do a bad job? If I do a bad job, well there you can blame Obama and the Democrats. If we do a good job, they’ll get a little bit more credit, but it’s still very faulty. It doesn’t work, and it’s too expensive. And I told our great secretary [of Health and Human Services] Alex Azar, ‘Don’t do a good job. Do a great job.’ Once we got rid of the individual mandate it made it better but Obamacare doesn’t work—but it works at least adequately now. (Vazquez and Luhby, 2019, para. 3-4).

One of the most contested aspects of the ACA was the extension of Medicaid to all adults under age 65—including those without dependent children—with incomes below 138 percent of the federal poverty level. In the

2012 landmark case *National Federation of Independent Business v. Sebelius*, the Supreme Court of the United States voted in a 5-4 decision that the Medicaid expansion served as a misuse of Congressional power and could coerce states into accepting the expansion to maintain existing levels of Medicaid funding. As a result of this Supreme Court decision, the Medicaid expansion shifted from a state mandate to a state elective, and Tennessee, in a formidable decision, elected not to accept the Medicaid expansion.

Coupled with logistic barriers, not accepting the Medicaid expansion—and underfunding Title X, which is discussed in the next section—has created insurmountable obstacles for poor and working class people to access free or low-cost contraceptives in Tennessee. This failure of the public infrastructure to provide adequate funding for contraceptive access created a gap which has been filled by funding from private donors to non-profit organizations. In 2011, Claudia Haltom, a former Memphis juvenile court magistrate, formed A Step Ahead Foundation (ASAF), a non-profit organization which provides long-acting reversible contraceptives (LARCs) and transportation to and from LARC-insertion appointments at no cost to anyone who signs-up. Over the last nine years, ASAF expanded from Memphis into five additional, independent sites across the state. Each ASAF site received start-up funding—totaling as much as \$250,000 for some sites. In this chapter, I focus on the six ASAF sites as a case which is representative of the phenomenon of LARC-only non-profit organizations (Luker 2008, Gubrium et al. 2016, Mann & Grzanka 2018, Gomez et al. 2014). ASAF is

the only non-profit in Tennessee which provides free LARC-only contraceptives, and due to the perception of organizational success, non-profits from other states have reached out to ASAF as a desirable model to replicate outside of Tennessee.

On the surface, a program which pays for contraceptives and transportation free of charge provides a much needed resource in a state with significant barriers to accessing reproductive healthcare and reliable transportation. However, at the center of ASAF's rhetoric is a narrative of "opportunity" granted by the use of long-acting reversible contraceptives where preventing unintended pregnancy is an essential catalyst for success, regardless of other social barriers (American Academy of Pediatrics, 2014; American College of Obstetrics and Gynecology, 2015; Ott & Sucato, 2014). Haltom has valorized planned pregnancy through LARC use as the determining factor for educational and occupational success in her recounting of ASAF's origin story:

During my legal career, I saw so many circumstances where families had tragedy, and so often, when I saw it, it began when they had a baby before they were ready. And that unintended pregnancy is what caused so many lost opportunities. What opportunity do young women have to prevent an unintended pregnancy? As I researched it, I found that the most effective methods of birth control were generally not

available. And so we sat down on my dining room table and said, “what would it look like to have a program where we could offer young women, free and safe, long-acting reversible birth control?”. By being able to offer that opportunity it was the turn key, it was what would change everything for a young woman to plan when she was going to have a baby. (Claudia)

By situating unintended pregnancies as the impetus for a life of poverty ignores the structural barriers—such as limited access to regular, high-quality healthcare; free or low cost contraceptives; reliable transportation; safe housing—which are much more likely to contribute to unintended and unwanted pregnancies (Mann & Grzanka, 2018). The persistent rhetoric of unintended pregnancies as the catalyst for limiting life chances feeds into the underlying logics of austerity politics. Specifically, the hyperfixation of the state to reduce public spending—typically through cuts to social welfare programs—perpetuates these known structural factors which contribute to increases in unintended and unplanned pregnancies.

With the systematic reduction of state and federal funds supporting increased access to reproductive healthcare and contraception, a gap in the public infrastructure becomes apparent. Attempting to mediate this gap is ASAF. Receiving no state or

federal funding, ASAF managed to grow an operating budget of \$1.9 million dollars per year through private foundations and private donors. Over 8 years, ASAF has grown their donor base by networking locally. You find them [donors] by the nefarious means of reading donations on the zoo list. You find out who owns major sporting franchises. You find out who has wives that are very committed to things. You send letters. And I show up at more stuff than you could possibly imagine. The people who donate, or foundations will steer you in directions of money. Rich people all know each other. (Claudia)

The vague information about the funding sources for ASAF was present with each of the sites. In fact, the donor who provides the \$250,000 seed money for each of the ASAF sites has remained anonymous, with executive directors at newly emergent sites claiming to be unaware of the identity of this major donor.

Of particular interest is the intra-organizational structure. Each of the 7 ASAF sites is fully siloed. That is, although the general functioning of the organization is the same—funding LARCs and transportation to LARC-insertion/removal appointments only—each site is responsible for independently acquiring funding to cover all the expenditures of the site. As such, the sites across the state are in competition, not only with other non-profit organizations,

but also with one another for the limited funds available to pay for LARC devices and transportation. This unique structure further solidifies the positioning of ASAF as a case representative of the larger LARC-only promotion organizations. ASAF has been particularly successful in maintaining this position through the targeted, and often exclusive, fundraising practices.

It is, perhaps, less surprising then that ASAF acts as a payer of last resort, more so than a full-service organization. The only contact a client might have with the organization is a phone call to request a LARC. ASAF will coordinate an appointment time and transportation to/from the designated clinic for LARC insertion; however, the healthcare facility will determine which fund will pay for the LARC. It might be that a client is eligible to receive a LARC through TennCare or Title X, in which case ASAF would not be billed for the device. However, in instances where a client cannot receive LARC coverage through TennCare, Title X, or another funding source, ASAF will be billed for the device and insertion procedure. Thus, outside of paying for transportation costs, ASAF only provides a limited solution to a larger failure of government infrastructure.

Title X and the Gag Rule

In 1970, President Richard Nixon signed the Family Planning Services and Population Research Act of 1970—colloquially, referred to as Title X—establishing federal grant funding for comprehensive family planning and preventative health services. Nixon’s (1970) statement upon signing the Act highlighted the “goal of providing adequate family planning services . . . to all

those who want them but cannot afford them” (pg. para. 5). Through this bipartisan endeavor, Title X provides family planning and preventative services at no cost to families at or below the poverty level and uninsured adults who are ineligible for Medicaid.

Support for family planning services was expanded further in 1972 when Congress required the Medicaid program in each state cover family planning services and devices. The federal government committed to the reimbursement of 90% of family planning services provided to people who use Medicaid. By 1975, the federal government established a national network of community health centers. With almost 4,400 community health centers providing family planning services in the U.S., Guttmacher Institute claims “the number of unintended pregnancies and abortions would be nearly two thirds higher” without these federal initiatives (Henderson 2014: 211).

Title X funding covers an array of services and devices: breast and pelvic exams, breast and cervical cancer screenings, sexually transmitted infection screenings and treatment, pregnancy diagnosis and counseling, and comprehensive contraceptive devices. According to Planned Parenthood (2016), 4 million people receive wellness exams, cancer screenings, birth control, and testing and treatment for STIs and HIV through Title X funding alone. Abortion is excluded from Title X coverage. Reduction of undesired births, then, can only be achieved through prevention of unintended pregnancies and not through abortion family planning methods.

In July 2019, the Trump Administration instituted a “gag rule” which prohibits doctors within the Title X program from providing information about where clients can safely and legally access abortions. In order to receive Title X funding then, doctors are required to omit information about abortion to their clients. Planned Parenthood has refused to withhold comprehensive health information to their clients; thereby, leaving the Title X program by the fall of 2019. The gag rule is particularly problematic for clients who use Planned Parenthood centers. Although Planned Parenthood centers only represent 13% of all Title X centers, Planned Parenthood provides care for 41% of all Title X patients. Thus, leaving the Title X program will have a direct impact on those who rely on Planned Parenthood for basic reproductive healthcare services.

Without Planned Parenthood, community organizations would need to compensate as follows to maintain previous levels of care by increasing reproductive healthcare services: Title X funded federally qualified health centers (FQHC) by 116%, Title X funded health departments by 31%, Title X hospital sites by 77%, and independent agencies by 101%, respectively (Gold and Cross, 2019). Although Planned Parenthood has gotten the most attention following their exit of Title X, Planned Parenthood is not alone in their decision to prioritize accurate patient services over continuing to receive Title X funding. Most recent reports estimate that in the wake of the gag rule, 981 service sites—nearly 25% of Title X sites—left the Title X network (Dawson, 2020). As a result of this exodus, it is estimated that 1.6 million patients experienced a reduction in

services, as sites which left Title X may have been the only accessible Title X-funded healthcare provider in the state.

Although most of the narratives surrounding Title X are centered on abortion—maintaining legalization and increasing access—LARC shifts the conversation to focus on preventing pregnancies, rather than terminating pregnancies.

Some people don't think we are active enough regarding abortion. And we think that really is the magic of Tennessee. Think about the politics of this. We are just prevention focused. We don't have an opinion about abortion. We don't offer it, it's what should be or what shouldn't be done, that's just not on our plate any more than what international policy should be on Syria. You know, I can't tell you that. I can't tell you whether I think abortion should or shouldn't be illegal. I will say this though: Planned Parenthood has been there for women when nobody else was, and I'll always be appreciative. (Amy)

Amy's response is fairly typical throughout the non-profit. Abortion—a topic deemed too controversial and too political—acts as a silencer, an informal gag rule whereby financially precarious organizations fear a reduction in necessary donations due to public acknowledgement of support for abortion services.

With the tape recorder off, the negotiation of personal and organizational political stances was even more apparent. As I was leaving an interview, board members for the non-profit organization stopped by the office. A brief discussion between the board members and the executive director ended with an announcement to the group that I was “alright” – a statement which signified a presumption that my politics were similar to their personal political allegiances as liberal Democrats. It is through navigating seemingly opposing moral claims within the political structure, the complicated politics of Tennessee become apparent.

Once again, my naiveté, well you can see who is in the White House right now, regarding the issue of abortion now, and the fact that the Christian community supports him is still, just, blows my mind. Because you know for them, it's all about abortion. It's the most incredible metamorphosis I have ever seen.

(Claudia)

The fear of losing access to and funding for abortions has shifted the focus onto highly effective birth control methods as a way to live without abortion access in what is likely to be a post-*Roe v. Wade* world. That is, successfully repealing and limiting access to abortion has made pregnancy prevention equally, if not more important, than abortion access. The systematic dismantling of *Roe v. Wade*, the Affordable Care Act, and Title X funding through the process

of stacking the courts with conservative, Republican, anti-choice judges reduces the ability for nuanced conversations on contraception. Specifically, those who are actively engaged in the fight to preserve and expand access and funding for reproductive healthcare, abortion, and contraception are often unwilling to acknowledge the ways in which reproductive control and reproductive choice are experienced through the complex intersections of race, class, and ability.

This reluctance to acknowledge differential experiences of “choice” are highlighted in discussions of who organizations targets for services. Although acknowledging that ASAF was born from years of work in the family court system, the narrative of who is an ideal client does not reflect a family in crisis.

Really, once again, we're women, and we approach this point of view from the perspective of 'What would I want?' and 'What would I want my daughter to get?' What would I tell my niece to get? I told her to get a Nexplanon. And she took it out, and you know what happened? She now has three children—three little girls under 6, and she's a smart lawyer and she and her husband can handle it, but she's got her hands full. She's had her tubes tied *laugh*. But this is what, we look at it in terms of what would we use, what would we recommend to our family, and what about it

scares us. What do we want to know? What are the questions we would ask? (Claudia)

When I asked Claudia about specifically recruiting women who have a history of substance use for LARCs, she pivoted back to a narrative that centered the experiences of privileged women. Specifically, she did not want LARC to be linked to substance using women. Instead, Claudia highlighted high rates of LARC use among women in medical school and law school as the image of LARC users promoted by the organization. There is this sense that the organization can support and promote the success of women by enabling women to control their pregnancies. However, because LARC insertion and removal are controlled by medical providers, LARCs are mediated forms of pregnancy management.

“Just Say No”: Abstinence-Only Programming

In 2012, the Tennessee House of Representatives passed HB3621 which expanded the abstinence-only sexual education curriculum to include a provision which allows parents to sue teachers or organizations which promote “gateway sexual activity”. The bill enacted by the Tennessee legislature defines abstinence as “not participating in any activity that puts an individual at risk for pregnancy or a sexually transmitted disease” which is reflected in a curriculum that centers “a holistic approach that addresses the physical, social, emotional, psychological, economic, and educational consequences of non-marital sexual activity” (HB3621, pg. 1). Of particular concern to critics of the bill is the lack of clarity of

“gateway sexual activity”, which is defined in the bill as “encouraging an individual to engage in a non-abstinent behavior” through “encouraging, advocating, urging, or condoning gateway sexual activities” (pg. 2). In an effort to avoid litigation, Tennessee public schools have largely avoided implementing any sexual education, in spite of research which indicates comprehensive sexual education decreases the rates of teenage pregnancy and sexually transmitted infections. In a seemingly contradictory legal mandate, minors aged 16 or older can receive prescriptions for contraception without parental consent in Tennessee. Thus, there is a gap between legally accessing prescription contraceptives and having comprehensive, accurate knowledge about sexual activities which has provided a pathway for ASAF to build networks within local high schools.

The first thing you start with is comprehensive sex education. Open and honest discussions. And parents are involved too. And that’s part of our outreach, to have mother-daughter talks and include parents so that parents can, so when parents have sat in on discussions at 14 or 15 and their daughter comes back in at 17 and 18 or has that serious boyfriend, the parent is empowered to say, ‘remember that session we went to, let’s talk about blah blah blah. And that women identify early on when they are being pushed

into sex or taken advantage of or when they're ready. When they're ready that's the thought of, "well, I need to get birth control". Unfortunately for Tennessee, it's not just a question of money, it's also a question of culture. So, you know, even if we had all the money in the world, we wouldn't be able to get sex ed, comprehensive sex ed where everybody is super comfortable talking about it. (Amy)

Outside of paying for LARC devices and transportation to LARC-insertion appointments, each ASAF site has a staff member who engages in community outreach and education. College campuses across the state are often targeted for community events.

We look to colleges, we go to colleges. We can either go into a classroom setting, you know like social work classes. We also go to other types of classes. I've been to classes that only talk about non-profits, you know, to talk about what we do, and so we take all our materials there. Here this spring, we've been having what we call "Real Talk" sessions with young women on campus. We meet afterhours and we provide, you know, we provide food and drinks, and we have

games so they get gifts and door prizes. So we recruit that way. (Sharon)

However, college aged women are not the only population being targeted by ASAF.

Tennessee has a law that only allows for the teaching as abstinence in the high school, and although we don't talk about sex, we talk about prevention, that's all we talk about. We're not able to get into the high school where we *really* need to be. . . So it really is important for us to get into the schools, and that is something that we're going to try. You know, we can't do it during school time, but we're starting a new program in the fall, where we're going to be starting with one particular school in Jackson, and that school has a high number of minority students and a high level of students in the low socioeconomic standard, so we're starting with them, and we're going to take 25 girls from the senior class, and uh, they will be nominated or fill out an application, and we're not looking for A students, we're looking for that B or C student who does well, you know, is in school and trying and may need some extra support. So what we

want to do with those students is we're going to meet with them once a month, and we're going to teach them about LARC, of course, but we're also going to teach them about etiquette. We're going to take them on a tour of the colleges that are here in the city of Jackson. We're going to introduce them to successful dressing. We're going to introduce them to successful interview techniques, uh, resume writing skills. And then at the end of the school year, we know we'll be able to give out two scholarships, but we're hoping to get more to the seniors. (Sharon)

Through these targeted programs and recruitment techniques, the ASAF argument that their ideal clients are “every woman” seems less likely than programming designed for “at risk” populations. Programming which limits access to LARC-only contraception is not a significant barrier for those with social and economic privilege. However, for those who cannot overcome structural barriers of unreliable transportation, non-existent health insurance, limited sexual education, and no financial resources, their only option to receive contraception may come through the LARC-only services provided by ASAF. As such, reproductive autonomy is limited to those with social and economic privilege, and reproductive control is exerted over the most vulnerable women.

Emerging to provide payment for contraceptives in the wake of austerity-based state and federal funding reductions, ASAF becomes both a necessary service—stepping in to mitigate the harms generated by the failures of the public infrastructure—and a non-state-based, non-profit organization—upholding the state and carceral logics rather than challenging the constraints of the state. In this way, ASAF serves as a case representative of the larger LARC-only and LARC-first promotion.

Chapter Summary

In this chapter, I have highlighted the ways in which three public structures in Tennessee—refusal of the Medicaid expansion, implementation of the gag rule for Title X, and mandated abstinence only sexual education—work together to create a system in which the influx of private funding is the only mechanism which allows for marginalized women to have access to reproductive healthcare and contraception. Thus, these private funders engage in the systematic reduction of pregnancies among marginalized women, specifically, as the failures of public infrastructure exclude the most marginalized from receiving needed information and services.

CHAPTER FIVE

IDEAL CLIENTS/TARGETED POPULATIONS

It's cloudy and grey as I drive up to a gated entrance. Karen—the Director of Community Services—emailed me specific directions about how to access the Department of Health offices. There is no signage on the building, and I'm trying to determine which of the uniform, brick buildings are my targeted destination. Counting the side-roads, I find a small driveway with a single, lift arm. There's a call box with multiple buttons, none of which are labeled. After hitting two buttons without a response, I finally hear a woman's voice—sounding like she was talking in a tin can—but am unable to make out what she had said. I tell her I have a meeting at 1 with Karen. With static on the other side, the arm lifts slowly, allowing me to drive into the parking lot.

I'm more than twenty minutes early for the interview so I sit in my car—applying make-up, listening to a podcast, and reviewing my notes and interview guide. At 12:55, I pack up my interview materials and walk toward the non-descript building. There is no sign on this side of the building either—just simple white stenciled numbers in the glass transom window above the solid steel, grey doors. As I attempt to open the doors, they move slightly, but the doors are locked. Through glass windowpanes next to the door, I can see a receptionist, a white woman who is probably in her 50s with short blondish brown hair sitting behind a counter. To her left is a young white man. He appears to be in his early twenties, and he's leaning against the counter casually. His khaki pants and blue polo shirt seem just as non-descript as the building.

I hear a buzzer and a sliding click of what I assume is the door unlocking. I try the door again, but it still doesn't open. I stand there awkwardly waving in to the receptionist, who after a moment, turns to the guy leaning on the counter, and motions to the door. The door opens slowly, and I make a joke about not being able to open the door. As I walk toward the worn grey counter, the receptionist makes a comment about how she thought I would have come in sooner since she had buzzed me in to the parking lot nearly twenty minutes ago. Surprised by her comment, I felt flustered and guilty like I had violated some rule by not coming in to the building immediately upon arrival. My anxiety about being late to interviews meant that I usually arrived at an interview location at least 30 minutes before the interview, but the extreme timeliness was never something I needed to account for or address. Unsure of what I should say—if anything at all—meant I struggled to explain my delay from arrival to my entrance to the building.

As I was standing at the counter, I realized the young man at the counter was going to escort me to Karen's office, and had likely been called down to the lobby more than fifteen minutes ago when I arrived. In the struggle to enter the building, I had missed the name of the guy who was waiting for me. He pointed to a visitor name tag, and handed me a pen. I quickly scrawled my name, dropped

the pen back onto the counter, and shifted quickly to my right to follow him toward the elevator.

The elevator feels like it is straining to move between floors, like time is moving in slow motion. Even the “ding” marking the elevator passing each floor seems to ring out more slowly. Standing next to the guy who has been tasked with signing me into the building and escorting me to Karen’s office, he cracks a joke about how we should have taken the stairs. I laugh politely, but I’m feeling trapped in the small space. The elevator comes to a slow, bouncing stop on the fourth floor where there is a long pause before the doors glide open slowly. Immediately across from the elevator is a wall covered in an early-90s dusty rose colored wallpaper with alternating matte and shiny stripes and an nearly indistinguishable white floral pattern. It reminds me of a dated doctor’s office. Light grey, industrial carpeting runs down the hallway.

He holds the elevator door for me, and I take one step out before pausing – unsure of which way to go. He moves around me, and mumbles something about heading down the hallway to the left. The hallway is empty, except for a single, fake fig tree in a wicker basket next to a solid wood door with a single, transparent glass panel. The plant looks like it’s been there since the wallpaper had been installed. He pulls his ID badge—which is on a retractable cord—from the side pocket of his pants, and taps the card against a black, plastic scanner between the door handle and the fake fig tree. He opens the door, and I walk through the doorway into a room that seems to span the entire length of the hallway we were just in. To my left is a white wall with windows, and to my right is a maze of grey fabric cubicles. I can’t tell how many cubicles are in the room, but there is surprisingly little chatter coming from the space.

On the wall directly across from the door I’ve just come through is a small office built into the corner. The door is slightly ajar. We walk back toward the door, and the case worker knocks while pushing the door open further. I hear a woman’s voice with a thick, East Tennessee accent say “Come on in!”. I say thank you to the guy who has escorted me here, and move past him into the office. The first thing I notice in the office is all of the décor – there is a tall bookshelf off to the right filled with what appears to be vacation photos, lanyards from conferences, awards, painted farmhouse-style kitsch with phrases like “Let go, Let God”. The space has a mixture of outdated mass produced, sterile government furnishings with Hobby Lobby décor. The office set up feels typical—an L-shaped desk in the left corner with two chairs on the other side of the long-work table. I thank her for agreeing to meet with me, and she jokes about the number of emails we exchanged before finally agreeing to meet. Karen was the most hesitant of all my participants to agree to an interview. She was responsible for developing the LARC program to reduce neonatal abstinence syndrome (NAS) in Tennessee. Despite the program being run entirely through public infrastructures—Tennessee Department of Health, Tennessee county jails, Title X funding—information about and access to the program have been limited to researchers affiliated with the project. (Fieldnote: February 2019)

Meeting with Karen was central to understanding the relationship of two state agencies—Tennessee Department of Health and Tennessee Department of Corrections. The failures of the public infrastructure described in the previous chapter provide the context and framework within which the most marginalized communities are forced to make reproductive healthcare decisions. Choice is limited to those within our communities who have access, financial resources, and social capital. The impact of systemic austerity politics—such as the rejection of the Medicaid expansion, the implementation of the gag rule for Title X funding, and the restriction of sexual education to abstinence-only programming—with the infusion of private funds through non-profits to “serve” marginalized communities neglects the inherent power and coercion which emerge in spaces where oppressed people are given, what is in reality, a false choice.

Public education surrounding the safety and benefits—particularly of IUDs—have reduced the stigma of long-acting reversible contraceptive use in the wake of the public health crisis produced by Dalkon Shield, an IUD designed with a multifilament string which led to more than 300,000 claims of injuries such as pelvic inflammatory disease, miscarriage, loss of fertility, sepsis, and death during the 1970s. A new generation of potential LARC users, most of whom are likely unfamiliar with the complications associated with Dalkon Shield, are experiencing aggressive marketing campaigns celebrating the freedoms associated with LARC usage—a tremendously low failure rate and a lack of

intervention required by the user. Once a LARC is inserted by a healthcare provider, a LARC user does not need to do anything to prevent pregnancy for 3 to 10 years, depending on the selected device. The logic for encouraging LARC use is clear: pregnancies can be efficiently and effectively avoided—without the use of abortions for terminating a pregnancy—until LARC users decide they are ready to have a child (Mann & Grzanka, 2018).

On the surface, the characteristics of LARCs that are touted as mechanisms enabling reproductive autonomy are the same characteristics which position LARCs as highly effective mechanisms of reproductive control. The reliance upon and discretion of a healthcare provider for insertion and safe removal of LARCs introduces a power imbalance which precludes LARCs from being truly liberating mechanisms enabling reproductive autonomy. The history of “progressive” reproductive healthcare—from Margaret Sanger at Planned Parenthood to state-based “better babies” competitions—emerges from eugenicist frameworks (Stern, 2002). There is a false notion that eugenicist logics are rooted solely in the prohibition of pregnancy among “undesirable”—poor, Black, indigenous, criminalized—people. Although pregnancy prevention, particularly through coercive and forced sterilization (Zampas & Lamačková, 2011) has been a part of eugenicist projects, it was rarely, if ever, the only proposed solution. Instead, pregnancy prevention among “undesirable” populations coexists with pregnancy promotion for “desirable”—wealthy, White, able-bodied—populations. For those who are criminalized, living in poverty, or

are non-white, the reproductive healthcare options available to them are designed, specifically, to prohibit pregnancies through the use of LARC-only targeted programming. For state and non-state actors, my participants framed their targeted populations—those mostly likely to be identified and pursued—as ideal clients. From the perspective of LARC-first and LARC-only non-profit organizations and state agencies, ideal clients are those whose lives are often unpredictable and chaotic. Criminalized substance use, unstable housing, incarceration and probation are consequences of structural inequalities, which disproportionately harm marginalized communities.

Criminalization

Building from the foundation of carceral citizenship, criminalized communities targeted by pervasive surveillance from state and non-profit actors are required, inherently, to become subjects of the carceral state in order to receive social services. The systematic reductions of state and federal funding allocated for social services with increases in funding for carceral systems—law enforcement, incarceration facilities—forces a convergence of systems of punishment into systems of care (Bach, forthcoming). Through these processes, reproductive healthcare decisions for criminalized, poor, and non-white people are legislated through judicial decisions or state policies.

From a long-line of East Tennesseans, Karen told me how proud she was to be in her current position as a Community Health Educator for the Tennessee Department of Health. In many ways, Karen's story of how she entered into

public service mirrored my own path. We bonded over being not only first generation college students, but also, the first people in our families to pursue post-graduate degrees. Karen shared with me stories from her family that mirrored experiences in my family and the families of so many others I had interviewed—substance use, criminal justice system involvement, and uncertainty for the children who are often present in the middle of these tumultuous times. It was clear from her tone throughout the interview that Karen was passionate about her job promoting public health, but it was also apparent that Karen was firmly aligned with the “Save the babies!” narratives in substance use.

Talking with Karen was critical to understanding how long-acting reversible contraceptives moved into the Tennessee county jails, as she was the primary architect of the program. When asked to explain how the LARC-program originated, her story started with the high rates of neonatal abstinence syndrome (NAS) in East Tennessee:

One day, back in 2013, I was called to a meeting, and there was a presentation on neonatal abstinence syndrome. This was probably in July, I think it was. And I had no idea, to be honest with you, what that was. I mean, I knew what fetal alcohol syndrome was, but you know, not NAS. And there were a few other executive level folks here in the office called to that

meeting, and they were showing, you know, how much there was. How much the burden was, and we were like “Oh my goodness, this is terrible”, cause I think there were like 900-and-some cases in the state at that time, and we were all just devastated, and we were like “Oh my goodness”, and they had made NAS a reportable condition that January so we finally had a snapshot of how bad it really was, and so, the regional director here, Judith Smith, pulled me aside after the meeting and said, “I want you to do something about this”, and I was like “What? Me?! Oh my gosh.” So I was like “Uhhhhh okay, so can I do whatever I want, get me a team together, the people I want?”. And she was like “Yeah, whatever you gotta do. I just want these numbers down”. Because in our fifteen county region, not including Knox, we made up 1/3 of that 900-and-some. It was ridiculous. (Karen)

This story about the origins of the LARC-program in the Tennessee county jails is particularly interesting because it reflects the pre-occupation of key stakeholders on NAS diagnoses—and the babies who are diagnosed—as opposed to focusing on programming designed to support pregnant substance users. Karen’s narrative about the beginning of the project is typical in that pregnant substance

users and opioids are non-existent, while reported diagnoses of NAS are driving the LARC-policies, thereby foreclosing structural explanations and accounts in prevention efforts.

Karen went on to explain the model used to develop the LARC-program in jails.

Back when I was a disease intervention specialist, we had several, several cases of hepatitis B. It was ridiculous. We actually, we noticed that there seemed to be one common denominator: almost everybody has been incarcerated at one point when we had done the interviews when we were investigating. We got a grant, and used the money to do hepatitis panels in the jails in Anderson county, and over 30% of the people were positive. I mean, it was really bad. And so, we done a program to where we did a presentation on what hepatitis was, and how, you know, you can control it, and how contagious it is. So I went into the jails on weekends, and conducted a presentation to the inmates on what hepatitis was, how easy it is to get it, what we can do to keep from getting it, and we were going to offer hepatitis B vaccinations, and I kept a particular system and I kept

up with it. And every weekend, I would do that. And if they were still in jail when it was due for their next one, great. If they weren't, you know, I had grandmother's phone number that the sheriff didn't have that way, I could reach them, where, you know, the sheriff couldn't. And you know, I would call them, and say "hey, can you tell so-and-so to come in, he's due to see me at the health department." We wouldn't tell them why or anything of course, but just tell them to call me at the health department, this is Karen. It worked out great. We started seeing our numbers come down. We still have that program, and it's federal now, and it's been great. That was 20 years ago! Anyway, I started thinking about that, and I started thinking maybe we could do an outreach in the jail. (Karen)

The description of the process through which criminalized, incarcerated people were targeted for LARCs in the Tennessee county jails did not include the explicit eugenic-based arguments which permeated the earliest sterilization laws in the U.S. Instead, Karen's description of the LARC program origins reflects the ordinariness of harm and control built into the logics of the carceral state. In this way, I was forced to confront my own beliefs about the people who were creating

and implementing the LARC programs in the county jails. For me, these programs represented the use of LARCs for the explicit purpose of prohibiting the reproduction of “undesirable” populations, particularly incarcerated substance users with the ability to become pregnant (Winters and McLaughlin, 2020). Instead, what I found was more reminiscent of the banality of evil described by Arendt (1963) whereby the horrific actions of Adolf Eichmann were juxtaposed against the “terrifyingly normal” nature of the man. Later, Arendt (1978) extrapolated on this by saying “The deeds were monstrous, but the doer—at least the very effective one now on trial—was quite ordinary, commonplace, and neither demonic nor monstrous” (pg. 4). Karen, a passionate public servant, was neither a Nazi nor a monster. She genuinely seemed to believe her actions were a service to people receiving the LARC and the community. However, the very notion that any “choice”—in this case, to opt to receive a LARC—while incarcerated is not inherently coercive must be interrogated (Roth & Ainsworth, 2015).

Of particular concern was Karen’s explanation that the Tennessee county jail LARC-program was simply a single component of what was a three phase “NAS Reduction/LARC Program”⁹. Phase 1 was the implementation of the LARC program in Tennessee county jails which house women. This program mirrored the hepatitis B program described above. Members of the Tennessee Department of Health LARC Team go into the county jails, give a presentation on

⁹ The program name has subsequently been changed to “Expanded Access to Family Planning Services”.

NAS, and then enable those who are incarcerated to sign up to receive a LARC. At a later date—which is not made known to the person receiving the device—a bus will pick up those who have registered to receive a device and take them to the closest health department for LARC insertion. Once at the health department, those who are incarcerated are brought into the facility through a side/back door into a waiting area separate from the entrance and waiting area for the general public. Karen indicated these accommodations were made to make those who are incarcerated—who would be shackled during most of their visit—as comfortable as possible. Karen stressed her requirement that everyone on the Department of Health LARC Team treat the people incarcerated with respect. Indeed, she insisted the Department of Health wanted to “roll out the red carpet” for them upon their arrival at the health department.

Phase 2 of the program expanded the LARC county jail program from East Tennessee to county jails across the state. Additionally, the second phase included offering the NAS presentation and LARC sign up at the health departments on a regular, recurring schedule. That is, a county health department might give the NAS presentation Tuesday from 1-3 p.m. and Saturday from 10 a.m.-12 p.m., weekly. Establishing regular presentation schedules was essential, because in the second phase, the Department of Health networked with county judges and court staff to establish the NAS presentation as a mandate of probation. Specifically, judges could mandate anyone—men and women—convicted of a drug-related offense to view the NAS

presentation at the health department within 90 days of sentencing. For those mandated to watch the NAS presentation as part of their probation requirements, failure to do so would result in a violation of probation and incarceration.

This was the phase the program was in during the time of my interview with Karen. Although she did not spend as much time talking about this phase, she told me a story about a 21-year old man, who was an opioid user, who asked if he could have a vasectomy because he already had 3 children, and he did not want any future children he might have to suffer with NAS. It is important to note that NAS can only be transferred to the fetus in utero, and therefore, it is not possible for the sperm of an opioid user to cause NAS. Karen's off-hand story about the preliminary "success" of the second phase reiterates the converge of the specific contexts of Tennessee—the fixation on NAS rates and abstinence only sexual education—which elucidate the emergence of Tennessee as the model state for LARC as a mechanism for reproductive control. In a state where students receive comprehensive sexual education, an understanding of the ways in which pregnancy and NAS occur could serve as a protective measure against state attempts of coercive reproductive control and a fuller cultivation of the aims of Reproductive Justice.

Phase 3, which has not yet been implemented, further expands the NAS presentation outside of jails and probation mandates into public schools and community organizations, including halfway houses and domestic violence shelters. Although the message of the NAS presentation is that opioid use during

pregnancy leads to NAS, the proposed solution of LARCs—like the ASAF assumptions—assumes that people cannot be trusted to engage in safe sexual practices which will prohibit pregnancy, and therefore, LARCs are the ideal solution to human error as LARCs require no action from the user once inserted by a medical provider. Thus, the expansion of the NAS Reduction/LARC Program outside of the criminal justice system into community spaces reflects the expanding carceral logics into non-explicitly carceral spaces through carceral creep (Kim, 2018; Thuma, 2014; Thuma, 2015; Willison & O'Brien, 2017; Rentschler, 2017).

Poverty

The inextricable connections between those who are criminal justice system involved and those who live in poverty are illuminated in the examination of the policies and programs which claim to assist or serve each group. Like the NAS Reduction/LARC Program described above, those who leave incarceration in Tennessee and want contraception are likely to struggle with many of the same barriers as those who live in poverty—unreliable or no transportation, no health insurance, and no regular healthcare provider. Much like the Tennessee Department of Health targets those who are incarcerated, A Step Ahead Foundation (ASAF) targets those who do not have reliable transportation or health insurance.

One of the questions I asked near the end of each interview was: Outside of contraception, what do you think would change the lives of the women you

work with? With this question, I not only wanted to explore how each key stakeholder understands their position within the larger social worlds, but this question also elucidates what these key stakeholders understand about their target populations and ideal clients. Importantly, answers were mostly consistent across all respondents, and answer variation was not based upon organization type, but rather, on geographic location.

One of the most thoughtful responses came from Sarah, a young white woman who seemed to articulate and want to advocate for the comprehensive needs of her clients.

Most of our clients need dignified work. They need livable wages. They need housing. They need therapy. A portion of the women I speak with will talk with me about previous instances of sexual assault, which I'm sure is not all of the women who have been sexually assaulted. There are some who will talk to me about it after class so if there's however many more women who *aren't* talking to me about it. They're facing horribly difficult situations where if they want to stay in the same home with their children, they have to stay with an abusive spouse. If they want to leave, they don't have the resources to fall back on. They don't have family here. They don't have good family here or

maybe their family is the reason they're in an abusive relationship or maybe their family is the reason they started using opiates. They need a lot of things. And I think birth control isn't always super high on the list, but they know that they need it. So when they have an opportunity to get something that they don't have to, it's just one less thing to think about. And one less worry that they have to have. I think that's a good thing, but they need housing and they need livable wages. Safe housing. (Sarah)

Although many other respondents listed housing, jobs, or transportation as critical needs for their target populations. Sarah advocated beyond a rattled off list to focus on changes to the conditions of life. That is, Sarah did not just want her clients to have jobs, but dignified work; not just housing, but safe housing. Sarah was the only respondent from her organization who articulated that while contraceptives were important, LARCs were not the “end all, be all” solution. Sarah also expressed the ways that she actively attempted to mediate any potential coercion of LARC-only programming.

One of my friends was concerned when I got this job because she said that other organizations that only touted LARCs were coercive, ummmm, and I wasn't sure, I hadn't seen that, like I didn't know what that

would look like or anything, but ummmmm I very,
very purposefully make steps *not* to be coercive, and
I encourage women to think about their lifestyle, and
what works for them. Like, if condoms work best for
them, if the pill works best for them, I have a sheet in
the bags that lists all the places you can get free
condoms, free birth control, free testing, so that they
know there are other options. (Sarah)

I was particularly surprised to hear Sarah discuss providing information about non-LARC contraceptive options as this was a direct violation of the policies of her organization. However, Sarah's personal commitment to comprehensive sexual education and comprehensive contraception led her to make decisions in her job that prioritized what was best for her clients, despite the potential repercussions for pushing against her organization's protocol. Sarah explicitly names the contradiction of her work—her commitment to comprehensive sex education and comprehensive contraception options are in direct juxtaposition to her role as a LARC-only provider. Sarah expresses good intentions regarding her involvement in LARC-only programming; however, her intentions do not negate her role in perpetuating the harms of LARC-only promotion. Sarah and Karen represent the ways in which divergent narratives can reproduce the same harms, despite differences in political commitments. That is, the programs administered

by Karen and Sarah—LARC-only services—have the same outcome, in spite of opposing ideologies.

Sarah also elucidated the overlap between the target populations and ideal clients living in poverty with criminalized populations.

Especially at the Department of Corrections, there were *a lot* of women that were sterilized, in what I would consider coercive circumstances, and now regret it. I've had more women ask me if there is a way to reverse sterilization than to ask me where can I get a tubal ligation for free. Probably twice a month, I'll be at a recovery center and someone will come up to me after class and ask, "Where can I get my tubes untied?" And was is, essure or ensure? Like, can they get those coils removed, and that has really reinforced the fears that my friend had or expressed to me. Like, I don't want to be that and I don't want to be a part of an organization that causes a woman to have regrets later on in her life. And women aren't always fully informed about their anatomy and the risks involved . . . so I think it's important that they're fully informed (Sarah)

The most significant points of divergence were along the rural/urban divides in the state. Transportation was a recurrent barrier for any location outside of Memphis or Nashville. Even though Knoxville and Chattanooga are metropolitan areas, the substandard public transportation systems and high percentages of their clientele residing outside of the city, mean that transportation access remains a tremendous barrier for accessing services. For urban based programs the answer to what other services clients need proved to be more difficult.

I don't think I have a good answer for you, because our clients all, you know, all are so different, and they all have different goals. That's why I hesitate. I think, education, for some of our clients, that would be really helpful. For others? Maybe not. Some of our clients have advanced degrees. So they're all unique. I just, I have a one-and-a-half year old, and I have never felt more passionate about what I do. I see how hard it is, how stressful it is—time-wise, sleep deprivation, financially, everything. I often times think, this would be really hard if I were in school, or if I were young, or if I didn't have family support, or if I didn't have a good job, or if, you know, rent was due, and I couldn't pay it. You know, everything is so stressful already, and I feel

really, even more so now, passionate about what I do,
because when you're not prepared for a child, I think it
can be really difficult. (Leslie)

The contrast between the tone of the conversations with key stakeholders in urban areas as opposed to rural areas was stark. Comparing Leslie's and Sarah's analyses of what their respective clients needed reflected a difference in how they perceived their roles within their respective communities. Leslie, who was in a major metropolitan area, worked with and had access to many more organizations which specialized in the various needs of her clients. She did not need to be as well versed in the nuanced needs of her clients as those folks likely received other specialized services. Whereas, Sarah, who was located in a rural area, did not have access to as many programs or organizations that could provide social services to her clients, and thus, it is more likely that her clients talked to her about the other needs they have as a way to, potentially, access additional services.

Race

While my participants openly talked about criminal justice system involvement or clients living in poverty, whether I was interviewing key stakeholders in the criminal justice system, public sector, or non-profit organizations, race was, simultaneously, non-existent and omni-present. With the exception of the activists and organizers—who are discussed in the next chapter—and two practitioners, the overwhelming majority of those I interviewed

were white. During these interviews, my participants never mentioned race unless prompted explicitly to do so, despite the fact that the racial and ethnic demographics of their clients varied significantly, and often, white people were not the primary target population or ideal client. Given the history that Black and brown bodies have routinely been the targets of state-sanctioned control (Roberts, 1997; Gomez, Fuentes, & Allina, 2014; Gubrium et al., 2016; Higgins, 2014; Higgins, Kramer, & Ryder, 2016; INCITE!, 2013), it was critical for me to interrogate the ways in which coercive LARC programs in Tennessee were shaped by race and ethnicity.

Central to the programming developed by ASAF are goals of academic achievement and professional success. Although these goals are not inherently problematic, the foundations of professionalization are rooted in white supremacy, and thus, represent proximity to whiteness. In the previous chapter, Sharon discussed the importance of teaching ASAF's teenage ambassadors "successful dressing" and "successful interviewing techniques" reflects the organization's focus on traditional pathways to success—trajectories of graduating from high school, attending a four-year college, getting a Bachelor's degree, pursuing a professional career—before having a family of their own. It is certainly true that within the current white supremacist capitalist heteropatriarchal system, this is the only suitable life trajectory (Ross, 2017; Ross & Solinger, 2017; Harris, 2011). Within this framework, children and families are burdens and barriers to professional and, by proxy, financial success. Whiteness and

proximity to whiteness by conforming to the ideals of a white supremacist capitalist heteropatriarchal system are simultaneously everywhere within ASAF's organization without ever being named as such.

The Facebook pages, Instagram feeds, and websites for ASAF feature racially and ethnically diverse photos and quotes of Black and white women, with more Black women represented in areas of Tennessee with larger Black populations—specifically, Memphis and Nashville. However, with the exception of a single section on the navigation bar on the official websites which say “Se Habla Espanol”, Latinx people are absent from the explicit marketing and recruitment posts. This was intriguing to me as repeatedly in interviews, each site indicated a significant portion of LARC recipients were Latinx.

People we tried to recruit to volunteer or to be on our board, we tried to hire, we got a huge uptick in services to the Hispanic population, and we had to hire a translator and we had to interview like, three people because they didn't agree with us, but eventually we did. (Sarah)

Yeah, I mean, you know, in Chattanooga they have a large Hispanic clientele. (Claudia)

I just started feel really concerned because I would look at my patient's charts, and you know, a lot of my female patients don't uhhhhh, they don't speak English as their first language, and a lot of them are undocumented, you know, and I would see, again and again, A Step Ahead Foundation listed as a payer in their charts so I knew they were getting LARCs, and just like, was there a translator present? We don't have anyone on staff so unless they are providing the translator, I'm just not sure my clients really understood or even consented (Kenneth)

While I had been looking for instances in which Black women were targeted for reproductive control, I had not anticipated coercive practices of reproductive control of Latinx folks in Tennessee. Kenneth, a federally qualified health center employee, was the first to really alert me to the concerns surrounding the number of undocumented Latinx clients receiving LARCs paid for by ASAF. This particular finding is difficult to unpack because of the nature of the organization. Although ASAF has educational programming and community activities, they are, primarily, a payer of last resort. Outside of scheduling an appointment for a client, ASAF has, potentially, extremely limited contact with their clients. Meaning, a person who is undocumented could call the ASAF number indicating they would like to receive free birth control, and it is possible that after ASAF secures the

appointment with the designated health facility, ASAF has no additional contact with the client. Thus, it is possible ASAF is unaware of their client's citizenship status.

Whether aware of citizenship status or not, providing LARCs to undocumented folks in Tennessee without a plan to address a client's potential detainment or deportation is irresponsible. Part of ASAF's core argument as to why they are not engaged in coercive practices is that they will facilitate removal of a LARC device at any time. Although this policy does, in fact, mitigate coercion, it is insufficient. Given the number of ICE (Immigration and Customs Enforcement) Raids in Tennessee, detainment or deportation of undocumented LARC recipients must be addressed by ASAF.

Chapter Summary

In this chapter, I have highlighted the ways in which criminalization, poverty, and race are inextricably interconnected creating webs of oppression. For those who manage to evade one aspect of these interlocking positions, the structures of oppressions are formulated so that reproductive healthcare options are so interrelated that total evasion of reproductive control feels unavoidable. Thus, these interlocking positionalities are targeted through public and private policies and programs to promote reproductive control of "undesirable" groups, specifically among criminalized, poor, and non-white populations.

CHAPTER SIX

RESISTING/RETHINKING

I walk into the massive ballroom which seems to run the entire width of the conference hotel. Black curtains run along the entire front of the ballroom. Hundreds of padded, hotel banquet chairs are arranged in five distinct sections. In front of the center section is a stage. In front of each of the other four sections—two on each side of the stage—are large screens. I'm early for opening ceremony, but I want to be able to find a seat in a location where I can see what is going on throughout the ballroom while still engaging with the crowd. The air conditioning in the space makes it feel like there is a cool breeze that blows periodically throughout the room. I've been at Sister Song's Let's Talk About Sex Conference since yesterday, when the pre-conference workshops started. This morning is official opening of the conference, and I can feel the energy in the air. As I stroll along the back aisle, a choir moves onto the stage for a soundcheck. The choir director moves in front of the group, counts to four, stomps her right foot, and the choir shouts "5, 4, 3, 2, 1" before moving into a four part, staggered, acapella version of Ciara's "Level Up".

As the choir starts and stops their song for soundcheck adjustments, a DJ wearing a chambray shirt and silver jewelry starts setting up their gear in the back left corner of the stage. Several people dressed all in black are moving microphones, setting up video cameras, and as the choir exits the stage, I find a seat of the edge of the section to the right of the center. More and more people are streaming in through the three sets of double doors in the back of the ballroom. The DJ starts playing "Queen Tings" by Masego and Tiffany Gouche. The atmosphere is energetic and open. People are greeting one another like it's the last few moments before the official start of a Pentecostal church service—hugs and handshakes. The DJ transitions to "Borderline (An Ode to Self Care)" by Solange and people are dancing in the aisles and in front of their chairs.

I'm trying to balance being present in the moment, in the space, while keeping notes of all that is happening around me. The woman in front of me was trying to take a selfie, and I managed to inadvertently be in the background of her photos. I lean forward and apologize to her before moving my photo just out of the camera frame. A group of people I had been in the pre-conference workshops sit across the aisle from me, and we compare notes on which panels and presentations we're planning to go to. The room has continued to fill with no empty seats in the middle three sections of chairs. Over the chatter in the room, the DJ starts playing H.E.R.'s "As I Am" as the lights in the ballroom dim even further. I'm surprised at the energy in the space—the room seems to buzz with anticipation, like the feeling at a concert after the opening act has played, right before the main band hits the stage. It's palpable, and even though I have no idea what to expect, I can't wait for it to begin.

The room is probably the most diverse space I've ever been in—butches, femmes, sex workers, elected representatives, Black, white, Latinx, Asian,

Indigenous, those dressed in their Sunday-best with hats to those dressed in their favorite club wear, from suits and ties to leggings and sweatshirts—somehow, in this space, in this time, it all feels right.

The lights dim all the way as India.Arie's "Strength, Courage, and Wisdom" starts to play. People in the crowd stand up at their seats, sing along, dance, clap. A group of four Black women dressed all in white begin to make their way to the stage from the back of the ballroom. The crowd cheers even more. As the song comes to an end, the crowd still standing, grows silent. Four Indigenous women walk out onto the stage. They share their names and their tribal affiliations. They begin the ceremony with a land acknowledgement – not only acknowledging the Indigenous people who were the original protectors of the land upon which we stood, but also acknowledged the need for community support to the Indigenous communities who continue to protect the land, water, and air—often in displaced spaces. There is a reverent silence in the room. Suddenly, from the back of the room, the sound of drums fills the space. Two men carrying traditional drums walk up the aisle, as they reach the stage, Monica Simpson, the Executive Director of Sister Song, also dressed in a flowing white dress, joins the other women dressed in white and the drummers at the front of the stage. The crowd applauds wildly.

Monica asks for everyone who is able to stand and to take a collective deep breath—in through the nose and out through the mouth. She then asks us to close our eyes and place our hands over our hearts. We walk through a gratitude exercise where we turn to face the north, south, east, and west, with a reading about the seasons of life—fall, winter, spring, summer—corresponding to each navigational direction. It is an exercise in mindfulness, reflection, and intentionality. To think about what has happened and what has yet to occur. To reflect on the past and the possibilities. As we return back to facing the stage, the Indigenous women return to the stage to complete a water ritual. In this process, Monica asks us to shout the names of spirits—those who have passed and those who are still with us—that we want to invite into the space. From across the room, I hear the names of influential Black women: Angela Davis, Audre Lorde, Toni Cade Bambara, Rosa Parks, Toni Morrison, Fannie Lou Hammer, Ida B. Wells, bell hooks.

As the ceremony comes to a close, we take another collective deep breath—in through the nose and out through the mouth. I can't really explain how I feel in this moment, but I feel connected. We created a space of intentionality as a way to begin the conference. In spite of—and maybe because of—our differences we are one. As I reflect on this moment at the end of the weekend, I realize just how important this ceremony was for developing the foundation for the hard conversations, the challenging dialogs we would have over the next three days. (Fieldnotes: October 2019)

In the last two chapters, I have highlighted the ways in which reproductive control and coercion uphold structural oppression and neglect intersectional frameworks. However, the coercive implementation of long-acting reversible contraceptive (LARC) only policies and programs are not only sites of reproductive control. They are also sites of resistance and reimaginings of the possibilities for reproductive liberation and bodily autonomy. The foundation of Reproductive Justice was developed through the situated knowledges of Black women who understood how the work of reproductive liberation and bodily autonomy necessitates a reflexivity of the specific conditions of identity, social location, and lived experience; thus, the pathway to liberation is always already complex and nuanced.

Throughout my fieldwork, I simultaneously experienced being demoralized with despair and rejuvenated with hope. The complex, interlocking webs of reproductive coercion reflected a larger experience of confinement—limited contraceptive options, minimal social services support, and restricted access to services, funding, and necessities required to survive. However, even in the depths of desperation, there was a resolve to persist in spite of the seemingly never-ending challenges to liberation. In many ways, the determination to survive was fueled by the complexity of the challenges and barriers to liberation. To be clear, I am not arguing the forms of resistance and reimaginings I highlight here—collectives, mutual aid, or rethinking Borderlands—are the singular pathways to reproductive liberation. Instead, these mechanisms and frameworks

represent responses to the particular geographic and cultural challenges in the U.S. South, generally, and in Tennessee, specifically.

As I highlighted in the previous chapter, reproductive control has historically emerged from “progressive” movements. Thus, the interrogation of organizations claiming reproductive freedom or emancipation and the frameworks from which these organizations operate is essential. I was routinely confronted by the recognition that people or organizations that I had assumed would be allies in fight for reproductive autonomy were often implementing policies or reproducing ideologies in opposition to the foundational principles of Reproductive Justice. Most intriguing was the lack of awareness or reflexivity people and organizations had regarding their perpetuation of factually incorrect narratives or eugenicist-based ideologies.

Additionally, even within these spaces of resistance, positions or arguments that challenged assumed “progressive” or highly visible organizations—such as Planned Parenthood—resulted in decreased access or support resulting in the deconstruction of coalition building required for transformative work. Ending this chapter by revisiting the concept of the Borderlands, I am arguing for a reimagining of sites of resistance as spaces freed from the restrictions and limitations of binaries and geopolitical barriers. That is, we must shift our perspectives out of colonized epistemologies and toward Black and indigenous situated knowledges in our pathways of liberation (Palacios, 2016).

Collectives

After spending time in the field, I developed a few relationships with community organizers who were actively engaged in an anarchist collective. This group was predominantly focused on issues related directly to substance use, and had been working to develop supervised use sites within the community. Although my research was not specifically focused on substance use, the collective had observed what they believed to be a calculated attack by state actors and non-profit organizations on the substance use community they served. I knew the group existed; however, I had no information about who was in the group or what their plans were. A rumor—the origin of which I was never able to determine—emerged claiming that A Step Ahead Foundation was planning to target people experiencing homelessness in an area known for being close to social services and to encampment areas. In an effort to develop a resistance plan, I was invited to a group meeting to talk about my preliminary findings.

The collective consisted of 8 members who worked in a range of related fields—from mainstream organizations to well-known anarchist groups. In general, the group seemed very hesitant to have me attend the meeting, and had the person who had invited me to the meeting not been a central figure in the collective—who could have been fired for their participation in the group's services—I would not have gained access at all. During my first meeting, I reiterated to the collective that my goal was simply to understand the work they

were doing related to the LARC programs and policies and to share any information I received about the next phases of LARC-promotion in Tennessee. One of the most vocal participants in the group, Katie, a well-connected woman in her late twenties, started giving the group background information on ASAF.

They started in Memphis, there was a judge who said something along the lines of, that they were tired of seeing all these women having children they couldn't afford, a lot of the people who are large donors to A Step Ahead and on their board are Republicans, a lot of them women, but they typically do not have a lot of medical representation. (Katie)

While most of this information is accurate, what is not correct is that the majority of the people who sit on the board are Republicans. In fact, most of the women heavily involved in A Step Ahead—either through board members or donors—are Democrats. Although this inaccuracy might seem like a slight issue, it represents a much larger problem. The default to a binary of Republicans are bad and Democrats are good creates a potentially dangerous precedent whereby the actions of Democrats cannot be critiqued. In the case of ASAF, the creation and implementation of the LARC-only programming both emerges from women who identify as Democrats *and* is potentially coercive. To default to party politics leaves no room for a critique of long history of liberal white feminism within the

Democratic party—and its role in expanding the carceral state (Murakawa, 2014; Gottschalk, 2014).

However, Katie also highlights the necessity of ASAF's services in the wake of the removal of Title X funding due to the implementation of the gag rule.

The local group does IUDs, implants, and depo shots, and they reach out to us a lot asking us to refer people to them, but they won't refer people to us as it is part of their charter that they are an adamantly anti-abortion organization. They will not work with or assist in any way any organization which provides abortion services so they ask, or our relationship with them, is that they ask us to refer to them, so they can refer to any health center that isn't us, but that's a complicated thing because A Step Ahead isn't in our principles, but when we do see patients who are like "I've done my research, I know my options, I want an IUD, but I can't afford it", that's, at this point, one of our only options to direct them to since we are no longer able to offer low-cost or sliding scale services in that area. Ummmm so we see them targeting us a lot. (Katie)

Utilized in this way, ASAF can be used in a non-coercive way, but in a larger context of reproductive oppression statewide and in the U.S., a program designed around limited contraceptive options reifies, rather than resists, reproductive control. Recommending well informed people who have decided to get a LARC prior to contacting ASAF mitigates the potential harm that would be generated from receiving a LARC simply because it was the only form of contraceptive device available to you. Again, because ASAF is really just a payer of last resort, people can use their services while having limited contact with the organization.

The collective wanted to discuss next steps to protect the communities they serve from coercive LARC-programs, and I was surprised to learn there were no plans or suggested plans within the group.

We're really looking for a place to begin, and we have connections with our organizations, but we're just not sure how to move forward. Some of us have gotten swamped with this legislative cycle, and I think there are other organizations who might support us. (Katie)

In that moment, I felt helpless as I did not have a plan to offer any additional suggestions for strategizing resistance. I had come to their meeting to present what information I had about the ways in which LARC-only policies and programs functioned and the ways in which the public and private worlds were integrated. I thought I would listen to the strategies for resistance they had been

brainstorming, and would offer insight into the ways in which their strategies could be most effective. For this collective, concrete strategies for resistance were limited.

Mutual Aid

One of the most effective strategies of resistance to reproductive control was wide-spread use of mutual aid. A survival tactic often utilized by activists and organizers, mutual aid is the process whereby people provide help and assistance to one another—often through financial donations, such as GoFundMe accounts to pay for medical costs; donating needed supplies, such as sending medications and cleaners that are out of stock due to pandemic related panic buying; or volunteering services, such as grocery shopping or providing transportation. Although mutual aid is used widely in progressive spaces, I want to highlight the work of one particular organizer—Laurie Bertram Roberts—who runs the Mississippi Reproductive Freedom Fund. Although the Mississippi Reproductive Freedom Fund is listed as an abortion fund, it functions as a reproductive justice mutual aid.

I mean, I'm just going to say it. We get listed as an abortion fund, and well, we are. You know, I will take the money people want to send in for abortions, but you know what else? I won't just be another, another person who wants to only pay for abortions for us Black folks. Because I know that some of those

abortion fund donors, the money those foundations give out, they all want the same thing. Stopping us from having more babies. Fewer Black folks. And brown folks. And poor people. I mean . . . (laughs) I will take their money, but only if I can use it to give my community what they need. And you know what else? And I tell them this, If you don't trust me or the people I give this money to, then don't give. Just don't. I will find the money someplace else. Because if you don't trust us, then you really aren't with us. And that's all I need to know. (Roberts)

Although support for abortion funding, transportation, and support are essential, so is support for those who choose to have children. Epitomizing reproductive justice, Roberts manages to balance both—providing resources for those who wish to terminate a pregnancy with celebrating Black motherhood. In an interview, Roberts said “Who celebrates Black women having babies? No one.” Roberts sentiment is clear, but so is her advocacy. Roberts celebrates Black women having babies through a Reproductive Justice epistemology.

The structure of the MRFF emerged from Roberts's own experiences—these powerful narratives from someone who is directly impacted by the structural oppressions of white supremacist capitalist heteropatriarchy are at the core of the Reproductive Justice tradition (Ross, 2017; Ross & Solinger, 2017;

Harris, 2011; Liddell, 2019). Roberts, who is biracial and disabled, shares some of her earliest experiences of racism being raised in a fundamentalist, conservative, predominantly white church in Minnesota. In spite of the oppression she experienced within the church, Roberts has transferred the skills she learned in the church as the foundation for her community organizing work. Of her experience in the church, Roberts has said:

The thing about being a “fundie” is they pretty much all believe in evangelizing—in going door to door, winning souls, and giving out those tracts to strangers. From the time I was 3, I was trained to do that. Community organizing is nothing compared to pushing religion on people. I was taught to have no fear (Grant, 2019)

After moving to Indiana, Roberts dropped out of high school, married, and had twin daughters by the time she was 16. Over the next decade, Roberts had five more children, whereby the experiences with healthcare providers and crisis pregnancy centers served as the catalyst for the later development of the MRFF. A positive experience at a Planned Parenthood clinic revolutionized Roberts then-pro-life perspective. Facing an unviable pregnancy and in need of an abortion, Planned Parenthood advised Roberts to seek treatment through Medicaid, which covered medically-necessary abortions; returned the cash payment Roberts had given Planned Parenthood for the abortion; and followed

up with her after her procedure. This moment of advocacy on the part of the clinic contradicted the lies about Planned Parenthood Roberts had been taught.

I was taught that Planned Parenthood will give you an abortion even if you're not pregnant, to take your money. [This experience] didn't make me super pro-choice at the time, but it opened my eyes . . . It debunked a lot of lies I was taught as a kid. (Roberts)

When Roberts needed a pregnancy test a few years later, she went to a crisis pregnancy center, which often advertise free pregnancy testing. Having recently given birth a few months before, struggling to maintain multiple service jobs, and trying to leave her abusive partner at the time, the crisis pregnancy center counselor impressed upon Roberts the importance of marrying the father of her unborn child, in spite of her desire to leave the relationship. The crisis pregnancy center counselor suggested Roberts to pray more as a solution to the complex circumstances she was navigating. The chasm between Roberts's experiences at Planned Parenthood and the crisis pregnancy center solidified Roberts resolve to develop a different kind of pregnancy center.

In the wake of the 2016 election, Roberts saw donations to her organization skyrocket from \$3,500 to \$34,000. The increase in funding enabled the MRFF to purchase a small house in Jackson known as the "fundshack". This community-oriented space, unlike the limited support model of A Step Ahead, houses a multitude of resources: the abortion-funding hotline, free

accommodations for patients traveling to Jackson for appointments, distribution center for condoms and Plan B emergency contraception, warehouse for a diaper bank, abortion doula support site, and community location to host baby showers. As a reproductive freedom fund, Roberts works to have the flexibility to provide those in her community with whatever they might need to support their reproductive health choices.

Our job is to facilitate wherever people need to go, on their own terms. We put the money in their hands because we trust women and poor people. I don't care if they take that money and put it towards paying their light bill. (Roberts)

This kind of mutual aid structure has received pushback as people who donate money often express a desire to control how their money is being used. This is particularly true for the MRFF since it is often listed as an abortion fund. Roberts has been clear that her experiences of being surveilled from state agencies as a Black woman, a mother, and a poor person are foundational to the way in which she operates her reproductive freedom fund. That is, if someone is requesting cash, Roberts provides cash assistance to them. Roberts's approach enacting trust of women and poor people to know what is best for them is controversial even in some self-identified progressive spaces. Following one panel presentation where Roberts had just outline her approach of treating women and poor people with dignity and respect by administering cash payments and not

requiring means testing or reimbursement for expenses, an older white woman from the audience raised her hand to share with the group that her church only provides gift cards to women in need to “make sure women spend the money on what it was intended”. What was perhaps most perplexing about this comment was that the woman making the comment seemed to believe that her church’s approach to financial support was the same as the MRFF. Although gift cards are preferable to more restrictive support programs—such as requiring recipients to “earn” dollars which can be used to “buy” used items from an organization—the gift cards represent underlying ideological logics of control centered in racialized notions of mistrust or disbelief that women and poor people do not truly know or cannot make decisions regarding what is best for them and their families.

Promoting her work at the SisterSong Let’s Talk About Sex conference and the Health and Free Tennessee Annual Convening, Roberts centers trust, dignity, and respect for Black, brown, and poor women as the foundation from which the MRFF was established. For Roberts, mutual aid is the primary method of assistance to those in need which does not require nor invite surveillance into the already hyper-surveilled lives of Black, brown, and poor people. Her agenda is clear—transforming the lived experiences of the communities she serves through the reduction of structural barriers rather than the reification of oppressive structures of the state and non-profit organizations, who promise freedom through continued subjugation. Organizations which require means-testing, reimbursement, or coverage for a limit selection of choices—no matter

how progressive they might claim to be—are ultimately indicative of the underlying ideological logics of patriarchy, white supremacy, and ableism which claim to “know better” than those who are surviving within oppressive structures.

Borderlands

Returning to the earlier conceptualization of living within the Borderlands, collectives and mutual aid represent concrete examples in our modes of resistance. However, the Borderlands are not merely spaces of resistance. Instead, the Borderlands are spaces where the freedom to reimagine the work of reproductive liberation and bodily autonomy emerge and thrive. Utilizing Anzaldua’s conceptualization of living within the Borderlands represents a cognitive and ideological shift in terms of how we think of reproductive liberation. To engage in reimaginings of reproductive autonomy, the geographic and cultural variations across the South requires a deconstruction of state borders as meaningful geopolitical boundaries, and instead, constructs the peculiarities of place as critical to successful resistance and liberation.

The conceptualization of deconstructing geopolitical boundaries and shifting to a Borderlands centered practice of liberation emerged from an interview I had with Kacie, a community worker in North Carolina. We connected through a close relationship I had formed with LM, a researcher and community worker in East Tennessee. In a discussion about the similarities between programming in western North Carolina and Eastern Tennessee, Kacie

highlighted on particular program which shifted through the work of community workers to become more client centered.

A very large grant-maker that funds health research and programs

here, funded a program that ended up being a peer support program, the first version of the grant, was to fund LARC for substance using women in these rural counties, and that was going to be this wonderful thing. The first version which had peers in it, the peers would like, talk to these women about how important it was for them to be on LARC. It was like, LARC coaching. . . [A subsequent version of the grant] focused on working with peers to identify their [substance using women's] goals, and work with them on their goals. And then so, . . . the second and third years all of the clients were like "my goal is to have transportation to job interviews, and appointments, and meetings at my kid's school" and "my goals are to get a job and buy a car". So the goals weren't about reproduction and the goals actually weren't about parenting either. Wow, I can actually parent my child more effectively if I can drive places. (Kacie)

This program reflects the importance of expanding the understanding of space in regards to community work. Western North Carolina, which is firmly situated in the Appalachian mountains, is largely poor and rural, and is distinct—culturally and geographically—from the urban centers of Charlotte, Raleigh, and Durham in the eastern part of the state. It is through this perspective where we can begin to see East Tennessee—which is also culturally and geographically distinct from the urban centers of Nashville and Memphis—and Western North Carolina as mirrored in terms of barriers and challenges.

However, the space of the Borderlands is not limited to geographic locations. In fact, the Borderlands is a space which exists outside of the binary—a construction that refuses to adhere to the false dichotomies created, introduced, and upheld by the structures of systemic oppression of state and non-state actors. Kacie highlighted this Borderlands work in action by highlighting the creative problem solving strategies utilized by the peer mentors described above.

Some of what came up in that was interesting because it was things like DSS would require going to a certain number of meetings to retain custody, and then people would be like “how am I supposed to get to those meetings? I don’t have childcare. There’s not childcare at those meetings, and I don’t have a car. So the peers would end up doing really creative

things like picking them up and driving them to the meetings, and then entertaining their kid while they were at the meeting. Which is not really what a peer is supposed to do. But the peer was like “well your goal is to keep your kid, and to get a job, and if you have to miss work to go to a meeting when you have childcare, well then, let’s just figure it out. (Kacie)

Borderlands also provides a useful framework for moving outside of the binary of the omnipresent question within the LARC-focused programming of who should or should not be having children. Although rarely explicitly addressed, the underlying ideological logics are built around this question whereby women who do not have an education, a successful career, or resources to provide for a child should not be having them. Unfortunately, the hyper-focus on the prevention of pregnancy among women who “should not” be having children, neglects the children many women—particularly those who are substance users, who have been incarcerated, or are poor, Black, or undocumented—already have.

On some level the LARC stuff is just so future focused. Like sure, convince this person not to have more children. What about the children they already have? Okay great, you just got them to accept a [contraceptive] method that means they’re not going

to have any more children for the next 5, or 7, or 12
years. What about the children they already have?
Are you going to help them in any way with that child?
(Kacie)

Instead, in Tennessee, the state has worked to expand child abuse charges where either mothers or their infants have tested positive for opioids, specifically, regardless of the presence of NAS symptoms, effectively, turning healthcare providers into informants for carceral agents. This expanding reach of mass surveillance is so pervasive that it extends beyond observations of “suspicious” behavior or visible signs of substance use into invasive—typically covert—testing of a birthing mother’s urine or of blood from an infant’s umbilical cord for drugs. By turning information about positive drug tests over to the state, healthcare providers are, then, enabling the removal of infants from their families—the first step in severing parental rights.

LM and I talk about this so much, and I also feel like
there are times when we take a break from talking
about it because it’s just so maddening. I, sometimes,
forget how bad it is there. I mean, it’s bad here, but
we have a prevention program so if you know there’s
going to be a notification there’s some things people
can do in advance to kind of get set up to prevent it
[child removal].

The experiences of surveillance or accessing resources is shaped by the complex intersections of gender, race, and class within geographic spaces. It is, perhaps, unsurprising that white people who use substances who reside in highly resourced areas—substance use treatment facilities, safe and reliable transportation, safe housing, high quality and culturally competent healthcare providers—are less likely to experience the same level of surveillance as Black and undocumented people who reside in the same locations.

But even in terms of where there's perinatal substance use treatment, you know, like, where there's any kind of treatment. And also, I think in some ways, you know, I don't think this holds true for folks of color, I think there's more awareness of NAS. I think you're no better off if you're an urban Black woman in terms of the likelihood of having your child removed, ummmm, I think if you're a white parent, being in an urban environment is significantly better. In terms of just providers' awareness and understanding and the likelihood that somebody is going to be able to provide comprehensive treatment. Or that your pre-natal provider is going to be able to refer you to substance use treatment. Or that your substance use treatment provider is going to know

anything about perinatal stuff. I think regardless of urban or rural, being a person of color or undocumented is going to be just as scary to think about accessing care.

The failures of community proposals which argue for increased resources alone is that the proposals are often “colorblind” in their development and implementation. However, neglecting to account for the disparities experienced by Black, brown, indigenous, undocumented, poor, disabled, queer, criminalized and substance using people cannot lead to liberation (Palacios, 2016). That is, simply making systems that are rooted in the logics of white supremacist capitalist heteropatriarchy “nicer” or “more accepting” will only benefit those who are, have proximity to, or uphold the very systems of oppression we are seeking to change (Maher, 1990).

It is from this perspective that the Borderlands emerges as a site of liberation. The Borderlands represents that which is always already—always already existing outside of a binary, always already a challenge to larger hegemonic structures, always already surviving in the face of destruction. It is from this space of the Borderlands that Black and indigenous women have resisted and reimagined ways of knowing and ways of being, and these traditions are the roadmaps to liberation for all.

Chapter Summary

In this chapter, I have highlighted the ways in which community collectives, mutual aid, and the concept of the Borderlands work together to resist systemic structures of oppression and reimagine pathways to liberation. The activists, organizers, and community workers who develop and manage community collectives resist the implementation of coercive LARC-only programming and inform the communities they serve about coercive policies and tactics. In addition, community collectives organize mutual aid to provide cash assistance, supplies, and services for communities in need without requiring the invasive surveillance of the state. Finally, the emergence of the Borderlands as a key concept for reframing the work of reproductive autonomy utilizes the work of Black and indigenous women as an inclusive path forward toward liberation.

CHAPTER SEVEN

DISCUSSION AND CONCLUSIONS

We currently face a new landscape of reproductive control. Long-acting reversible contraceptives have emerged as unchallenged emancipatory mechanisms in the long fight for reproductive autonomy. The highly effective devices prevent pregnancy for 3 to 10 years, depending upon the device, without any intervention of the user after insertion by a healthcare provider. The current political climate in the United States, the Trump administration and emboldened, overwhelmingly Republican, state governments have sought to revoke or chip away at abortion protections across the U.S., generally, but in the South, particularly. Thus, the fear surrounding the inability to terminate an unwanted pregnancy through abortion has contributed to the rise of long-acting reversible contraceptive promotion as the primary solution to the legislative assault on reproductive autonomy.

Given the history of myopic focus on abortion access by white feminists, it should be, perhaps, unsurprising that many of the organizations implementing and engaging in LARC-only promotion are organizations operated by white, Democratic voting women. In Tennessee, the legislative challenges to abortion access are further complicated by the bipartisan efforts to stop opioid substance use during pregnancy to reduce the number of babies born with neonatal abstinence syndrome (NAS). High rates of opioid use during pregnancy and subsequent, NAS treatment have posed significant financial challenges in Tennessee due to limited state resources as a result of austerity-based

legislative decisions. Specifically, opting out of the Medicaid expansion provided through the Affordable Care Act has eliminated the ability to treat expectant mothers struggling with substance use disorder. Thus, with no resources to pay for treatment and inadequate facilities to accommodate substance users with children, pregnant opioid users, often, do not receive any treatment and are, often, incarcerated.

Severely restricted state funding as a result of austerity-based legislation has created a gap in healthcare access which enabled the emergence of non-profit organizations—such as A Step Ahead Foundation—outside of the constraints state and federal funding through the reliance upon private donations. By utilizing private funding, organizations can avoid the protections built into federal legislation—such as Title X, which requires coverage of all forms of contraceptives—to provide selected services, informed by their own ideologies. The characteristics of LARCs—highly effective and user-friendly—are cited as the primary rationale for providing LARC-only coverage. Recognition of the power imbalance produced by the discretion of healthcare providers in the required insertion and safe removal of LARCs is excluded entirely from the narratives of LARC-only promotion.

Outside of non-profit organizations, state entities—such as the Tennessee Department of Health and the Tennessee Department of Corrections—serve as a secondary site of LARC-only promotion in the state. By using NAS-reduction specific programming, the state of Tennessee developed a LARC-only promotion

position to target criminalized, incarcerated, and criminal justice system involved people for pregnancy prevention. Although this programming centers on the premise of voluntariness, administering a program to people who are incarcerated or under the threat of incarceration while on probation eliminates the ability to enact voluntary choice; thereby, being involuntary as an explicit function of the carceral state (Alexander, 2012; Sufrin et al., 2015; Sufrin, 2017).

The centering of LARCs as the primary mechanisms of reproductive control by state and non-state actors has also led to an emergence of resistance and reimaginings of the pathways to reproductive liberation and bodily autonomy. Activists, organizers, and community workers have engaged with LARC-only promotion as mechanisms of reproductive control through the work collectives and the redistribution of capital through mutual aid initiatives. Although collectives and mutual aid are insufficient to produce reproductive liberation, they provide support, services, connection, and community, which are essential in the continued pursuit of bodily autonomy. It is from my fieldwork with activists, organizers, and community workers, that the critical importance of understanding and utilizing the Borderlands as a framework for reimagining the work of reproductive liberation emerged. To move beyond the limitations and restrictions of the colonized epistemologies, which serve as the foundation for the cultural and geopolitical understandings of the law, is only way to move beyond the binaries that are created and recreated, even in spaces of resistance. To reimagine resistance to reproductive control through the Black and indigenous

situated knowledges of the Borderlands is to center the complex and multiplicity of pathways that must be moved forward toward bodily autonomy.

Limitations and Directions for Future Research

This study elucidates the how the convergence of unique characteristics within the state of Tennessee provided a foundation for the ideal conditions of reproductive control through the coercive implementation of LARC-only policies and programming. By exploring the influx of private funding into public infrastructures, the identification of target populations and ideal clients, and the emergence of resistance and reimagining in the face of this new wave of reproductive control, this dissertation represents a snapshot of the current processes of reproductive control in the state and provides a foundation from which future work can be built.

Despite the critical findings outlined in this project, increased access to actors and spaces within the criminal justice system are needed to further understand the processes of reproductive control in incarceration facilities. The only criminal justice system-based participants who were willing to go on the record with me about LARC programming in jails were in roles related to advocacy of reproductive healthcare access for those who are incarcerated. Judges who promote the integration of LARC programming through drug courts or probation mandates seemed less inclined to agree to speak on the record with me, which might be related to the proximity of my data collection and the public

controversy of a Middle Tennessee Judge who was sanctioned for offering reduced jail sentences in exchange for LARC-insertion.

Additionally, after spending an additional 12 months in the field during my dissertation research, I gained increased expertise and meaningful access to the organizations who are doing the work in the communities of either promoting or resisting LARC policies and programs. Although I was knowledgeable about the basics of LARCs, reflecting upon my early interviews in the field, I recognize the lack of established research on LARCs as mechanisms of reproductive control contributed to missed opportunities to ask follow up questions that would have yielded additional insights into the ways in which LARCs are utilized that I had not even been aware of at the time of the interviews.

Particularly important for future work, my initial results have indicated the importance of partnering with researchers, healthcare providers, and organizers across the U.S. and abroad, specifically in Ireland, to understand the shifting nature of reproductive control. In a 2018 referendum, the people of Ireland voted overwhelmingly to repeal abortion prohibition laws. This victory for abortion access emerged from a strategic targeting of the general public and by systematically moving reproductive healthcare outside of the control of the state. The strategies utilized in Ireland can provide a framework for understanding how meaningful shifts toward reproductive autonomy are possible, even within highly contested spaces. That is, examining the ways in which reproductive control is implemented across diverse spaces—geographically, politically, culturally—

enable us to avoid replacing one system of reproductive control with another and to develop strategies of resistance that are most effective based upon the challenges and barriers unique to the communities with whom I am working.

There were many findings from my data which I could not cover in this dissertation and which require further exploration: the diversity of religious responses in the promotion of LARC devices as mechanisms of reproductive control, the impact of geography on the promotion and resistance to LARCs, the prevalence of cisgendered heteronormative construction of LARCs both within LARC promotion programs and LARC-only resistance, and the perceived lack of power between stakeholders in the criminal justice system. Each of these additional findings represent areas of future research.

This project is the first step within a larger research trajectory of understanding the ways in which laws and policies shape the most intimate aspects of our lives. Through these initial, exploratory findings, this project evolved beyond centering programs designed to control the reproductive capacities of incarcerated people into a broader understanding of the ways in which reproductive healthcare in the U.S., writ large, is so easily coopted to perpetuate systems of reproductive control. I hope to bridge the gap between Reproductive Justice and mass surveillance research. Reproductive Justice, as it is broadly understood, is essential to the future work in mass surveillance, which has largely focused on the impact of carceral creep on the neutral subject. However, the lives of the hyper-surveilled are not neutral. The lived experiences

of surveillance are shaped by the complex intersections of gender, race, class, sexuality, and ability (Malat, 2000; Paugh, 2017). Without an integration of the inherently intersectional Reproductive Justice theory and praxis with our understandings of mass surveillance, we cannot understand how to recognize and resist surveillance, particularly as it accompanies reproductive control.

Concluding Thoughts on Reproductive Control

In concluding this dissertation, I return to the reasons which motivated my decisions to explore LARCs as mechanisms of reproductive control. I started this project to understand the logics and processes which led to a LARC-only program run by the Tennessee Department of Health in the Tennessee county jail system. With the long history of sterilization abuses of people who are incarcerated by the state, I was suspicious of any program that targeted the bodies of those who are incarcerated, whose lives are obfuscated by the walls of bureaucracy and social isolation.

Beginning with the criminal justice system, the logics which support the reduction of reproduction among not free, not white, not cisgendered, not heterosexual, not able-bodied, not employed, not sober, not financially secure people tend to be much more direct. Often those who are not free, particularly those whose lived experiences are defined by the compounding nots, are villainized as burdens to the larger social system, and often, because this perceived status as a burden is further accompanied by assertions that those who are not free deserve to be punished, there is little public outcry against

programs which systematically control the reproduction of those who are not free. The proliferation of the logics of deservedness—specifically who does and does not deserve to have a family—feeds the underlying logics of white supremacist capitalist heteropatriarchy (Ross, 2017; Ross & Solinger, 2017; Harris, 2011; Nayak, 2015).

What is so dangerous about the proliferation of reproductive control of the most oppressed within the U.S., is the failure to understand the powerful, much cited, quote by Audre Lorde: “I am not free while any woman is unfree, even when her shackles are very different from my own”. To assume that one is beyond the reaches of reproductive control does not fully appreciate the precariousness of reproductive choice in a society which is built upon reproductive oppression. The precariousness of reproductive choice is apparent in the reduction of free and low cost birth control options which had previously been provided by federally qualified health centers who have been harmed through the implementation of the gag rule in Title X funding—particularly, reproductive healthcare centers like Planned Parenthood.

In the current political moment, with the fruition of a decades long process of stacking the U.S. court system with anti-choice justices, the precariousness of reproductive choice has become a rallying cry among many white, liberal, Democratic women. Unfortunately, the focus on *Roe v. Wade* alone, misunderstands the actual gravity of reproductive choice in the U.S. and the essentiality of a political vision grounded in the fullness of Reproductive Justice.

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APPENDICES

Appendix A: Informed Consent Statement

Informed Consent Statement

Study of Long Acting Reversible Contraceptive Programs

INTRODUCTION

You have been invited to participate in a research study. This study seeks to trace how long-acting reversible contraceptive (LARC) programs emerged and currently operate in East Tennessee. It is my hope that it will provide valuable information for states considering ways to address the public health issues associated with contraceptives and pregnancy.

INFORMATION ABOUT PARTICIPANTS' INVOLVEMENT IN THE STUDY

I expect interviews for this study to take between one and two hours, and intend to record the interviews with the use of audio recorders or video conferencing software so that I can transcribe them for research purposes. The recordings and transcriptions will be kept secure and will not be provided to anyone outside the research team without your written permission unless required by law.

RISKS

The only risks associated with participation in this study are professional. For example, if you make a statement to the research team that could be negatively interpreted by someone in your professional institution and that statement becomes public, that might have negative consequences for you as a professional. This could occur either because of a breach in confidentiality procedures or because you agreed to participate for attribution (see Option B below).

BENEFITS

There are no anticipated direct benefits to you that will result from participating in this study. This study is designed to provide information for states and researchers considering ways to address the public health issues associated with contraceptives and pregnancy as well as the broader issues concerning the relationship between public health and criminal justice systems.

PARTICIPATION

Your participation is entirely voluntary. You are free to refuse to be interviewed as part of this study. You are free to decline to answer any question or questions, or to withdraw from the study at any point without consequence. If you withdraw from the study before data collection is completed your data will not be used in any published report.

CONFIDENTIALITY

Information in the study records will be kept confidential. Data will be stored securely and will be made available only to persons conducting the study unless participants specifically give permission in writing to do otherwise or unless required by law.

If you agree to participate you have two options regarding the use of information you provide.

Option A: Under Option A, although no researcher can absolutely guarantee that your identity could not be discerned from published work, you can participate under conditions of confidentiality. That means that you would not be identified by name or position in any published study and the author will do everything in her power to prevent readers from discerning your identity. For example, your statements would be generally identified as one made by a pseudonym holding your general position (e.g. doctor, attorney) in a geographic location of your kind (e.g. rural town, county seat, large metropolitan seat).

Option B: Under Option B you would participate for attribution, which would mean that your statements might be quoted and attributed to you by name.

CONTACT INFORMATION

If you have any questions about the study of the interviews, I may contact Della Winters at 614-795-7458 or dwinter5@vols.utk.edu or Dr. Michelle Brown at 865-974-6021 or mbrow121@utk.edu. If I have questions about my rights as a research participant, I may contact the UT Office of Research IRB Compliance Officer at utkirb@utk.edu or (865) 974-7697.

CONSENT

I, the undersigned, understand the above explanation, have received a copy of this form, and volunteer to participate in this study. I further agree that I indicate my form of participation by checking Option A (confidentially) or Option B (for attribution) below.

_____ Option A (confidential participation with pseudonym)

_____ Option B (participation for attribution)

Participant's Name (printed)

Participant's Signature

Date

Principle Investigator's Signature

Date

Appendix B: Interview Protocol

LARC Program Operations Interview Guide

This study seeks to trace how long-acting reversible contraceptive (LARC) programs emerged and currently operate in Tennessee. It is my hope that it will provide valuable information for states considering ways to address the public health issues associated with contraceptives and pregnancy.

Tell me how [your organization] works.

Who came up with the idea of bringing the organization to [city]? How had you heard about [the organization]?

Do you have ideal populations/clients?

Who are they?

How do you reach them?

What barriers do you have to getting to that population?

After you've connected with a potential client, what happens?

How long do you expect they wait for services? Do you have agreements with providers?

Process for obtaining a LARC?

LARC Program Effectiveness

What determines program success?

Is success the number of LARC administered?

Is success getting LARC a targeted percentage of ideal population?

Is success tied to the number of women who keep a LARC after insertion?

Do you look at estimates in the reduction of babies born (with NAS)?

Do you have goals you/your organization would like to meet?

How will you go about meeting those goals?

Your organization is not alone in providing these services to women in the community.

Do you work with other programs?

How is your program different?

LARC Program Reception

How have others in the community responded to your organization?

Are people/organizations supportive?

How do you know?

Have you gotten any pushback? From whom?

How do you know? What does that look like?

Closing Questions

What do your clients need?

Other than LARC, what do you think would change the lives of the women you work with?

Is there anything I didn't ask you about that you would like to tell me?

Who else should I talk to?

Do you have any questions for me?

Pre Interview Checklist

- _____ Review informed consent form
- _____ Permission to Record

Post Interview Checklist

- _____ Convert signed informed consent form
- _____ Upload interview to recording system

- _____ Upload completed transcription
- _____ Assign pseudonym information to transcript

Appendix C: Interview Participant Demographic Survey

Interview: _____

1) What is your age in years?

- ☐ Please specify: _____
- ☐ Prefer not to answer.

2) How do you currently describe your gender identity?

- ☐ Please specify: _____
- ☐ Prefer not to answer.

3) With which race/ethnicity do you identify? (Select all that apply)

- ☐ African America or Black
- ☐ American Indian or Alaska Native
- ☐ Asian American or Asian
- ☐ Hispanic or Latina/o/x
- ☐ Middle Eastern
- ☐ Multiracial
- ☐ Pacific Islander
- ☐ White
- ☐ Additional racial/ethnic identity: please specify

4) Which categories best describe your educational background? (Select all that apply)

- ☐ Some high school
- ☐ High school diploma or equivalent
- ☐ Vocational training
- ☐ Some college
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Some post undergraduate work
- ☐ Master's degree
- ☐ Specialist degree
- ☐ Applied or professional doctorate degree
- ☐ Doctorate degree
- ☐ Additional degree: please specify _____

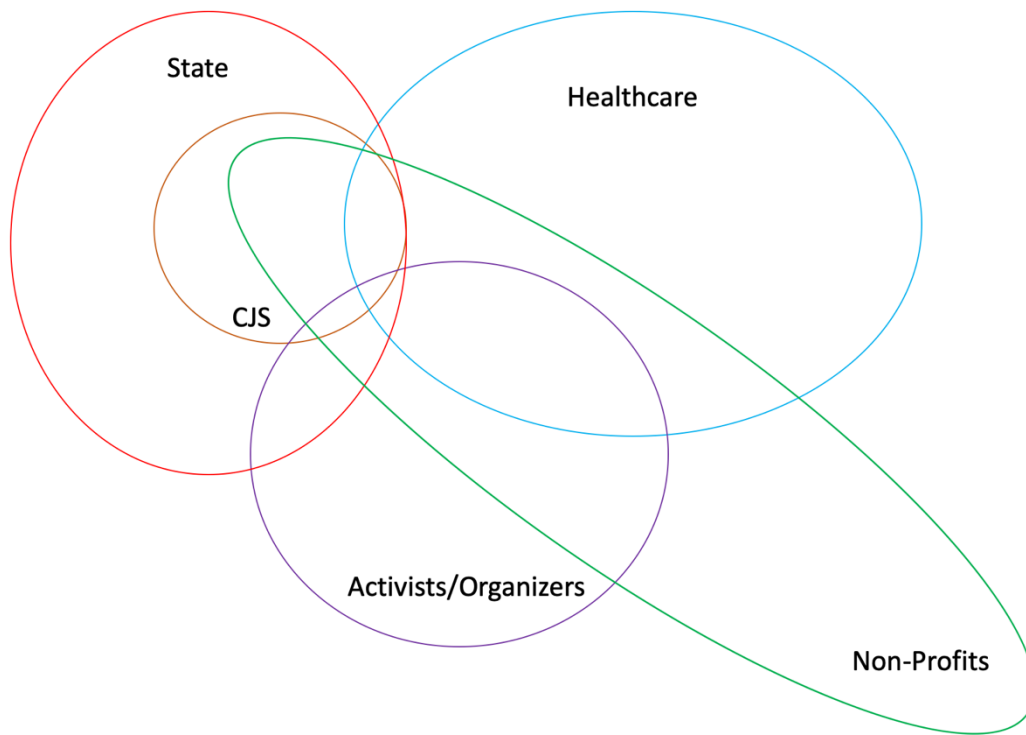
Appendix D: Description of Interview Participants

Name	Age	World of Influence
Toni	38	Criminal Justice System
Ashley	32	Criminal Justice System
Sheema	26	Criminal Justice System
Arin	36	Criminal Justice System
Karen	54	Medical Provider
Sean	35	Medical Provider
Lucille	38	Medical Provider
Meghan	27	Medical Provider
Sonya	34	Medical Provider
Claudia	63	Non-Profit
Lynn	61	Non-Profit
Marcie	24	Non-Profit
Kenneth	25	Non-Profit
Sarah	32	Non-Profit
Leslie	34	Non-Profit
Lindsey	39	Non-Profit
April	57	Non-Profit
Alexis	38	Organizer/Activist/Community Worker
Sarah	30	Organizer/Activist/Community Worker
Charlie	42	Organizer/Activist/Community Worker
Laurie	45	Organizer/Activist/Community Worker
Kelsy	23	Organizer/Activist/Community Worker
Chris	31	Organizer/Activist/Community Worker
Sam	28	Organizer/Activist/Community Worker
Mary	24	Organizer/Activist/Community Worker
Kacie	35	Organizer/Activist/Community Worker
Erika	42	State Social Services
Sam	27	State Social Services
Kayla	26	State Social Services
Greg	38	State Social Services
Sheryl	55	State Social Services
Cora	36	State Social Services
Morgan	30	State Social Services

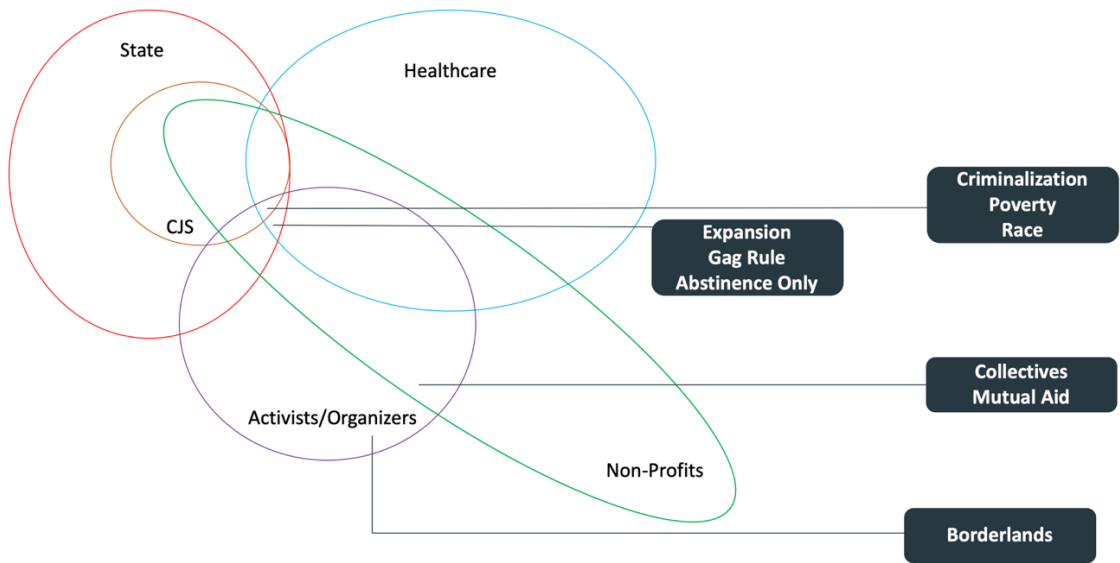
Appendix E: Situational Map



Appendix F: Social Worlds/Arenas Map



Appendix G: Positional Map



VITA

Born in the coal-fields of West Virginia, Della J. Winters is the only child of Timothy and Jean Maynard. She attended Chillicothe High School in Chillicothe, Ohio. After graduation, Della attended Ohio University in Athens, Ohio where she earned a Bachelor of Specialized Studies in Sociology, Psychology, and Family Studies in 2007. After working as a school social worker, she returned to Ohio University to earn a Master of Arts in Sociology in 2011. Della accepted a graduate teaching assistantship in the Department of Sociology at the University of Tennessee Knoxville in 2016. After completing a Doctor of Philosophy in Sociology in 2020, Della has accepted a position as an Assistant Professor of Criminology at Arkansas State University in Jonesboro, Arkansas.