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Toward Sustainable Advocacy:

Comparing Contraceptive Policy Advocacy in Texas and California

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Sociology

by

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Chatillon, Anna, Maria Charles, and Karen Bradley. 2018. "Gendered Ideologies." Pp. 217-226 in *Handbook of the Sociology of Gender*. Edited by Barbara J. Risman, Carissa Froyum, and William Scarborough. New York, NY: Springer Publishing.

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Chatillon, Anna. 2015. "TWHC Wins Funding for Preventive Health Care in the 84th Legislature." *Texas Family Physician* (Magazine of the Texas Academy of Family Physicians) 66(3): 15.

Chatillon, Anna. 2014. "Texas Women's Healthcare Coalition: Working to Improve Texans' Access to Health Care in the 84th Texas Legislature." *Texas Family Physician* (Magazine of the Texas Academy of Family Physicians) 65(4): 34.

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Coordinated team of researchers to survey Austin, TX 2017 Women's March attendees for this multi-methods project examining organizing, strategies, and motivations of people attending post-inauguration Women's Marches. PI: Professor Zakiya T. Luna

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2020 "From Copper Kool-Aid to Silver Bullet: Comparing Advocates' Arguments for Long-Acting Reversible Contraceptive in Texas and California." Sociologists for Women in Society (San Diego, CA)

2019 "Easier to Proclaim than Practice? A Multidimensional Theory of Feminist Organizational Intersectionality." American Sociological Association (New York, NY)

2019 "Costs and Savings: Advocacy for Long-Acting Reversible Contraception in Texas." Pacific Sociological Association (Oakland, CA)

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Introduction to Sociology
Qualitative Content Analysis
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Sexuality and Race
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Gender & Society, Journal of Social Issues, Women's Studies International Forum, Women & Health

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ABSTRACT

Toward Sustainable Advocacy:

Comparing Contraceptive Policy Advocacy in Texas and California

by

Anna H. Chatillon-Reed

In state legislatures across the United States, a coalition of progressive, moderate, and conservative lawmakers have come together in the last twenty years around a common goal: funding highly effective contraception for low-income state residents. The political tensions and media debates about contraception suggest it could be a difficult area for bipartisan collaboration. In fact, it represents an area of rare interest convergence for some members of the two major political parties and, more broadly, for a wide range of stakeholders. This study analyzes how this process unfolded in two states, Texas and California.

Drawing from fifty-five interviews with actors across the ecology of reproductive policy advocacy in Texas and California, alongside qualitative content analysis of documents published online by the organizations that employ them, I ask how reproductive policy advocates in these states discursively construct long-term, highly effective contraception for low-income residents as a worthwhile state investment. Placing these efforts in the broader historical context of racialized and class-based reproductive control in the United States, I argue that framing low-income people's pregnancies as expensive to the state, and long-term

contraception as a solution, has been central to this process. I find that some stakeholders have drawn on the rhetorical construction of low-income people as simultaneously capable of reducing state spending by not becoming pregnant and too unreliable to take a daily oral contraceptive. I theorize these interrelated processes as *reproductive responsibilization*. I argue, moreover, that advocates should move toward a more sustainable advocacy in pursuit of the deeply important goals of expanding reproductive justice and access to reproductive healthcare.

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Introduction: A "Politically Versatile Technology"[1]

> *We went to [a Republican senator's] office. […] I remember talking about the cost savings [of LARC]—for every one dollar spent, seven dollars in Medicaid pregnancy [costs] were prevented. […] And he started talking about preventing "anchor babies" from being born in the United State, [… saying,] "If we can stop […] these 'illegal' people getting pregnant and having 'anchor babies,' we can save Texas a whole lot more money." […] I was repulsed, but also, that senator was on our side. It was very weird. [laughs] It was probably one of the most horrifying experiences I've had in lobbying. […] But it was also—it was super appalling, but that person was on our side, so, I'm not saying that made it worth it, I'm just saying that that's an argument some people buy into. I don't know. I think there's a lot of talk in advocacy spaces, [about] if the ends justify the means.*
>
> ~Amanda; woman of color; Texas reproductive health, reproductive rights, and reproductive justice advocate[2]

> *We've had a significant financial investment in women's health from the Legislature [lately…] But again, I think that's really tied to averting Medicaid births, and so it really does fall within that cost-savings frame and not reproductive justice, [laughs ruefully] and economic freedom for women and all of those things that people who are coming from the movement [believe in]. The reason we're doing the work is very different than the reason the work is being funded by this government, oftentimes.*
>
> ~Emily; white; Texas reproductive health advocate

In state legislatures across the United States, a coalition of progressive, moderate, and conservative lawmakers have come together in the last twenty years around a common goal: funding highly effective contraception for low-income state residents. The political tensions and media debates about contraception suggest it could be a difficult area for bipartisan collaboration. In fact, it represents an area of rare interest convergence (Bell 1980) for some members of the two major political parties and, more broadly, for a wide range of

[1] (Takeshita 2012:3)
[2] All participants are identified using pseudonyms in this text to protect their anonymity.

stakeholders. This study examines how reproductive policy advocates[3] in two states—Texas and California—discursively construct long-term, highly effective contraception for low-income residents as a worthwhile state investment. Placing these efforts in the broader historical context of racialized and class-based reproductive control in the United States, I argue that framing low-income people's pregnancies as unacceptably expensive to the state, and long-term contraception as the solution to this "problem," has been central to this process. I find that in this work, some stakeholders have drawn on the rhetorical construction of low-income people[4] as simultaneously hyper-irresponsible—too unreliable to take a daily oral contraceptive—and hyper-accountable—held responsible for balancing the state budget by not becoming pregnant. Drawing from fifty-five interviews with actors across the ecology of reproductive policy advocacy in Texas and California and qualitative content analysis of documents published by the organizations that employ them, I theorize this process as *reproductive responsibilization*.

The scholarly literature on contraception demonstrates that wealthy and middle-class white women and other people with uteruses still must struggle to access birth control. These concerns are critically important. Yet their struggles pale in comparison to the panoply of social welfare programs, court rulings, immigration laws, and medical experiments that onerously restrict the reproduction of people of color, immigrants, and poor white people through coerced or forced sterilization and contraceptive use (Flavin 2009; Gutiérrez 2008;

[3] I use the term "reproductive policy" to refer to the broad fields of reproductive health, reproductive rights, and reproductive justice policy. The word "advocates" encompasses formally registered lobbyists alongside many others who conduct advocacy on these topics, such as organization leaders, policy analysts, external affairs staff, government relations staff, and research staff.

[4] In this research, I use the term "low-income" to refer to the populations who use publicly funded long-acting reversible contraceptive methods, because the healthcare programs that are the primary focus of long-acting reversible contraception advocacy are explicitly and exclusively available to low-income people (defined in relation to the federal poverty line).

Roberts 1997; Solinger 2001). Controlling images (Collins 1994, 2004) and intersecting structures of power (Crenshaw 1989) organize this pattern. The reproductive capacity of targeted groups is considered ripe for control because they are women, while their reproduction and mothering are devalued because they are specifically *low-income* women, *immigrant* women, and women *of color*.

Yet often, social movements for reproductive healthcare and reproductive rights have focused on the single-axis frame of increasing access to contraception, attending specifically to gender-based oppression. Despite the worthiness of increasing such access, this approach leaves to the side the multiple-axis raced and classed reproductive control that people of color and low-income people experience (Breines 2006; Luna 2020; Luna and Luker 2013; Roth 2004; Silliman et al. 2004). Reproductive justice movements, defined by advocacy for the right to have children, the right to not have children, and the right to parent in a safe and healthy environment (SisterSong, Inc. 2017), in contrast are concerned with a multi-axis analysis rooted in the mutual co-construction of systems of oppression based on gender, race, class, immigration status, sexuality, and more (Beal 1970; Combahee River Collective 1977; Hull et al. 1982; Luna 2020; Moraga and Anzaldúa 1977).

This contrast is evident in reproductive justice, reproductive rights, and reproductive health organizations' policy efforts across a range of advocacy areas. It shapes issue prioritization, advocacy strategies, and collaborative work. Critically, it also shapes the goals of these three movements, goals that vary not only across movements but within them (Luna 2020; Silliman et al. 2004). Together, reproductive health, reproductive rights, and reproductive justice form a "complementary and comprehensive solution" to the problem of

"reproductive oppression" (ACRJ 2005), as discussed further below.[5] To develop a picture of the full reproductive advocacy ecology in the two states I compare, I draw on data from each of these movements in each state. While a formal comparative analysis of these three kinds of movements within each state is beyond the scope of this study, I do note broad similarities and differences among them as they are relevant to the larger findings.

I compare how reproductive policy advocacy organizations in Texas and California approach one specific policy issue: public funding for long-acting reversible contraception (LARC).[6] LARC is a category of highly effective contraceptives made up of intrauterine devices (IUDs) and subdermal hormonal implants. Advocacy on this topic is a rich field for sociological analysis because of the fundamental characteristics, history, and symbolic weight of long-acting contraceptive methods. These aspects are best viewed through a wide lens, one capable of transcending any one era or advocacy campaign to include the much broader context in which advocates operate. As such, I open with a discussion of this context before describing LARC and LARC advocacy specifically.

Reproductive policy advocates inherit social structures that shape their choices. The existing structures in Texas and California profoundly shape how advocacy campaigns unfold. These structures include political context, coalition-based relationships, and state fiscal orientations, among others. Advocates also, however, have agency to make decisions

[5] Many advocates, however, report that "We're not [all] having the same fundamental conversation" (Shirley; Black; California reproductive health researcher and reproductive justice advocate). Reproductive justice, reproductive rights, and reproductive health advocacy organizations are not currently in agreement about what their movements' goals are (increasing access to reproductive healthcare, reducing the unintended pregnancy rate, increasing reproductive autonomy or reproductive justice?), what their framing should be, or what tactics they should use. In some cases, different parts of the movements are speaking at utter cross purposes or are using language the others literally do not understand or consider legible.

[6] Following the most common phrasing in my data, I use "LARC" to abbreviate "long-acting reversible contraception," a singular noun. To indicate the corresponding plural noun, which encompasses the collection of individual contraceptive methods that make up "long-acting reversible contraception," I write "long-acting reversible contraceptive methods" or "devices."

within or in opposition to those structures. Advocates at reproductive policy advocacy organizations respond to those features (and to their perceptions of them) when establishing goals, frames, ally relationships, tactics, and strategies. Understanding the interaction between structure and agency is necessary for understanding how advocacy campaigns for public funding for LARC have unfolded differently in Texas and California. The different ways these states' structural contexts interact with the range of arguments and techniques considered possible in reproductive advocacy is a central focus of this study. These structures are broadly agreed upon by advocates and other stakeholders in reproductive policy advocacy in Texas and California.

Less agreed upon, though, are the possible consequences of advocates' decisions within those structures. The disagreements and tensions in the field cluster around whether the ends of a particular advocacy campaign do or can justify the means used to advance them; if advocates' rhetoric can "poison the well" of reproductive healthcare policy and funding; if or how much advocates should compromise their values for efficacy; the relative benefit of long-term versus short-term organizing and "wins;" and if it is helpful or necessary to have every relevant organization's or stakeholder's voice at the table when shaping advocacy campaigns. These tensions are clearest when understood within their historical contexts, accounting for how reproductive healthcare has been understood across the political spectrum.

Disagreement about reproductive healthcare between conservatives and progressives has often been framed as a tension between "family values" and "women's rights," respectively. In response, progressive lawmakers and stakeholders have reframed reproductive healthcare as fundamentally about supporting families. Meanwhile,

conservatives have sought to justify their divestment from reproductive healthcare as rooted in fiscal conservativism rather than sexism, while identifying some small areas of reproductive healthcare in which to invest. In this process, the two sets of interests have converged in the area of funding reproductive healthcare services that can be understood as both fiscally conservative and pro-family. Although a range of possible healthcare services might be considered to meet these needs, one in particular has seen a dramatic rise in state-level legislative support in the last ten years: long-acting reversible contraception. To understand why, it is useful to begin by examining the problems LARC is most directly understood to solve.

LARC has been set forth as a "silver bullet" solution to problems including high rates of unintended pregnancy and high incidence of maternal mortality. Many scholars and activists contest the grounds on which these items are construed as "problems," however. "Unintended pregnancy," for example, is a hotly disputed metric that is both classed and racialized. Pregnancy intentions are poorly understood, but it is clear that approaches to planning pregnancies vary substantially by race and class, with unintended—but happily received and joyfully birthed—pregnancies disproportionately common among low-income people and people of color. In this context, unintended pregnancy is a concept ill-suited to measuring a population's ability to achieve their many and varied reproductive goals (Finer and Zolna 2016; Mann and Grzanka 2018; Potter et al. 2019).

For maternal mortality and related issues, the construction of the problem LARC is purported to solve is not as concerning as the particular "solution" that LARC constitutes. High maternal mortality incidence in the United States, for instance, is driven by particularly high rates among Black Americans (Centers for Disease Control and Prevention 2020). The

unacceptably high rate of Black maternal mortality in Texas (MacDorman, Declercq, and Thoma 2018) is a problem in need of a sweeping solution, to be sure. Yet as a contraceptive method, LARC can only prevent Black maternal mortality by preventing Black maternity. For the hundreds of thousands of Black people in the United States who hope to become pregnant, carry a pregnancy to term, and deliver a baby without serious injury or death, to offer LARC as a solution to Black maternal mortality is a profound insult. I offer these brief critiques not as an exhaustive rebuttal to the framing of LARC as a silver bullet, but as an opening to the conversation. While LARC is an effective means to prevent pregnancy for those who desire contraception, and should be readily accessible to those who desire it, it is merely that.[7] To construe it as more is to risk treading into dangerous waters.

Nonetheless, some moderates and progressives have been willing to meet conservatives in this area of interest convergence. In interviews I conducted in Texas they often privately noted, though, that conservatives seem to be motivated by something other than fiscal conservativism. If it was a matter of fiscal responsibility, they argue, more conservatives would support Planned Parenthood and Medicaid expansion. Both of these policy initiatives would save state governments money—the former by utilizing a markedly efficient reproductive healthcare provider, and the latter by drawing down increased federal funding for healthcare. That the right has applied their "fiscally conservative" support for reproductive healthcare inconsistently should raise the question of why they support particular initiatives over others. Much of the reproductive health and reproductive rights field in Texas, working under difficult conditions, has not been able to launch a serious consideration of this question.

[7] I note here that LARC may also be used for other reasons by consenting individuals, including treatment of menstrual pain, management of ovarian cysts, and for dermatological reasons, among many others.

An exploration of this question, partially undertaken in this study, illuminates why a one-dimensional analysis—of sexism—is insufficient for understanding the possible consequences of this interest convergence. Sexism clearly intersects with racism and classism and xenophobia, in this case as in many others. An intersectional analysis such as that put forward by reproductive justice advocates is therefore critical. Yet because the constraints of advocacy work can render this level of complex analysis elusive, in the worthy effort to increase access to contraception some advocates have at times tacitly endorsed the racism, classism, and xenophobia of the right.

I find, however, that advocates for progressive causes are on the whole neither unaware of nor comfortable with this tacit endorsement. Although there is, to be sure, a range of attitudes toward this strategy, there is substantial discomfort with it. Advocates' willingness to use it, they report, is due in part to external structural pressures, particularly in Texas. "In this state," I heard participants say in several different ways, "we don't have any choice but to do it their way." This framing conveys two key assumptions. The first is that these tactics are only tempting in a state hostile to reproductive healthcare. That is, in a more progressive state, advocates would see no benefit to these tactics, and would easily decide against them. The second assumption I discern is that in such hostile states, no other approaches are possible or could be successful. Through interviews and qualitative content analysis, I find that both of these assumptions rest on shaky ground. The first is dispelled by reports from my comparative case, California, that these arguments were also favored there by a swath of the advocacy community. The second is put to rest by the fact that many organizations in Texas steer far clear of arguments in this category. In fact, nearly every advocate I spoke with in both states shared ideas for approaching their work without such

arguments. This combination of points suggests that this interest convergence is compelling to particular organizations—and not to others—no matter the state context.

Therefore, organizations in even the most hostile states have more agency in this matter than might be immediately apparent, and those in even the most progressive states must be careful in their advocacy approaches. Critically, California partially pivoted away from this problematic rhetoric in part due to the advocacy structures and collaborations advocates there have built over recent decades. Even without those structures and collaborations, there are some organizations in Texas charting different courses toward reproductive autonomy without using this convergence—a point organizations in California might consider when determining what their state structure truly requires of them. Advocates in Texas and California, in other words, each have experiences that their counterparts might find useful.

Theoretical Framing

In this section, I present a brief overview of the theory and literature on which this research builds. I first discuss the relevant literature on long-acting reversible contraception. I then look more broadly to the empirical work on eugenics and its theoretical implications for conceptualizing "responsible" and "burdensome" pregnancies. Next, I discuss the broad theoretical framework in which I situate this research: Black feminist theory. I attend specifically in this section to intersectionality and controlling images, including a brief history of the reproductive justice movement and accompanying theoretical framework. Finally, I review theoretical understandings of responsibilization, a key foundation on which this study builds.

Long-Acting Reversible Contraception (LARC)

Made up of intra-uterine devices (IUDs) and subdermal contraceptive implants, long-acting reversible contraceptive methods are over ninety-nine percent effective at preventing pregnancy. They are designed for long-term use, ranging from three to twelve years of effectiveness. As doctor-managed methods, moreover, they require no patient action—or even knowledge—to prevent conception (Foster et al. 2012, 2014; Stoddard, McNicholas, and Peipert 2011). While these facts make long-acting reversible contraceptive methods appealing to many medical providers and indeed, many patients, they also make the methods highly "imposable" (Clarke 2000:50). Once using a long-acting reversible contraceptive device, patients have little ability to return to fertility unassisted by a medical professional. Historically, the provider-controlled aspect of LARC has facilitated forced or coerced use of it in the United States, targeted primarily at people of color and low-income white people, even as other people struggle to access desired contraceptive care (Frost, Frohwirth, and Zolna 2016).

Funding to develop the first intrauterine device came from various sources with population control or eugenics goals, including The Population Council, a Rockefeller-funded project (Takeshita 2012). These funders had radically different goals for the IUD than did the people who hoped to use them. The rapidly growing population in the Global South, combined with distrust by many medical professionals that poor people would reliably use a daily oral contraceptive correctly, led to new federal funding for contraceptive methods and for research and development in the field during President Lyndon B. Johnson's administration (Takeshita 2012). For domestic use, that federal funding was framed as a

financial boon to the government because of its supposed reduction of welfare payments due to reduced births to low-income cisgender women, particularly Black women (Tone 2001).

Population control advocates considered the IUD—which is inserted into the uterus during an outpatient visit to a physician—to be a particularly good answer to these concerns because of its high level of "imposability" (Clarke 2000:50) on patients who had to make just one decision to contracept (Takeshita 2012). Early IUDs on the market, particularly the Dalkon Shield, were designed poorly and tested unethically. They were first distributed primarily to cisgender women who used public health services, particularly low-income women of color, but uptake rose rapidly among other groups, as well. Significant side effects and sometimes-fatal infections in users eventually caused the Dalkon Shield to be pulled from the market in the U.S. (Tone 2001).

In the time since the Dalkon Shield was recalled, the IUD has undergone multiple technological advances and a revolution in public opinion. Its popularity is rapidly increasing among patients and physicians alike. With the safety concerns of its previous iterations addressed, medical doctors and professional associations now recommend it as a "first-line contraceptive" with excellent efficacy and low user error rates (Mann and Grzanka 2018). The IUD has not fully transcended its roots, however. Patients continue to have very little control over its removal, and it continues to be over-prescribed to cisgender women of color (Dehlendorf et al. 2010). These conflicting facts about the contemporary IUD reflect its status as what Takeshita (2012) calls a "politically versatile" technology. It is adaptable to many different, even competing, sets of needs and concerns, ranging from women of color feminist organizing for highly effective contraception to modern-day eugenics efforts to impose long-acting contraception on low-income people and people of color. That

adaptability generates debate about the status of the IUD (and, I argue, subdermal contraceptive implants) as inherently problematic or inherently positive—or perhaps, as Takeshita argues, more generally "imbued with politics" (2012:6).

LARC usage rates are rapidly increasing (Curtis and Peipert 2017; Finer, Jerman, and Kavanaugh 2012; Kavanaugh, Jerman, and Finer 2015; Mann and Grzanka 2018), and medical doctors and professional associations now highly recommend it as a preferred contraceptive with excellent efficacy and low user error rates (American College of Obstetricians and Gynecologists 2009). In a shift from earlier generations of long-acting reversible contraceptive devices, current technologies are considered appropriate for cisgender women of any age or demographic group. Programs are underway across the country to expand access to the methods through improving provider training, including LARC in publicly funded reproductive health programs, and improving reimbursement systems for providers to ensure their willingness to prescribe it. These policies are intended to overcome the barriers patients may encounter when seeking LARC, such as difficulty paying for the device out of pocket, inability to access clinics that provide the method, and complications in billing and reimbursement that delay or block access (Association of State and Territorial Health Officials 2014; Batra and Bird 2015). Pilot programs have also been undertaken to provide LARC free of charge, substantially reducing unintended pregnancy rates in program areas (see, e.g., Birgisson et al. 2015; Ricketts, Klingler, and Schwalberg 2014; Secura et al. 2010).

A growing body of literature examines long-acting reversible contraception from an increasingly critical perspective. Although contraception has in many ways expanded women's freedom, Gomez, Mann, and Torres (2018) note it has also been, and continues to

be, used by government agencies or other powerful structural forces to limit the reproductive options of low-income women and women of color. Alongside activist groups in the 1990s, Dorothy Roberts (1997) raised early concerns about long-acting methods in particular. Her seminal text *Killing the Black Body* included a detailed chapter about the racialized dangers of Norplant, a contraceptive implant. LARC has been the topic of many recent studies (see, e.g., Mann and Grzanka 2018), in part because the method neatly encapsulates both the potential of contraception and the dangers of contraceptive coercion (Gomez et al. 2018). Forced or coerced sterilization and contraception in the United States, further, has been documented well into the 2010s—and financial, carceral, or welfare-based incentives to undergo sterilization or receive a long-acting contraceptive device continue to this day (Gomez et al. 2018).[8]

Providers' and policymakers' enthusiasm for LARC is particularly concerning when it is promoted specifically for use by low-income women and women of color. Reproductive oppression based on the devaluation of marginalized women's reproduction, and perceptions that their fertility is both dangerous and uncontrolled, continues today. LARC, critics warn, has already become part of that oppression (Gomez, Fuentes, and Allina 2014; Gomez et al. 2018; Mann and Grzanka 2018). In just one example of the issue as it may play out in medical offices, providers recommending contraception based on videos of women of various races recommended IUDs more frequently for low-income women of color—even when compared to low-income white women (Dehlendorf et al. 2010). That outcome is consistent with other studies' findings that women report racial discrimination when seeking

[8] As only the most recent high-profile example of this broader phenomenon, in 2020 a whistleblower revealed that an Immigration and Customs Enforcement detention center was forcibly sterilizing detained immigrant women (Manian 2020).

reproductive healthcare (Becker and Tsui 2008; Borrero et al. 2009; Downing, LaVeist, and Bullock 2007; Thorburn and Bogart 2005; Yee and Simon 2011).

Mann and Grzanka argue that to understand the increasing popularity of long-acting reversible contraceptive methods, scholars and activists should interrogate the societal construction of unintended pregnancy as a "social problem" (2018:2). The people understood to be "at risk" for unintended pregnancy tend to be cisgender women who are marginalized societally and economically, and LARC is seen by medical providers as one answer to this "problem." That purported solution, however, does not take into account the disproportionately negative views some people have of certain long-acting methods (Gomez et al. 2018; Mann and Grzanka 2018). Nor does it support patients' agency in selecting their own methods of contraception. Dominant groups' longstanding focus on preventing unintended pregnancy because of its perceived societal cost, rather than on ensuring individuals' health or freedom (Mann and Grzanka 2018:3), may partially account for this mismatch between the proposed solution and the reality of patients' needs and desires.

"Responsible" and "Burdensome" Pregnancies

Long-acting reversible contraceptive methods are best understood in historical context and with close attention to the ways that reproduction more broadly is gendered, classed, and racialized. Eugenics efforts historically have emphasized a population's responsibility either to reproduce or to refrain from reproducing. That focus and the corresponding distinction between "good" and "bad" reproduction is reflected in a more general distinction between "responsible" and "burdensome" pregnancies. State agencies and medical professionals often cast cisgender white women of means as capable of doing pregnancy "correctly" and "responsibly," and therefore pressure such women to reproduce.

They frame women of color and low-income white women, in contrast, as people who irresponsibly produce "burdensome" pregnancies and who therefore should refrain from becoming pregnant. Much of the scholarly literature on pregnancy focuses on one side or the other of this dichotomy, whether or not the authors explicitly address race.

Although corners of American social science have a long tradition of examining the differential value of reproduction based on an individual's social location, the concept entered the mainstream of the field with Colen's (1986) theory of stratified reproduction: the different valuation of people's reproduction based on their location in power structures of race, class, and gender. Colen's argument originally emphasized the different reproductive labor conducted by cisgender women in different social locations. More recently, the theory has expanded to include the many ways reproduction is valued unequally, patterned by access to power. Scholars have traced those patterns in medical settings, economic and legal programs, and cultural understandings of "good" versus "bad" motherhood (Flavin 2009; Gutiérrez 2008; Oaks 2015; Roberts 2002; Solinger 2001). Low-income mothers and mothers of color often fall into the latter category. They may be framed as "burdening" the state with their offspring, and have at times faced pressure from medical providers or state officials to avoid reproducing (Bridges 2011, 2017; Denbow 2015; Gutiérrez 2008; Lombardo 1985; Roberts 1997; Stern 2005a). These and other policies both reflect and re-entrench stratified reproduction.

Many scholars note that because cisgender women are given the responsibility of reproduction (Armstrong 2003), they bear immense scrutiny and criticism of their

reproductive decision-making (Waggoner 2013, 2015, 2017).[9] The ideal of the responsible pregnant woman who carries the weight of the responsible pregnancy, labor, and delivery is racialized. As Waggoner argues, white women are portrayed as "planners" and women of color as decidedly "not planners" (Waggoner 2015, 2017). That planning is expected to include the time before conception, despite very limited evidence that actions taken before pregnancy affect fetuses significantly (Waggoner 2017). Eugenics ideology influences the construction of (some) women as "mothers-in-waiting" and is closely tied to public health control of women's bodies for the supposed good of the general population (Waggoner 2017).

The repercussions people face for failing to live up to the ideal of the responsible pregnancy are intense and racialized (Flavin 2009; Roberts 1997; Springer 2010). Pregnant people may be considered to fail at achieving such a pregnancy through their actions or simply through their race, age, or class position. Some pregnancies, in other words, are constructed as burdensome even if the pregnant person does not violate any proscriptions aside from their social location. This category includes adolescent mothers, particularly those who are of color or low-income (Tapia 2011), immigrant mothers using public health services for prenatal care or delivery (Park 2011), or women of color using hospitals assigned to low-income women (Bridges 2011). These pregnancies, consistent with eugenic logic, are

[9] Scholars argue that cisgender women face strong pressure to make "correct" reproductive decisions, including about how to prepare for pregnancy (Waggoner 2017), about whether or not, and how, to conceive (May 1997; Roberts 1997), and about fetal genetic testing. Medical and social control of cisgender women's pregnancies, moreover, extends to the birthing process. Where people give birth, what kinds of medical interventions are undertaken, who attends them, and how they experience the process often reflects the power of the medical institution to impose a so-called "responsible" pregnancy and birth on patients (Almeling 2015; Davis-Floyd 2003; Jordan 1993; Martin 2001, 2003).

constructed as a burden to the state, powerfully shaping ideas about who has a responsibility to contracept.

Stern (2005) defines the word "eugenics" as "a multifaceted set of programs aimed at better breeding that straddled many social, spatial, and temporal divides" (18). That definition includes both "positive" and "negative" eugenics, which generally speaking encourage the reproduction of the "fit" and discourage the reproduction of the "unfit," respectively. The difficulty separating the two types of eugenics is apparent in the direct connection between eugenics and white concerns about "race suicide," which became increasingly influential in the twentieth century when white fertility rates began to drop faster than those of immigrants and people of color (Gutiérrez 2008; Roberts 1997).

The early twentieth-century eugenics movement embraced the theory that personality traits are genetically determined. They constructed an image of cisgender women of color in the mainland U.S. as excessively fertile and in need of reproductive control. Their supposed irresponsibility meant they were presumed incapable of reproductive control, however, and therefore needed others to undertake it on their behalf. Low-income white women were likewise considered in need of such external control, in part because of a refusal to acknowledge or challenge how their economic marginality combined with their domestic centrality.

Early in the twentieth century, state governments began to approve involuntary sterilization bills. Such statutes allowed state authorities to order sterilization of people in jails or other institutions without their consent. The U.S. Supreme Court did not rule on this issue until creating federal policy in 1927. In that year, the Supreme Court case *Buck v. Bell* legally approved eugenic sterilization based on mental illness in the United States (Lombardo

1985, 2008). After this case, involuntary sterilization bills spread rapidly across the country. They were used not only for race-based population control, but also to punish purported promiscuity or other socially proscribed behaviors (Roberts 1997). Stern (2005) argues there is no clear distinction between the eugenics of the pre-World War II era, such as that established in *Buck v. Bell*, and the eugenics of today. Although the word "eugenics" fell out of favor in the United States following World War II because of its association with Nazi Germany, the movement itself remained. Eugenicists were sheltered by and coalesced with neo-Malthusianism, a movement that considered overpopulation to be the main cause of poverty and sought population reduction, especially in the Global South (Takeshita 2012). During this time, eugenics followers split into two camps: one that focused primarily on individual choice, and another that focused on population control with an emphasis on the environment. Involuntary sterilizations continued to rise into the 1960s, as doctors targeted Black women and other women of color for the procedure (Roberts 1997). Meaningful challenges to this "new" form of eugenics did not arise until the social movements of the 1960s and the 1970s. Despite those challenges both types exist today in explicit form and—via more subtle avenues—in policy (Stern 2005a).

Eugenics in the United States has long been tied to white concerns about policing borders, both of the country and of the population. That concern is particularly clear in relation to the "Latino Threat" (Chavez 2008), the fear that Latinas and Latinos are too different from previous waves of immigrants to the country to assimilate. The dominant narrative constructs them as an army penetrating the United States from the South, desperate to seize parts of the country that were previously theirs. This fear often concentrates on Mexicans but applies as well to other parts of Latin America and to Latinas and Latinos who

are citizens of the United States (Chavez 2008:3). It is directly associated with North American fears of Latin American reproduction, both social and biological, and draws on long-held ideas of Latin American "leakiness"—including fears of leaky borders, leaky biological bodies, and leaky national bodies (Chavez 2008:74).

Such constructions of Latin American women as hyper-fertile "invaders" have material ramifications for immigration policy and for medical policy in the United States. Stern (2005a) documents the origins of today's Border Patrol in early twentieth century medical rites and racial exclusion quarantines on the Mexican border, which served both to solidify the border and to racialize Mexicans. The policies intensified racial tensions and anti-Mexican sentiment, leading to an increase in eugenics efforts against them. Stern writes, "In tandem… medicalization and militarization—worked to create a regime of eugenic gatekeeping on the U.S.-Mexican border that aimed to ensure the putative purity of the 'American' family-nation while generating long-lasting stereotypes of Mexicans as filthy, lousy, and prone to irresponsible breeding" (Stern 2005a:58–59).

In California in the 1970s, one example of the medical effect of those stereotypes unfolded at the Los Angeles County Medical Center (Gutiérrez 2008; Tajima-Pena 2015). Medical personnel coerced or forced cisgender women of Mexican origin—determined by surname—to undergo sterilization. Staff efforts to that effect included such practices as withholding medical care during childbirth until sterilization consent was given or refusing to explain the content of the consent forms. Gutiérrez (2008) connects this practice to white outrage about immigrant use of social services, including healthcare, though in actuality immigrant use of public benefits was and is negligible. She also documents Latina resistance to these efforts, including an unsuccessful class-action suit (*Madrigal v. Quilligan*) and

women of color organizers' successful fights for more ethical sterilization practices. Efforts to curb Mexican-origin immigrants' fertility, alongside attempts to limit the entry of Latin American immigrants to the United States through immigration policy, were closely tied to population control and eugenics efforts in the 1970s. They continue today through state efforts to force or coerce marginalized people to undergo sterilization or to otherwise contracept, a broader context that frames the findings of this study.

Black Feminist Theory

Black feminist theory is explicitly attuned to how different structures of oppression intersect and influence one another. Building on Kimberlé Crenshaw's (1989) theorizing of intersectionality, which in turn built on prior Black feminist work,[10] Patricia Hill Collins (2015) argues that "intersectional knowledge projects" (14) are guided by the assumption that different identities must be understood in relation to one another and as shaping intersecting power systems. These systems, she writes, generate "fundamentally unjust" (14) social inequalities and different lived experiences for different people. Intersectionality is central to the data and analyses in this study: the interaction of axes of identity and oppression shapes the perspectives of the people who advocate for increased access to LARC, the state policies they help shape, and the experiences of those around whom that policy is constructed.

Intersectionality (Crenshaw 1989, 1991) illuminates the failure of traditional gender-based single axis feminist organizing to account for the experiences of people who are marginalized as women, but also as immigrants and as people of color. These experiences, Crenshaw writes, cannot be divided into those based on race and those based on gender.

[10] For excellent overviews of Black feminist work and history, see Collins (2009) and Springer (2005).

Rather, women of color occupy a space at the intersection of these two identities (along with others, such as class, immigration status, and languages spoken), a qualitatively different space from that occupied by white women or by men of color. This space is characterized in part by particular controlling images (Collins 2009) of Black women, including that of the welfare mother. As Patricia Hill Collins writes,

> Creating the controlling image of the welfare mother and stigmatizing her as the cause of her own poverty and that of African American communities shifts the angle of vision away from structural sources of poverty and blames the victims themselves. The image of the welfare mother thus provides ideological justification for the dominant group's interest in limiting the fertility of Black mothers who are seen as producing too many economically unproductive children. (Collins 2009:80)

The controlling image of the welfare mother haunts today's state-funded reproductive healthcare programs for low-income women. In particular, as Collins describes it gives cover to efforts to control the reproduction of Black women and, I argue, that of other marginalized people.

As Collins also notes, women of color have resisted controlling images and reproductive control for generations. Beginning in the 1970s, Black feminist scholars and members of what would become the reproductive justice movement built on that foundation, arguing for reproductive justice as an intersectional approach to reproduction (Luna 2020; Luna and Luker 2013). Advocating for an analysis of race, immigration, and class (Beal 1970; Combahee River Collective 1977; Hull et al. 1982; Moraga and Anzaldúa 1977), they understood all systems of oppression to be inextricably linked to reproduction (Briggs 2017; Luna 2020; Luna and Luker 2013; Ross 2006; Silliman et al. 2004). Women of color developed the phrase "reproductive justice" in 1994 to express this connection between social justice and the struggle for reproductive rights.

Members of the reproductive justice movement born of this history avoid language of reproductive "choice" in favor of "access." According to leading reproductive justice organization SisterSong, these advocates prioritize the human rights (Luna 2020) to "maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (SisterSong, Inc. 2017). Other organizations, including one of SisterSong's founding organizational members, define it more broadly. Asian Communities for Reproductive Justice, for instance, describes reproductive justice as "the complete physical, mental, spiritual, political, economic, and social well-being of women and girls" (ACRJ 2005). Such breadth expresses the impossibility of understanding one element of a person's lived experience without understanding the others. The reproductive justice framework rests on the fact that equity cannot be attained simply through legally identical treatment of all subjects, acknowledging that differently situated people have different needs. In this way, the reproductive justice movement addresses barriers faced often by marginalized women but rarely by upper middle class, white, straight, cisgender women.

Reproductive justice is connected to, but distinct from, reproductive health and rights. Members of the reproductive justice movement rely on human rights and justice frameworks, with emphasis on intersecting oppressions (Luna 2020). Its advocates demand more from the government than cisgender women's healthcare services (the primary focus of reproductive health advocacy) or privacy in reproductive decision-making (the foundation of the reproductive rights movement for legal abortion), noting that mistaking privacy for sufficient reproductive self-determination "assumes access to resources and… autonomy" (Luna and Luker 2013:329). Reproductive justice advocates also note that focusing on privacy leads the

reproductive rights movement to seek negative rights rather than positive ones. This includes emphasizing the right to freedom from government interference with a person's abortion over the right to an abortion itself, which would imply government responsibility for patient access to such care. Reproductive justice advocates' emphasis on not sacrificing broader reproductive justice goals for narrow policy priorities, their concern for how marginalized citizens are framed, and their attention to historical and contemporary intersectional reproductive oppression are of particular relevance for my arguments.

Responsibilization

A recurring feature of neoliberalism, across a wide range of arenas, is the process by which government institutions transfer responsibility to individual citizens and non-governmental organizations. This process of *responsibilization*, originally put forth in research and theoretical work in the field of criminology (Garland 1997; Cruikshank 1999), renders private citizens and organizations accountable for achieving goals previously considered to be the appropriate responsibility of the state. This shift is achieved in part through a continuous process of decentralization, through which systems of control both expand and gain power (Cohen 1979). Myers (2013) offers the additional perspective that alongside the criminal justice system, the state also achieves responsibilization through welfare inaction. While the state transfers responsibility to individual citizens in these systems, however, it does not simultaneously transfer power. Rather, it retains or even builds its own power while eliding its earlier responsibility for meeting particular stated or implicit goals. In the broader neoliberal turn, this process unfolds in a range of particular locales.

In the criminogenic arena specifically, responsibilization manifests through a criminal justice system that "offshores" accountability for managing criminogenic risk in part onto

individual residents of that society or onto community organizations seeking to mediate the damage done by a neoliberal governmental approach. Rose (2000) expands on this point, calling responsibilization a "technology of governance" (334) that allows the state to govern by operating *through* individuals' decisions, rather than around or in spite of them. Doing so provides a way for the state to continue to exert control over individuals and society more broadly without shouldering responsibility for doing so, disconnecting their authority from potential negative outcomes, failures, or accountability. Singer (2017) connects this analysis to theories of reproductive governance in Latin America (Morgan and Roberts 2012), explaining that through responsibilization, "the state, along with a coterie of institutions such as churches, hospitals, and schools, acts from afar, steering human behavior to cultivate self-managing subjects who come to internalize and embody responsible dispositions" (448). By means of this "steering," the state achieves its aims while wiping its fingerprints from the process and from the results.

I build on these bodies of literature to theorize what I term "reproductive responsibilization." In doing so, I build on the work of reproductive justice activists and scholars who have leveled analyses of these various components for generations (see, e.g., ACRJ [Asian Communities for Reproductive Justice] 2005; Luna 2020; Silliman et al. 2004; SisterSong, Inc. 2017). As I argue in this study, through reproductive responsibilization the state responsibilizes individuals to achieve particular ends via their reproductive decision-making. Just as in the context of crime management criminogenic risk is managed through responsibilization strategies, in the arena of reproduction, reproductive risk is managed through *reproductive responsibilization*. Yet in this process, the state and its representatives cede neither control over residents' reproductive outcomes (e.g., conception) nor authority

over the means by which they reach those outcomes (e.g., contraception). This process is not, moreover, race-neutral or class-blind. Rather, it connects closely to histories of eugenics and controlled reproduction in the United States. Long-acting reversible contraception, which is framed as "the only responsible contraceptive choice" (Mann and Grzanka 2018:350) in a neoliberal public health context, emerges as one technology of reproductive responsibilization. As Takeshita writes of IUDs, LARC "embodies the paradox of the simultaneous possibility of giving women control over their bodies and taking it away from them" (2012:5).

Methodology

The findings in this study are based on two qualitative data collection methods: in-depth, semi-structured interviews with staff members and related stakeholders affiliated with organizations that advocate for increased access to LARC, and qualitative content analysis of LARC advocacy materials produced by those organizations. In addition to people working for or directly affiliated with an advocacy organization, I interviewed state agency staff, clinical staff, researchers, and other parties with a "stake" in this conversation.[11] To contextualize and provide background for the interviews, I also conducted content analysis on the materials each interview organization posts on their front-facing websites regarding their organizational histories and priorities, as well as their policy platforms related to contraception generally or long-acting reversible contraceptive methods specifically.

[11] In using this term, I reference a common understanding of "stakeholder" in this field as any party interested in the outcome of a given piece of legislation. I note that in practice interview participants most frequently use this term to mean representatives of the state government.

Qualitative interviewing allows interviewees to present their experiences and beliefs in their own words (Blee and Taylor 2002). This flexibility was particularly important in this project, given its focus on how participants understand the ethics guiding their professional decision-making. The meaning they ascribe to their actions and experiences is of primary importance and cannot be captured using quantitative methods. Qualitative content analysis evaluates data published for a purpose separate from the research study (Schreier 2012) and with a particular audience in mind, and therefore provides a window directly into the framing of LARC advocated by the organizations.

This study compares one very progressive state and one very conservative state, which are otherwise similar, and therefore illuminate details that might not otherwise be obvious. Texas and California are politically very different but are demographically and geographically comparable: they are the two largest states in the continental United States and the two most populous states in the nation. Unusually in the United States, they both have Latino/a populations nearly as large as their white populations. Both states have bicameral legislatures that control large health and human services budgets, and in each state, healthcare committees in each legislative house have significant influence over healthcare policy, including policy on LARC. Finally, both states border Mexico, and their borders are crisscrossed by official and unofficial crossings, leading to high percentages of Latin American immigrants in their populations, some with documents and some without. These characteristics are particularly important in conceptualizing the role of state government in providing healthcare for a given state's low-income population. Yet despite these similarities, California is one of the most liberal states in the nation while Texas is one of the most conservative. This divide is especially clear—and relevant to this study—at the level of state

government. As of the beginning of data collection for this research, Democrats held approximately two-thirds of California's state Senate and Assembly seats. The same proportion of Texas State Representatives and Senators were Republicans. The differences between the two states strongly influence how the study's interviewees navigate advocacy for increased access to LARC, how they frame long-acting methods and the relevant public healthcare programs, and how they identify policy goals as reasonable or desirable. I also, however, find strong and unexpected similarities in advocacy approaches across both states.

Data Collection and Analysis

The organizations initially contacted for inclusion in this project included all statewide organizations that, based on their websites, appeared to advocate on the topic of public funding for LARC in Texas or California. After conducting the first interviews in each field site, I used snowball sampling from those interviews to identify additional possible interviewees, asking to be introduced to advocates in this field or those who otherwise might have useful expertise. For each organization, I conducted interviews with the staff members organization leaders identified as most able to speak to LARC policy and advocacy. These included registered lobbyists and many people more generally considered "advocates," such as leadership, external affairs officers, and researchers. Although I initially sought to interview anti-LARC organizations, I was not able to identify any organizations in either state that advocated against increasing access to LARC in any substantive way.

My strategy for interviewing included in-person interviews at a location of the interviewee's choosing, typically their office or a public location such as a café. Upon the beginning of the COVID-19 pandemic in March 2020, all interviews were moved to video call or telephone. Interviewees were offered the choice between the two media; most chose

video call. Across all types of interviews, most lasted between half an hour and two hours. The initial methodological protocol filed with the Internal Review Board at the University of California, Santa Barbara included the option of video or phone interviews as needed, to accommodate any interviewees who were unable or unwilling to meet in person, so no changes to the protocol were required when the pandemic began.

To analyze the interview data, I first used an automated transcription software, Temi, to produce rough transcriptions of the interviews. I then listened to each interview in its entirety while reading the machine-produced transcripts, correcting them by hand as necessary. Next, using an inductive data analysis approach, I printed and read a selection of the interview transcripts, marking emerging themes by hand. After identifying these initial themes, I developed a tentative list of codes based upon them. I then used the qualitative coding software Dedoose to apply these codes to the interview transcripts, revising the code list in an iterative process as my understanding of the data developed.

For each interview organization, I also conducted qualitative content analysis of website materials regarding their advocacy or policy platforms, particularly as they relate to contraception. I additionally analyzed their mission and values statement documents. These materials were downloaded from each organization's front-facing websites to assess their public statements about their goals and identity as organizations and their public statements about both the level of priority LARC takes in their work and their position on it. I identified these documents for inclusion by searching Google for each organization's name, navigating to the home page, and clicking each link on the home page (and the links on each page to which those links led me) searching for pages about the organization itself (e.g., "About Us," "Mission and Values," "History") or about the organization's policy platform or advocacy

work (e.g., “Our Work,” “Policy Efforts,” “Issues”). These data do not form a substantial portion of the data cited directly in this work. Rather, they inform and contextualize my broader findings, my categorization of the organizations as reproductive health, reproductive rights, or reproductive justice organizations, and my interpretation of participants’ statements. I coded the website data in Dedoose, reading each webpage at least twice, first to identify themes and then to code.

A Note on Word Choice

The language used to describe reproductive health services and related concepts is contested and politically charged. Terms frequently move among the fields of public health, medicine, public policy, and social movements, often without careful attention to the original meanings of the words in question. These “translations,” therefore, are often to the detriment of intra- and inter-field communication. In part due to the intense political debate around this work, futhermore, even the initial conceptualizations of such terms can be muddy or deliberately opaque. At times, as these terms migrate from one field to the next or evolve with social movement organizing and pressure, the definitional opacity or meaning lost in the process has important ramifications for individual people on the ground, including clients and patients of reproductive healthcare providers. Here, I explain how I have navigated the tensions and ambiguity inherent in three terms in this work: “women,” “family planning,” and “unintended” or “unplanned” pregnancy.

First, in both Texas and California, reproductive policy advocates are moving toward more gender-inclusive language to describe clients served under reproductive health programs. Nonetheless, “women” is by far the most frequent descriptor in my data. Aside from a few cases in which a participant interrupted themselves to re-orient to gender

diversity, in fact, "women" is used nearly to the exclusion of other terms or broader phrases. This near uniformity reflects the fact that the narratives and logics at play in this field generally relate specifically to cisgender women, exclusive of cisgender men, transgender women, transgender men, and gender non-binary or gender non-conforming people—despite efforts to shift that orientation. In this study, then, when I speak specifically to the words or logics of interview participants or others in this field, I typically use the terms "woman" and "women" to accurately reflect their language. Otherwise, I use more specific terms, such as "cisgender women," "people who use reproductive health services," "contraceptors," or "people with uteruses," as appropriate.

Second, "family planning" is an umbrella term often used to describe reproductive life course decision-making. At its broadest it can include services to support childbearing (e.g., intrauterine insemination). It typically refers, however, to contraceptive services, devices, and medications, such as hormonal contraception, intrauterine contraceptive devices, and tubal ligation. To avoid the definitional ambiguity it carries, I have avoided using this term in this study except where strictly necessary (e.g., in a direct quote or program title, or in discussion of the same). In its stead, I use terms such as "contraceptive services" or "reproductive healthcare."

Finally, the terms "unintended pregnancy" and "unplanned pregnancy" are often used interchangeably with "unwanted pregnancy" in my data and in the reproductive policy field broadly. These terms, though, have important differences. Unintended pregnancies are pregnancies that happened earlier than desired, while unplanned pregnancies are those that happened despite contraceptive use or while a patient did not want to become pregnant (whether or not they were contracepting at the time) (Potter et al. 2019; Santelli et al. 2003).

Neither of these terms maps neatly onto "unwanted pregnancies." In fact, substantial portions of patients with unintended or unplanned pregnancies report being happy to discover they were pregnant (Santelli et al. 2003). Despite the importance of these distinctions, population-level measures of these phenomena often distinguish between these terms poorly or not at all.

This conceptual "fuzziness" has several important consequences, three of which are particularly relevant to this study. First, it leads to confusion about the relative frequency of the three phenomena. Public health researchers, medical providers, policy analysts, and scholars all write about this topic, without sufficient inter- or intra-field clarity about the human experiences the numbers reflect. Second, the "fuzziness" means policy efforts to reduce "unintended" or "unplanned" pregnancies in fact aim to reduce some *desired* pregnancies. While unwanted pregnancies may be reduced to zero without preventing any desired pregnancies, unintended pregnancies cannot. This point is particularly concerning in light of the third consequence relevant to this work: unintended pregnancies are not distributed evenly throughout the United States population. Rather, they are disproportionately concentrated among marginalized people (see, e.g., Finer and Zolna 2013, 2016).

Taking these three points together, the conceptual slipperiness of the concept of "unintended" or "unplanned" pregnancies means many public policy efforts explicitly aim to reduce some desired pregnancies, disproportionately among marginalized people. Efforts are underway to increase clarity and refine programming to address this point (see Potter et al. 2019 for a recent discussion of possible new approaches). In the interim, the confusion stands. The lack of clarity, moreover, means that many disparate groups can come together

around the goal of "reducing unintended pregnancy" in the United States—despite what may be large disparities in their understanding of that term.

Research Overview

In this research, I compare case studies of the reproductive advocacy field in Texas with that in California. I use these data to examine how organizations in each state make the legislative advocacy argument for increasing access to long-acting reversible contraception. To describe these processes, I analogize advocacy to farming.[12] Drawing on the concept of sustainable agriculture, I use the term "sustainable advocacy" to explicate the ecology of reproductive policy advocacy in each state. This ecology includes inherited conditions of the "soil" (the policy advocacy landscape), individual "farmers" (advocates, lobbyists, and other stakeholders), specific "planting" techniques (the legislative strategies advocates cultivate), and a "harvest" of the fruits of their labor (the results of advocates' efforts—bills, budgets, and beyond). I use each of these aspects to frame one chapter of the broader study.

I describe the structural landscape that policy advocates inherit as the metaphorical ground, or *soil*, they work. The soil a farmer works has specific and set constraints, such as the nutrient fertility, the friendliness or hostility of the weather and growing season, and the mix of sunlight and shade that play on its surface. While some of these aspects technically can be changed, to do so is a long, arduous process, unlikely to yield immediate results. Similarly, advocates inherit advocacy landscapes that were formed long before they came to the scene, and they confront particular constraints of that landscape. Described in more detail in Chapter 1, these constraints include the politics of the state's populace and legislators,

[12] For writing on the utility of metaphor, see Lakoff and Johnson (2003) and Tomlinson (2018).

statewide budgetary constraints, and the state legislative system itself (including how frequently and for how long legislators meet). Like changing the soil in a growing field, some of these structural conditions might feasibly be changed, likely quite slowly. For both farmers and advocates, the techniques they employ in their work are more easily changed than is the field itself.

In this metaphorical ecology, reproductive advocacy organizations, and the advocates they employ, represent the *farmers.* Farmers come to the field with varying core motivations, from a range of backgrounds, and in different affiliative relation to one another. These might include a love of or desire for farming or plants or financial security, from life experiences including lifelong farming or other careers entirely, and in relations of collaboration or competition. Each of these aspects informs how they approach their work. Likewise, as I describe in Chapter 2, reproductive advocacy work is conducted by a range of organizations and, within them, by individuals who bring a range of experiences and motivations. The organizations range from medical professional associations to grassroots community groups, and the individual advocates might be motivated by a love of advocacy or a passion for justice, among other possibilities. Just as for farmers, these elements influence how organizations and advocates approach their work, including by shaping their priorities and their efficacy.

In this study, the *cultivation techniques* or *planting* represent the legislative advocacy strategies that advocates use. Farmers choose among agricultural cultivation techniques and among kinds of seeds, determining the crop they will reap and shaping the approach they will take to growing it. These approaches include monoculture and permaculture, which contrast planting only one crop with planting a range of crops that complement one another, among

other aspects. The types of seeds they choose among include, for example, short-term crops (one season) and long-term (multi-season) crops. Each of these techniques and types of plant has costs and benefits. Likewise, advocates must choose among a range of legislative strategies and arguments. These strategies might include leaning on one argument or using a range; the arguments might include return on investment or reproductive justice. The various techniques and arguments carry different sets of consequences, and advocates must deliberate among them, as I elaborate in Chapter 3.

The result of those choices, the outcomes of legislative advocacy strategies and arguments, are the metaphorical fruit of advocates' *harvest*. Just as farmers harvest both a crop and its influence on the land after the crop is in, so too do policy advocates. Based on their decisions about planting, for example, farmers might harvest corn, wheat, alfalfa, or apples. Yet in addition to generating food or sales, these crops affect the soil the farmers work and its future fertility. Planting corn through monoculture, for instance, leaches nitrogen from the soil, rendering future crops far less healthy and robust. In contrast, planting a range of complementary crops through permaculture can invest in the long-term health of the soil by returning nutrients to the ground. In metaphorical parallel, advocates harvest both policy outcomes and long-term effects on the ground they work. Based on their strategic decisions and advocacy arguments, advocates might harvest budget increases or cuts, bills passed or blocked, or healthcare programs altered. In addition to these specific wins or losses, though, advocacy outcomes have the potential to change the ground advocates work on in the future, by making it more or less "fertile" for future advocates As I describe in more detail in Chapter 4, in this way advocates' choices change the very soil on which they work, with critical implications for their future efforts.

To bring each of these metaphorical aspects together, some farmers, working with the set conditions of their fields, choose particular cultivation techniques and crops that not only generate short-term benefits but provide for the long-term health of the soil. Broadly, this approach is known as "sustainable agriculture." I argue that my interviews, taken together, suggest that reproductive policy advocates can and should move toward what I term *sustainable advocacy*.

Some reproductive policy advocacy organizations are currently planting short-term advocacy "crops." In agricultural terms, these crops are easy to plant and grow. They are reliable, and they follow a predictable path over the course of the years. In the first few growing seasons one plants corn, for instance, the harvest will be productive. For this reason, corn can be very compelling—especially when the short-term need is very great. Over the long term, though, planting corn year in and year out will drain the soil of nutrients, reducing its capacity to provide for future generations. Unchecked, this process will eventually make the ground infertile, unable to sustain future planting. In reproductive policy advocacy, my data suggest, short-term advocacy arguments and strategies for funding LARC follow just this path. They are reliably effective in the short term, producing meaningful (though perhaps modest) gains—slight budget increases or level funding, a few bills passed. In the long term, though, strategies such as cost-savings arguments will legitimize the idea that reproductive healthcare is worth funding only because it provides a good return on investment. This discourse can make future advocacy work more difficult by implicitly strengthening class-based and racialized ideas of whose reproduction is valuable and worthy.

In contrast, other organizations argue for "long-term crops." Metaphorically, these might look like an orchard made up of different kinds of complementary fruit trees. This

approach requires a long build-up period from seed to harvest before it bears the amount of fruit you see in short-term crops. Critically, however, it will feed the community for generations to come. In advocacy, in parallel, organizations following this approach draw on long-term arguments for long-acting reversible contraceptive access, leaning on reproductive justice or other human rights tenets to argue that everybody has a right to reproductive self-determination. These arguments might take time to take root. After all, for many legislators in states hostile to reproductive healthcare, these ideas constitute an entirely new framework. This timeline can be a concern when the need is immediate (that is, when reproductive healthcare budgets are profoundly threatened). Ultimately, though, this approach will produce a bountiful harvest, year after year, because it supports the health of the soil itself.

Sustainable agriculture combines these approaches, in part by "planting" multiple complementary crops with different growing cycles in one field, minimizing or offsetting the use of those that drain nutrients from the soil. In this approach, there is always a short-term harvest growing, but the long-term goal of maintaining fertile ground for future needs is also supported. What emerges from my interviews, in parallel, is sustainable advocacy.

Sustainable advocacy involves a diverse array of persuasive arguments, carefully combining those that are most effective in the short term and those that work best in the long term, while minimizing or mitigating the damage of those that "leach nutrients from the soil." It also includes an investment in changing the structures and the landscape within which advocates work, metaphorically planting shade trees or sustainably irrigating fields: creating long-term coalitions, building electoral strength among marginalized populations, and working toward redistricting, for example. It both generates some short-term gains—though fewer than might be possible without regard for the health of the soil—but also builds the

long-term capacity of the fields to produce each year, supporting the people around for generations to come.

Sustainable advocacy as I describe it here is a decidedly "crowdsourced" approach. I did not develop it alone, nor did one specific set of interviews provide the bulk of its content. It appeared instead in bits and pieces in different interviews across two states; it is drawn at least in small part from nearly every interview I conducted. Sustainable advocacy is not, then, a recrimination or set of directions from one part of a given movement to another, from one movement to another, or from outside these movements entirely. Rather, it reflects and expresses a clear consensus, although not expressed as an exact term, that emerged across interviews with people from nearly every part of the ecology of reproductive justice, reproductive rights, and reproductive health advocacy in Texas and California.

In what follows, I first introduce the people I interviewed and the organizations they work for in each state. Next, I describe the structures within which these actors operate. Third, I explain the choices actors have made within their given structures, some of which are similar and some strategically different. Those choices have often changed the course of what comes after, indicating that even in Texas, where the structure constrains advocacy profoundly, there is a critical role for actors' agency. Finally, I present the tensions my interviewees experience in these decision-making processes. In the concluding chapter, I draw a rough roadmap forward as it emerged from my interviews.

My hope is that in these pages I faithfully convey the many lessons my participants taught me. I am responsible for the analyses I present here, and any mistakes are my own. Yet I owe a tremendous debt of gratitude to the people who shared their thoughts, hopes, fears, and experiences with me over the course of the last three years. I dedicate this

manuscript to their incredible wisdom, to their cumulative centuries of tireless work, and to their dedication to justice.

As a Texan born and raised, I love the state fiercely, the scorching heat and the bluebonnets and the stretches of perfectly straight highway shimmering in the sun; the Mexican food and the *folklórico* and the Broken Spoke dance hall; the Blue Bell ice cream and the barbecue and the beaches; the Hill Country and the plains; the pecan trees and the Rio Grande and the swamps; the music; the Friday night lights. Yet it is a terribly painful state to love as somebody who values reproductive justice, racial justice, and immigration justice. It has a painful history and a painful contemporary reality. These facts have shaped me profoundly, as a person and as a scholar. Over the centuries and through the generations, however, there have always been Texans who resisted. To the resisters and to their visions, and to Texas itself, I dedicate this work.

Chapter One: "The Land We Till"[13]

> *I think that's sort of the desperate thing in Texas right now, is we're struggling so hard just to hold onto the very basics [of reproductive healthcare] that the nuance gets lost. And the people that affects, then, are the people at the edges. So, it's people of color, it's undocumented patients, it's gender nonconforming or gender diverse patients, you know? So those are the people that are getting lost, because right now we're just in survival mode. And I think that's a frustrating thing about Texas, is it really just feels like you claw your way up this hill and then you just slide down. […] You're stuck just trying to just hold onto very basic [reproductive healthcare] services. And you know, we always keep those patients in our minds when we're trying to fight for this, but it just keeps getting harder.*
>
> ~Angie; race not disclosed; Texas reproductive health and rights advocate

This chapter presents the structural conditions any given reproductive policy advocate in Texas or California will inherit—the ground, or "soil," on which they work. These conditions include the states' political settings, their histories, their finances, and the broader and more diffuse concept of the state "identities." These structures make up the setting against which organizational and individual actors move, and it both enables and constrains their rhetorical and political movement. The data in this chapter are drawn from interviews and website content analysis in each state, from additional research I have conducted into state-level politics and context, and from my background knowledge. I first describe the structural conditions in which reproductive advocacy organizations operate in Texas. I next present the same contextual information about California, discussing what the two cases reveal about one another and what is added by considering them side by side. As the data described here reveal, while the structural conditions in which lobbyists and other advocates work in Texas and California differ greatly, they also share important similarities. Both the

[13] (Wright 1941:32)

differences and the similarities are critical to understanding who the organizational and individual actors are (discussed in Chapter 2), to making sense of how they navigate these settings and the effects of those decisions (discussed in Chapters 3 and 4, respectively), and to clarifying the possible alternative approaches they might take (discussed in the Conclusion).

"Deep in the Heart of Texas": The Structural Context

Texas has a powerful sense of place. The state's identity can be distilled down so clearly that just a few words between Texans can capture it all: "Texas is a particular kind of place," "Texas being the way it is," "since we're in a place like Texas." These phrases, though, capture a state that is anything but singular. From the Rio Grande Valley to the bayous of east Texas, from the Hill Country west of Austin to the plains north of Dallas, the Texan geography (ies), people(s), and culture(s) defy easy categorization or facile definition. Located at the meeting point of the Mexican North, the United States South, and the United States West, Texas encompasses a tremendous range of sociopolitical experiences and traditions. Yet among Texans, this capaciousness is readily communicated by way of a shorthand that reflects affection either wry or uncomplicated, at times alongside exasperation or disappointment. This shorthand surfaced in nearly every interview I conducted in the state. In Texas, as my mother says and my interviewees echo, for better or for worse you really know you are *somewhere*.

What we now loosely understand as the "state identity" of Texas reflects a somewhat winding path toward United States statehood. Over the last five hundred years, Texas has flown six national flags: Spain (1519–1685; 1690–1821), France (1685–1690), Mexico (1821–1836), the Republic of Texas (1836–1845), the United States of America (1845–1861;

1865–present), and the Confederate States of America (1861–1865).[14] Each of these eras left a mark on the state, the Republic of Texas and Mexico perhaps most obviously. While the period of time when Texas was a sovereign nation was temporally brief, the state's sense of nationhood has never entirely faded. Many Texans still speak and act as though Texas is a country unto itself, and public sentiment for secession from the United States periodically swells. Yet for contemporary Texas culture and politics, the flag of Mexico is at least as important as that of the Republic of Texas. Most prominently in the southern half of the state, Mexican identity still runs strong, not least because some families have lived on the same land since it was Mexican. Mexican-American activist and actor Eva Longoria's speech at the Democratic National Convention in 2016 captured the experience of many Tejanos/as: "I'm ninth-generation American. My family never crossed the border. The border crossed us."

As Longoria references, the 1,240-mile border between Texas and Mexico has been both changeable and porous over the course of the last three centuries. Goods, bodies, and cultural traditions have moved in both directions. These currents have been critical to the Texas economy. Historically, even conservative state politicians have supported their movement back and forth. Yet just as the *frontera* has always been permeable, so too has it always been firmly policed (Chavez 2008; Stern 2005a). Rhetoric about the need to police the "leaky" border is mirrored in rhetoric about the need to police immigrants' reproduction and the boundaries of the definition of "citizen," as Chavez (2008) argues, with clear implications for the state's reproductive healthcare policy. At the time of this writing the border is increasingly militarized and contentious, yet nonetheless, daily trade and traffic

[14] These are the eponymous flags of the Six Flags amusement parks.

continues to move across it in a testament to the economic and cultural connectedness of Texas and Mexico well into the twenty-first century. That connectedness stands in what may seem to be stark contrast to the political tradition of conservativism in Texas.

Conservative Politics and Progressive Resistance

Texas has long been a conservative stronghold in the United States. Although conservative Democrats held substantial statewide power even through the 1980s, the Republican Party consolidated its strength at the end of the twentieth century. In 1994, Governor Ann Richards (D) lost her re-election campaign to George W. Bush (R), opening the current political era in which Republicans dominate. Yet as my interviewees describe, until the Tea Party wave of the late 2000s there was a clear tradition of moderation among Texas Republicans. While far from progressive, the party included staunch defenders of policy priorities such as access to healthcare and incorporation of immigrants into the economy. With the election of President Barack Obama and the rise of Tea Party politics nationally, however, the state Republican Party began to move decisively rightward. This was a particularly dark time for reproductive healthcare, with dramatic and draconian cuts to state-funded programs, the slow but sure exclusion of Planned Parenthood from the provider network, and the shuttering of many safety net clinics across the state. Now, as the population of Texas skews increasingly young and of color, several of my interviewees suggested a different kind of change might be on the horizon.

Alongside the powerful conservative forces in the state, Texas has a long and proud history of resistance from the left. This history includes women of color who have led fights from labor organizing (Emma Tenayuca) to civil rights (Christia Adair), and it continues in the dedicated work of activists such as Graciela Sanchez of San Antonio's Esperanza Center

and Marsha Jones of Dallas's Afiya Center. It also includes a prominent legacy of leftist populism, in the politics of Carl Parker and Ralph Yarbrough, the political humor of Molly Ivins, and the political activism of Antonia Castañeda and Martha Cotera. A critical counterbalance to their powerful conservative counterparts, these voices have long represented an alternative view of Texas and pushed and prodded the state leftward, often with a grin. Today, these organizers contend not only with the rise of the Tea Party but with the state's increasingly dominant fiscal conservativism.

The Texas State Legislature and State Agencies

Long a part of Texas' political identity and all the more so in the years since the Tea Party gained power, fiscal conservativism holds great sway over lawmakers and lawmaking in the contemporary state legislature. In a state with no income tax, this approach both results from and is generative of limited revenue. Yet it is also broader than strict economics, a mentality that my participants see as pervasive in times of plenty as well as leaner eras. It is a primary cited reason why state lawmakers support or resist particular initiatives, leading them toward those that produce money and away from those with what is termed "a fiscal note," or an associated cost to the state. It is difficult to overstate how fervent the legislature's rhetorical commitment is to cost savings. Yet it is not quite so all-encompassing or internally coherent as one might think. The state did not expand Medicaid, for instance, despite the notable savings to the state. Nor, importantly, did state lawmakers hesitate to rewrite their reproductive health programs to excise Planned Parenthood from the provider network—although as a profoundly efficient provider, Planned Parenthood was an excellent and affordable contractor for the state. For many on the left, the underlying pattern is clear: conservative Texas lawmakers are in favor of cost savings, except when it comes to

reproductive healthcare or "entitlement" programs more generally. As I argue here, though, this logic is inconsistently applied to reproductive healthcare initiatives, and that inconsistency bears additional consideration.

To understand this and other dynamics at the Texas Legislature, a bit of contextual information about how it operates is helpful. Unlike the many state legislatures that hold a session every year, Texas state legislators are at the Capitol in Austin for only one hundred and forty days every other year. This is one of the shortest and most infrequent state legislative sessions in the United States. The session structure shapes the lawmaking process in two key ways. First, Texas state legislators are not career politicians. Nearly all of them hold a full-time job in their home district, where they spend their non-session months. This means that legislators might be dentists or small business owners or ranchers most of the year, and they carry that occupational knowledge with them to Austin. It also means it is a rare first-term state legislator who arrives at the Capitol with deep or broad policy knowledge. The advocate who drops by their office with a bundle of information, therefore, is correspondingly influential.

Second, the condensed legislative session means that once session begins, everyone involved in the legislative process, from lawmakers and staff to lobbyists and advocates, is profoundly pressed for time. The Capitol fairly hums as people scurry from floor to floor, papers sometimes literally flying in their wake. In this context, it takes an unusually calm advocate to keep a cool head. The "interim" time between sessions is therefore a critical time for doing preparatory work in anticipation of session. The condensed timeline also means that the relationships built in the interim, specifically, are crucial. Advocate after advocate I spoke with emphasized the futility of waiting till session begins to knock on a legislator's

door for the first time. Several people additionally spoke of the importance of "legislative champions" who would take a particular interest in one's primary issue. Based on strong relationships built during the interim, champions represent that issue behind closed doors once session begins. Legislative champions therefore have great power, and advocates work hard to cultivate strong relationships with them. These relationships have been all the more important to reproductive policy advocates over the last ten years, when the state's reproductive healthcare delivery system has seen unprecedented upheaval.

State-run reproductive healthcare services in Texas have historically been administered through the Department of State Health Services (DSHS) and the Health and Human Services Commission (HHSC). More recently, all reproductive health services have been reassigned to HHSC alone. As of this writing, the two active programs are Healthy Texas Women (HTW) and the Texas Family Planning Program (FPP). Among a wide range of other responsibilities, HHSC manages the state budget allocation for reproductive healthcare, distributing it to medical providers either through grants or through cost reimbursement for specific expenditures. Ultimately, agency staff are responsible for ensuring every eligible low-income Texan receives the reproductive healthcare they want and need.

This is a tremendous undertaking. Texas has nearly 30 million residents distributed over 250,000 square miles of enormous cities (including the fourth-, seventh-, and ninth-largest cities in the country) and vast, sparsely populated rural areas. Nearly fifteen percent of Texans live in poverty and almost thirty-five percent are low-income. The state's uninsured rates are the highest in the country (Center for Public Policy Priorities 2019). To this effort, HHSC brings a team of career civil servants headed by a rotating cast of political appointees,

which change at the discretion of the governor. Agency staff manage everything from billing and reimbursement systems to data management and reporting. In the vast network of relationships that make up reproductive healthcare delivery in Texas, they are situated between the Legislature—which defines their scope of work and budget—and the medical providers who work directly with low-income Texans.

In 2011, the Texas Legislature dramatically slashed funding for, and restructured, the state's public reproductive healthcare programs. In addition to cutting the budget for these programs by two thirds, they reorganized the state-federal partnership Medicaid program to exclude Planned Parenthood and other organizations affiliated with abortion providers.[15] That exclusion violated federal policy, causing the federal government to end their nine-to-one match for state dollars allocated to the program. The state of Texas, in other words, voluntarily went from financing just ten percent of the program to financing all of it, to the tune of tens of millions of dollars. They also abruptly shifted to managing all reproductive healthcare services in-house, a profoundly logistically demanding task. In short order, twenty-five percent of the reproductive healthcare providers in the state closed or ended provision of contraceptive services. Thousands of Texans lost access to the full spectrum of reproductive healthcare services (White et al. 2015). In the years since, the state has slowly increased funding for this line item, attempting to build back capacity and service numbers. Partly as a result, nearly every legislative session since has seen some major reorganization of how these programs are administered, causing repeated shocks to the provider network

[15] Neither state nor federal public funding may be used to pay for abortion care, so all abortion providers taking state funds before this point underwent rigorous procedures to separate abortion services from the services paid for using public funding.

seeking to keep up with administrative requirements. These efforts to build back have met only limited success.

As this brief history suggests, abortion politics structure contraceptive politics in Texas. This effect unfolds in three ways. First, abortion politics shape the healthcare landscape across the state: determining which medical providers are funded, which other providers they can work with, and what services they can cover. Second, it divides the playing field of organizations that advocate on the topic of reproductive health into pro-choice organizations, pro-life organizations, and "just about preventive healthcare" organizations (i.e., relatively moderate organizations that do not advocate at all on post-conception care). This division plays out both behind the scenes and "on stage," including shaping who will and can work with whom. In particular, many progressive organizations that are not unabashedly "abortion-forward" fear being perceived as pro-abortion by legislators and other key stakeholders. As a result, they constantly calibrate and recalibrate their work toward that end—including, literally, not speaking to friends who staff pro-choice organizations in the hallways of the Capitol building. Finally, abortion politics structure even the most basic understandings of other forms of reproductive healthcare. Some conservative legislators perceive contraception in general as capable of terminating a pregnancy. Hence, for example, reproductive health advocates only tentatively introduced the copper intrauterine device (branded Paragard) into their advocacy. Paragard can be used as emergency contraception by means of preventing implantation of sperm, and its precise mechanism was poorly understood. Advocates feared, therefore, that it would be misunderstood as an abortifacient and negatively tint all intrauterine devices by association. Abortion politics shape contraceptive politics in these ways despite the fact that, as one

interviewee put it, “the anti-abortion groups have taken state legislative efforts—at least in Texas—as far as the courts are going to allow them to go” (Rob; Caucasian; Texas reproductive health advocate).

“California Calling”: The Structural Context

California has outsize influence in the cultural narrative of the United States, just as does Texas. The home of the Gold Rush, the Hollywood stars, and Silicon Valley, known for cowboys and entertainment and the Golden Gate Bridge, it is one of the largest states in the nation. To some, it represents the epitome of the best this country can offer. To others, it is better understood as the site of government internment of Japanese and Japanese American residents, forced sterilization of Latinas, and dehumanization of Chinese railroad laborers and, later, their families. Across its history and its time under the Spanish, the Mexican, and the United States flags—along with one very brief period under its own—California has been hailed as a land of plenty. It is a spectacularly beautiful stretch of land with a rich and varied history and people, from the mountains of northern California to its southern border with Mexico. Although that border stretches across the short side of the state, it still measures one hundred and forty miles and exerts a powerful influence over southern California culturally, economically, and politically. The currents moving back and forth across it generate tensions similar to those described in Texas. It is celebrated as part of what makes California the state it is, but it is also decried as dangerous, as “leaky,” and as a liability. Situated farther to the left of Texan leaders, however, California’s elected officials today are more likely to describe Mexico, and the border specifically, positively than are their Texan counterparts.

Progressive Politics and Conservative Resistance

Today, California is widely understood to be a progressive standard-bearer in an increasingly polarized nation, and it correspondingly represents "too far gone" in many conservative jokes. Many progressive Californians pride themselves on this fact. Some see their role as constantly pushing the envelope toward better public services, more protected land, air, and water, and a more just society. Compared to many states in the country, this reputation is well earned. Yet within California's borders the politics are as varied as the landscapes, which include not only purple mountains and redwoods but barren plains and deadly deserts. Its rural areas cover far more ground than the big coastal cities for which it is best known. Far from the Hollywood sign, conservatives still hold the eastern part of the state. Although they lack real influence in the Legislature, they have much greater sway in parts of California than some outside the state imagine.

In California as everywhere, moreover, the distribution of power is structured by intersecting and co-constitutive systems of power and domination such as race, gender, immigration status, class, and (dis)ability. Interpersonal and systemic marginalization on these bases is as active in California as it is in Texas, albeit often in subtler ways. Californians have a strong history of resisting that marginalization through organized resistance, from Dolores Huerta and César Chávez—who fought big agriculture and led mass mobilizing for labor and immigrant rights beginning in the 1950s—to Alicia Garza, and Patrisse Cullors—two key Black Lives Matter leaders and founders who live and work in California. Leftist organizing, by these activists and many others, deserves substantial credit for California's reputation as an exemplary progressive state. They continue to press the state government to live up to its ideals, to implement programs to effectuate the values they proclaim, and to honor the true meaning of progressivism by constantly moving forward.

Partially as a result, California legislators are indeed far friendlier to progressive causes than members of most state legislatures in the nation.

The California State Legislature and State Agencies

The California State Legislature is one of only a few full-time legislatures in the United States. Each session lasts two years; shortly after one ends, the next convenes. Few state senators and members of the assembly, therefore, hold other paid positions. Historically, incumbent politicians drew district lines, resulting in high concentrations of party supporters in each district. Currently, redistricting is conducted by a citizen redistricting committee. State legislative districts are still overwhelmingly safe for one party or the other, but less so than when incumbents drew district lines. As a result of these shifting districts, Democrats now hold veto-proof supermajorities in both the Senate and the Assembly, with little risk of their seats changing hands to Republican control. Reproductive policy advocates report that this distribution of power means that there is little need to lobby Republicans on issues related to reproduction. One interviewee reported: "On almost any vote on any bill […] if it has to do with birth control or abortion, there's a 99 percent chance that all the Dems will vote with you and all the Republicans will not" (Pamela; white; California reproductive rights advocate).

In a political system with few real Republican powerbrokers, however, the diversity within the Democratic Party comes to the fore. In part, this reflects the fact that many moderate Republicans, in a state with few paths to power for Republicans, have changed their party affiliation. Running as moderate Democrats, they have occasionally won. This process has two important results. First, some legislators registered as Democrats are more moderate than might be expected in such a progressive state, though interviewees note none

of them are truly conservative. Second, "in California today, if you're an elected Republican, the chance that you are a massive, crazy Trumper is really high—because of the way redistricting happens, you get lumped in more and more with the people who think just like you" (Pamela; white; California reproductive rights advocate). These legislators' votes, though, are far outnumbered by Democrats in both houses of the legislature.

The power of the Democratic Party in California might suggest relatively loose purse strings when it comes to the state budget. Indeed, they are more inclined to fund social services than are their counterparts in Texas. Yet despite that inclination, even among Democratic legislators there is ample concern for preserving state dollars. In part, this concern reflects the responsibility of any governing body to allocate public money responsibly, carefully, and efficiently. It also, however, reflects California state policies that artificially constrain state income, such as Proposition 13. This measure dramatically limits property tax collections, with a progressively greater effect on properties with values that have risen more sharply since 1976. The fiscally conservative bent also reflects the external conditions in which the California legislature operates—notably, the 2008 recession that resulted from massive predatory subprime lending by banks to low-income people and, particularly, low-income people of color. State spending contracted as a result of the recession, only slowly rebuilding over the following decade. As research for this project unfolded, a second economic contraction developed as a result of the COVID-19 pandemic. Coupled, these factors have led to a relatively conservative fiscal approach, even in California. This approach places substantial financial pressure on state-run programs.

One such state-run program is tasked specifically with delivering reproductive healthcare service to low-income Californians: Family Planning, Access, Care, and

Treatment (Family PACT). Family PACT, which is administered by the state Office of Family Planning in the Department of Health Care Services, provides contraception, screening and treatment for sexually transmitted infections, HIV testing, cervical cancer screening, and "limited fertility services" to residents "of childbearing age" living under 200 percent of the federal poverty line. Specifically, it funds the relevant medicines and medical devices, along with the services needed to provide them to patients. Federal Title X funding, which provides wraparound funding to pay staff and "keep the lights on" for providers, runs through the office of Essential Access Health. That funding complements Family PACT, which pays specifically for reproductive healthcare—not, for example, for the staff hours necessary to process billing or clean exam rooms.

The Family PACT program was created in 1997 in response to concerns that the state was funding prenatal care but not contraception. It was initially funded solely by the state. In 1999, California sought to include Family PACT in their state Medicaid program via a Medicaid waiver, which allows states to innovate in their Medicaid programs in ways not usually permitted. The approval of that waiver enabled the state to fund Family PACT partially through matching federal funds. In 2011, it became a permanent "State Plan Amendment" rather than a temporary waiver program, ensuring its longevity as part of California's Medicaid programming. Today, Family PACT provides services to over a million Californians via 2,200 providers. Its delivery system is extensive, and it faces immensely complex logistical demands. Despite its far reach, it strains to reach the most vulnerable state residents and the most rural parts of the state.

Many of the advocates I spoke with for this project emphasized how lucky they feel to be doing this work in California rather than in Texas or another conservative state. Yet

several reproductive justice interviewees also described the state as controlled by a deeply flawed political system often hostile to reproductive justice. While crediting some of their accomplishments to the relatively friendly political context, they nonetheless saw their work as unfolding in an advocacy space that often was misaligned with their goals. They frequently cited the state's histories of forced sterilization and contraception (Gutiérrez 2008; Stern 2005b) and emphasized that their communities and constituencies have long intergenerational memories of these traumas.

Many of my reproductive health and reproductive rights interviewees, in contrast with the reproductive justice interlocutors, frequently identified their role as Californian advocates as that of a beacon to progressive advocates in other states, showing how politics can unfold in the best-case scenario. Although they noted that reproductive healthcare in the state was far from perfect, and at times also referenced California's reproductive healthcare abuses, their perspective was more uniformly positive. They suggested that only rarely did they see an intractable political issue of reproductive health. Yet they also reported a personal downside to this political context, noting that it generated a certain boredom and a corresponding interest in working someplace where advocating for reproductive health and rights—and particularly, contraception and abortion—represented more of a challenge. In no interviews, though, did any of my interviewees report intention to move to a different state for this reason.

Although my interviews in California were specifically and explicitly about long-acting reversible contraception, there as much as in Texas abortion is in many ways the center of the reproductive healthcare world. It similarly structures the field on which all other reproductive healthcare unfolds. Time and again, participants in California turned their focus

to it unprompted. It is the reference point against which contraception generally and long-acting methods specifically are assessed, and it is an area in which California has played a key role nationally. Critically, abortion is covered under public healthcare programming in California. However, it sets the terms of the reproductive healthcare debate in California in large part because it is nonetheless the most controversial aspect of such healthcare, and the aspect perceived as being most endangered. As such, nearly every advocate I spoke with articulated a concern for protecting access to abortion care.

Texas and California: A Structural Comparison

Although the loudest voices in Texas and California disagree on nearly everything, there is one clear area of agreement: just how different the two states are. A billboard in Texas captures a popular conservative comparison: "California? Too late. Texas. Still great. Vote Republican." The progressive version of this sign in California could well read, "Texas? Your time's past. California. Moving fast. Vote Democratic." The two states both cover enormous stretches of land in the western United States, with vast swaths of conservative rural areas studded by enormous blue cities. They both border Mexico, with which they have longstanding and important relationships that play defining roles in the states' histories and contemporary identities. They both are cultural icons in the United States, with powerful state personalities and disproportionately large roles in the national conversation. These similarities work to cast into stark relief their one key difference: Texas is run almost entirely by Republicans, while in California Democrats hold the reins.

In part as a result of this political difference, California has codified its reproductive healthcare delivery program, ensuring some stability across the years and allowing more breathing room for program administrators and healthcare providers to innovate. In contrast,

Texas has seen a decade of dramatic upheaval in the funding mechanisms, structural contours, and service delivery of its corresponding programs. The state government continues to overhaul the programs regularly, operating them differently from year to year and even month to month. Yet even in these deeply dissimilar political contexts and amidst the corresponding program differences, there are some important similarities in how the two states deliver reproductive healthcare—and, therefore, in how reproductive policy advocates operate.

In this section, I lift up four of these similarities that I argue are especially telling. In both Texas and California, the sprawling size and large population of the state make reproductive health delivery logistically difficult; the need to preserve state dollars is paramount; coalitions play a critical role in increasing access to reproductive healthcare, reproductive rights, and reproductive justice; and abortion powerfully structures the field of play for reproductive policy advocates. Placing the two states side by side in these four areas highlights the implications for reproductive policy advocacy, with particular attention to the campaigns to increase access to long-acting reversible contraception.

Logistical Complications

Delivering reproductive healthcare to low-income populations represents an immense logistical challenge in both Texas and California. In my interviews in both states, nearly every person described this complexity, from state agency administrators to reproductive healthcare providers to reproductive justice advocates. Although different people emphasized different aspects of the challenges faced, the difficulty inherent in making the system work as it should, and, particularly, reach everyone equitably, was a constant refrain. In both states, the geographic reach of the state, the large population, and the extensive rural areas far from

large cities were particular concerns. State healthcare programs are rarely designed with maximum ease of use in mind, for administrators, providers, or patients. Their sometimes labyrinthian processes are often experienced as Kafkaesque in nature. My interviewees also frequently mentioned how hard it is for some residents to physically reach or more generally access program services, regardless of where they live or how far they have to travel to reach a medical provider. The barriers they described included lack of translators, difficulty finding childcare, concerns about immigration status and checkpoints, and struggles with public transportation or with accessing a car. These concerns were broadly similar across the two states.

The two states' success at negotiating these complexities, however, differ. California has more successfully minimized barriers and maximized access, while Texas has struggled in these areas. In part, this is a result of self-imposed problems by the Texas state government, including serious unforced errors for program function, and the lack thereof in California. In Texas, the devastation of the reproductive healthcare provider network in 2011, including eliminating Planned Parenthood—one of the largest and most efficient providers in the state—cut the legs out from under the entire system. In part as a result, the provider network is substantially weakened and at times chaotic. In the years since the cuts, the government has attempted to build back the programs, newly separated from the federal government. In that process, each legislative session has brought substantial changes to the contours of the programs. Rules and regulations are subject to short-notice change, the billing and reimbursement systems are moving targets, and at the most basic level, the systems necessary to determine who is eligible for the programs change so frequently as to be endlessly confusing. The process of communicating information to patients is often in flux.

Agency records of the patients enrolled are rarely correct. Even the list of providers changes constantly.

These providers have been the backbone of the system by which the state communicates with patients. Their staff have gone far above and beyond in their efforts to keep up with these changing dynamics, and their advocates have fought nobly to minimize the effect of those changes on patients. They are not able, though, to close the communication gap between the state agency and patients. As a result, it is often exceptionally difficult for patients to determine eligibility, access a provider for the first time, and sustain a consistent relationship with that provider—in turn making patients less likely to receive the medical care they want and need. My interviewees left little doubt that they place the blame for this lack of access squarely at the feet of Republicans in the Texas Legislature. Although it is true that legislators confront a logistically complex and administratively arduous system, they report, self-imposed blunders and ideological decisions have made things immeasurably worse than that complexity necessitates.

Although Californian legislators confront many of the same built-in difficulties, the publicly funded reproductive healthcare system has been largely stable over the last thirty years. The three funding streams (Family PACT, which provides contraception to people below 250 percent of the federal poverty line; Medi-Cal, which provides contraception to people below 133 percent of the federal poverty line; and Title X, which provides wraparound funding for providers) are interwoven fairly successfully. California's Contraceptive Equity Act, further, codified the contraceptive coverage component of the Affordable Care Act into California law, providing further support for these programs. Taken

together, these factors make for a remarkably steady base of reproductive healthcare service delivery in California.

Although reproductive healthcare delivery programs in both Texas and California face substantial administrative and logistical complications, legislators have approached those dynamics very differently. Advocates in Texas are regularly distracted from their core concerns by the need to fight the latest proposed changes to the programs or help the agencies iron out the newest administrative wrinkles—some of which seriously threaten the ability of providers to offer even baseline care to only a small portion of the eligible population. In contrast, advocates in California report more ability to innovate, building on a reasonably steady foundation and decades of state experience in successful healthcare delivery using similar models. The two states' reproductive healthcare systems, overall, differ sharply in terms of coverage and stability.

Fiscal Conservativism

In the face of such demanding service delivery landscapes, the amount of funding available to state programs is centrally important. A second area in which the two states share an important similarity is therefore notable: the powerful imperative to preserve state dollars. It is a truth universally acknowledged that state governments are always short of money. Their budgets are hotly contested, there is never enough money to go around, and advocates struggle to secure funding even for crucial state functions such as healthcare. At this general level, this point is true in every state in the country. It results partly from a reasonable desire to be responsible with taxpayer money, as several of my interviewees in both Texas and California reported, and partly from a scarcity mindset that many progressive advocates across issue area contest on the merits. Regardless of where the budget tension stems from,

as a result of it, reproductive healthcare administrators and state agencies (and, in turn, healthcare providers) often lack the funding necessary to provide quality care. Advocates report they must accommodate these concerns or risk losing coverage.

Although the scarcity of state funding shapes the landscape on which advocacy for reproductive healthcare unfolds in both Texas and California, the details differ by state, as do the effects on advocates. In Texas, it is almost impossible to overstate the influence of fiscal conservativism discourse on advocates, per their report. Combined with a deep skepticism of reproductive healthcare on the part of many legislators, every dollar is hard won, often over the objections of a substantial portion of the legislature. Advocates report struggling to pass any legislative priorities that come "with a fiscal note," or cost to the state, attached. Due to the state's self-imposed limited revenue streams and resistance to drawing down the state's "rainy day fund" even in an emergency, these struggles are additionally enhanced by often serious budget shortfalls across the state budget.

Perhaps unexpectedly, a commitment to fiscal conservativism is also alive and well in California. Interviewees report that this commitment waxes and wanes over the decades, and suggest that in recent history, the deep recession of 2008 dramatically reduced the funds available to the state and increased legislators' commitment to a conservative budget. The economy rebounded between 2009 and 2019. As I write, the human and economic devastation of the novel coronavirus in 2020 seem to be effecting a similar contraction of the California state economy and regenerating legislators' ideological commitment to reducing state spending. Although contraception is a clear priority for the state, in this context advocates nonetheless face pressure to demonstrate that these services are fiscally responsible as well as morally imperative.

In both Texas and California, the need to spend public dollars conservatively is a frequently cited state legislative concern. It is inarguably important, of course, for legislators to spend taxpayer money responsibly, as they are trusted to do and indeed, as they must do to keep the state solvent and to preserve public faith in their leadership. Yet this commitment also places pressure on reproductive healthcare advocates to frame such care as an economic benefit to the state as well as (or instead of) a human right. This framing is appealing to many legislators on both sides of the aisle, and it can improve the likelihood that a bill or line item passes or is increased. As nearly all my interviewees suggest, however, and as I argue in this writing, doing so also comes with a cost.

Coalition Structures

A third relevant similarity between Texas and California is the central role of coalitions in increasing access to reproductive healthcare. In Texas, the coalition most explicitly focused on increasing access to LARC is the Texas Women's Healthcare Coalition (TWHC). TWHC was founded in 2012 in response to the 2011 cuts to reproductive health funding at the state level. Its stated goal is "promoting access to preventive healthcare for all Texas women" (TWHC 2016), with particular emphasis on contraceptive access. The word "preventive" in this phrasing distinguishes TWHC from organizations that advocate for increased access to abortion, as "preventive" care by definition precedes conception. This coalition was formed with a specific focus on mitigating the damage done when reproductive health funding was slashed in the early 2010s. Its members are largely reproductive health and reproductive rights organizations, with minimal representation from reproductive justice organizations, and membership generally is understood to constitute agreement with a close focus on preventive care.

By many accounts, TWHC's relatively moderate focus on preventive healthcare is what has enabled it to advocate effectively for the state's reinvestment in reproductive healthcare. In part, this is because a large contingent of powerful state legislators is unwilling to work with organizations that advocate on the topic of abortion—but may be persuaded to work with those that advocate on preventive care alone. Many of my interviewees credited TWHC with nearly single-handedly preventing substantially more damage to reproductive healthcare delivery in Texas in the 2010s. Some abortion-forward organizations and reproductive justice organizations, though, have critiqued the coalition's approach. The former two groups argue TWHC has taken too moderate an approach and has, in the process, made it more difficult to advocate for abortion care or reproductive justice more broadly. Partially because of these tensions, reproductive health, reproductive rights, and reproductive justice organizations rarely collaborate closely on policy priorities or approaches.

The California Coalition for Reproductive Freedom (CCRF) has similarly structured the LARC advocacy landscape in California in important ways. CCRF includes representatives from organizations across the reproductive justice, reproductive rights, and reproductive health landscape; the coalition website lists its primary goal as "promot[ing] sexual and reproductive health, rights and justice" (CCRF 2021). The coalition was formed in the late 1980s to provide a structure within which organizations focused on reproductive health and reproductive rights could coordinate their advocacy work. Throughout its history, CCRF has emphasized that its member organizations hew to a wide range of philosophies and approaches, and active discussion of internal tensions and disagreement has been an important part of its work and its role. Particularly important to this project, CCRF has been a central site of inter- and intra-movement debate about LARC advocacy arguments. This

debate has included reproductive justice representatives' pushback to cost-savings arguments. In Texas, the lack of a parallel coalition meant the absence of a space in which to have this conversation. Despite these differences between CCRF and TWHC, which have had important implications for LARC advocacy, each of these coalitions serves the function of a meeting space of sorts for organizations committed to increasing access to contraceptive care in their respective states.

Abortion's Gravitational Pull

A final important similarity between the structural landscapes in Texas and California reproductive policy advocacy is the gravitational pull of abortion politics. As demonstrated by the brief descriptions of the states' coalitions above, the right and access to high quality abortion care has become the single "heaviest" issue in the galaxy of reproductive politics in the United States. That weight is reflected in the tremendous amount of time, energy, and discourse dedicated to it; when reproductive healthcare arises in conversation, the focus often inexorably moves toward abortion politics. I find that this gravitational draw has the capacity to narrow conversations about reproductive health more generally down to this one topic, to the detriment of advocacy for, policy regarding, and legislative efforts toward reproductive justice more broadly. This dynamic was very clear in my interviews in both states: participants returned to the topic of abortion again and again, despite having been explicitly recruited for an interview on contraception. On repeatedly turning interviews back to the topic at hand, only to find myself once again in a conversation about abortion politics, I came to see this gravitational pull in both states as a research finding in and of itself. Beyond this general level, though, dispute over legal abortion structures the advocacy landscape in Texas and California quite differently.

In Texas, political tensions about abortion literally organize reproductive healthcare delivery programs, including funding streams, provider networks, and rules and regulations. They also divide organizations from one another, shaping which organizations work together and which maintain a determined distance, publicly, privately, or across the board. One result is the existence of a long list of organizations that advocate for increased access to contraception but determinedly do *not* advocate on the issue of abortion care. Likewise, the provision of abortion or lack thereof divide medical providers from one another, and those that do provide abortion care are structurally excluded from state-funded reproductive health programs. Abortion tensions also constrain reproductive policy advocacy. Organizations must clearly situate themselves in relation to abortion care, and the need to distinguish other kinds of reproductive health from abortion affects how some frame contraceptive services and emergency contraception.

In California, abortion care is not politically distinguished from contraception as sharply. This plays out across the organizations that advocate for it, the coalitions that coordinate around it, and the providers who provide it. In fact, in my interviews it was difficult to separate abortion from contraception. Participants reported that there were very few, if any, organizations that advocated for contraception but not abortion care; likewise, they suggested that pro-contraception legislators were generally pro-choice. However, they explained that abortion drew far more political attention than did contraception, making it difficult to find time or space to discuss contraception—which was, in any case, perceived as needing less discussion or action. Abortion politics also casts a long shadow over advocacy for increased access to contraception in California in other ways. For example, some people I interviewed explained that despite pressure to find economic savings in advocacy priorities,

they were hesitant to use economic arguments for contraception for fear of seeming to suggest contraception ought to be funded to prevent (pricier) abortions. This stood in contrast to Texans' reasons for hesitancy in this regard—fear of seeming to suggest contraception ought to be funded to prevent (pricier) children.

These differences between how abortion discourse structures the advocacy landscapes in Texas and California affect how reproductive policy advocacy unfolds in each state. Three of the most important ways it does so are in influencing which organizations work together, what they advocate for, and how they advocate for it. But across both states, abortion takes center stage in political conversations about reproductive healthcare and, often, in my interviews. As the more controversial and flashier of the two topics, abortion has a gravitational pull with which contraceptive policy advocates must contend—regardless of the state in which they live.

Conclusion

In both Texas and California, the campaigns to increase access to long-acting reversible contraception have unfolded against the backdrop of these broader state contexts and specific histories of reproductive health services described here. The two campaigns share similar roots in their respective states' logistically complex healthcare delivery systems and pressing need to conserve state dollars. Yet in the early stages of the two campaigns, the differences between the states' structural conditions made for meaningfully different advocacy strategies, campaign contours, and policy priorities. In both states the logistical complexity of delivering healthcare and the vein of fiscal conservativism in the legislature originally led advocates to draw heavily on cost-savings arguments for LARC, as described further in Chapter 3. In California, however, the long history of communication and

collaboration across reproductive health, reproductive rights, and reproductive justice organizations in the California Coalition for Reproductive Freedom provided a space for reproductive justice organizations to raise concerns about and critiques of this argument when it was first introduced in the early 2000s. As a result, after the initial movement toward this argument as a central tenet of the case for increasing access to LARC in the state, advocacy organizations in California reoriented. In Texas, in contrast, in the absence of such avenues of communication the cost-savings argument became and has stayed a central tenet of the campaign to increase LARC access. Decisions and strategies pursued by previous generations of "farmers" in this way have had a profound effect on the "soil" today's advocates work.

Yet the advocacy fields in Texas and California are more alike than is obvious from their national reputations as one of the most conservative and one of the most progressive states, respectively. This likeness stands across much of their histories, their geographies, and their people. The ways these structural conditions play out are different in the two state contexts, as I note here. The similarities, however, are nonetheless instructive in understanding who advocates in each field. I turn next to this topic, taking up the question of who operates in these structural conditions—or who "farms" these "fields"—in each state.

Chapter Two: "Tillers of the Soil"[16]

> *So, I mean, we make those hard decisions every day in Texas. The politics that we have to navigate are not easy. The hills we think we're going to die on, we end up making them over, [… and] there's always a bigger one coming down the road.*
>
> ~Emily; white; Texas reproductive health advocate

In this chapter, I overview the "farmers" in the ecology of reproductive policy advocacy in Texas and California. Metaphorically, the farmers are the advocates, lobbyists, and other adjacent stakeholders who plant and tend the "field" in question. As part of tending this ecology, they are responsible for deciding what strategies and arguments to use (which "crops" to "plant"), for harvesting the "fruit" of those decisions, and for stewarding the long-term health (and future fertility) of the soil in which they work. As prelude to analyzing how planting this field and harvesting the crops unfold, therefore, in this chapter I present some background information about the "farmers" themselves. This information includes the demographic characteristics of my interviewees and their relevant professional positions, a brief discussion of the organizations that employ them, and some overview about the path they followed to arrive at this juncture in their careers. I first discuss this information for the Texas-based interviewees, before turning to those in California to place this information side by side, considering what is revealed by comparing the two states.

In both states, most of the advocates and other stakeholders I spoke identify as women. The racial, ethnic, and class composition of the group differs greatly by type of organization, reflecting the different constituencies they represent—reproductive health and reproductive rights organizations were predominantly represented by white women in this

[16] (Wright 1941:31)

sample, while reproductive justice organizations were largely represented by women of color. Almost to a person, though, in both states advocates are passionate about their cause, defined variously as social justice, women's rights, reproductive choice, or related issues, and they often report finding this professional path through their passion, rather than by happenstance. Finally, they frequently explain that this passion is rooted in personal or family experiences.

In this chapter, as in this study more broadly, I do not systematically analyze the similarities and differences in how reproductive justice, reproductive rights, and reproductive health organizations approach this topic. Rather, the primary comparison I take up is between the field of LARC advocacy in Texas and that in California. For ease of reference and for clarity, however, I distinguish among reproductive justice, reproductive rights, and reproductive health organizations in this discussion of participants and the organizations for which they work. This terminology is common in the field and appeared frequently in my interviews and in the website data I analyzed. Moreover, it communicates useful additional information about political ideology, orientation to abortion, race of leadership, and perceived accountability relationships. I do note that organizations are at times identified differently in different places or by different people, or fall into more than one category.[17] Categorizing organizations in this way is not an exact science, but rather a means to communicate the rough outlines of the organizations that make up this sample.

[17] This approach is just one of many ways organizations in this ecology might be divided. Other categorizations might include type of organization (non-profit, membership, pharmaceutical, funder, medical provider, state governmental body), political ideology (radical, progressive, moderate, conservative, religious right), orientation to abortion (abortion-forward, abortion-supportive, abortion-neutral, anti-abortion, anti-choice), orientation to LARC (LARC-forward, LARC-supportive, LARC-nuanced, anti-LARC), race of leadership (white-led, people of color-led, BIPOC-led), or perceived accountability relationships (accountable to individual marginalized state residents or communities, accountable to medical providers, accountable to membership [e.g. specific category of providers], accountable to the Legislature).

The "Farmers" in Texas

The people who advocate on the topic of LARC in Texas are a passionate group. On the whole, they speak of their jobs and their advocacy work with great energy and commitment, and with an acute sense of the injustice of the system within which they work. They generally see themselves as "fighting the good fight," whether that means advocating for increased reimbursement rates for physicians inserting IUDs, pressing for contraceptive coverage for minors, or advocating for public funding for post-partum hormonal implants. Many participants experience their work as a labor of love undertaken on hostile terrain, and describe their work as, for example, "claw[ing] your way up this hill—and then you just slide down" (Angie; race not disclosed; Texas reproductive health and reproductive rights advocate). This mindset, while not universal, was pervasive. Yet advocates also see themselves as skilled navigators of the complex system of reproductive healthcare delivery in Texas, and often report pride, deep meaning, and even joy in wresting wins from an unwilling state government. These characteristics are shared across many important distinctions among my interviewees, from race, gender, and age to deep differences of politics and constituency.

The Participants

Reflecting the demographic makeup of the reproductive justice, reproductive rights, and reproductive health advocacy field, my 30 Texas-based interviewees overwhelmingly identify as "women" or "female," or report using she/her pronouns. Most identify as white or Caucasian, with several specifying "non-Hispanic white," echoing common survey classifications in Texas that distinguish "Hispanic white" from "non-Hispanic white." Roughly one third report identifying as Latina, Latino, Latinx, Hispanic, or Mexican; one

identified herself as Black and one as African American; and one identifies with a particular Asian American/Pacific Islander ethnicity. The vast majority was between thirty and fifty years of age, with a few in their late twenties, in their fifties, or in their sixties.[18] Roughly half hold policy or advocacy positions in the organizations that employ them; the same proportion serve in leadership roles. A very few are in other positions, such as external affairs or clinical roles, that also touch contraceptive advocacy or provide an additional useful perspective on the topic.

Org. Type	Pseudonym	Age	Gender	Race/Ethnicity
All	Amanda	40s	Cis gendered straight woman	Woman of color (details redacted)
Reproductive rights	Angie	Declined to state	Declined to state	Declined to state
Reproductive rights	David	40s	Male	White
Reproductive rights	Heather	30s	Female	Caucasian
Reproductive rights	Laura	Declined to state	Declined to state	Declined to state
Reproductive rights	Lisa	30s	Female	Hispanic
Reproductive rights	Monica	30s	Woman	Latino
Reproductive rights	Nicole	40s	Female	White, non-Hispanic
Reproductive rights	Scott	40s	Male	White
Reproductive justice	Leslie	50s	Lesbian	African American
Reproductive justice	Sara	20s	Female	Latina
Reproductive health	Amy	20s	Female	Latina
Reproductive health	April	Declined to state	Declined to state	Declined to state
Reproductive health	Christa	30s	Female	Caucasian non-Hispanic
Reproductive health	Christina	20s	Female	Hispanic
Reproductive health	Elizabeth	40s	Female	White
Reproductive health	Emily	30s	Female	Caucasian; white
Reproductive health	Erin	40s	Female	White; Caucasian

[18] All demographic information presented in this research was elicited through open-response questions (e.g., "What is your racial and/or ethnic identity?", "How old are you?", "How do you identify for gender, or what pronouns do you use?") so as not to externally limit interviewees' responses. When noting participants' race or ethnicity in this text, I use their terminology. Note that because racial and ethnic identities are not mutually exclusive, some interviewees fall into more than one category.

Reproductive health	Jeff	60s	Male	White; Caucasian
Reproductive health	Jennifer	20s	Female	Hispanic
Reproductive health	Jessica	60s	Female	White
Reproductive health	Julia	40s	Female	White of Hispanic origin
Reproductive health	Melanie	50s	Female	White non-Hispanic
Reproductive health	Melissa	60s	Female	White; Hispanic
Reproductive health	Michelle	30s	Female	White
Reproductive health	Liza	60s	Female	Caucasian
Reproductive health	Rebecca	Declined to state	Female	White
Reproductive health	Rob	40s	Male	Caucasian
Reproductive health	Shannon	30s	Female	White; Caucasian
Reproductive health	Stephanie	30s	Female	Latina

The Interview Organizations

The people I interviewed in Texas are affiliated with a broad range of organizations in the reproductive justice, reproductive rights, and reproductive health fields, as assessed via the organizations' website language, policy priorities, and position in the broader movements. People who work at reproductive health organizations made up slightly more than half of interviewees. Representatives of reproductive rights organizations make up the next largest block, totaling more than a third of participants. Reproductive justice organizations are the smallest sector, making up just more than a tenth of the total. These proportions roughly reflect the ratio of reproductive health, reproductive rights, and reproductive justice organizations that advocate on the topic of LARC in Texas. Notably, increasing access to LARC is a matter of relatively low priority for reproductive justice organizations, which are often focused on a much broader range of concerns than simply contraceptive services. It is a moderate priority for reproductive rights organizations, which

tend to be additionally focused on access to abortion. Finally, it is a high priority for reproductive health organizations, which have taken a "LARC-forward" approach in the last decade. The sample consists mostly of non-profits, with notable representation from membership organizations and providers, plus a scattering of state agency representatives, funders, and pharmaceutical company representatives. With the important exceptions, however, of religious right, anti-choice, and anti-LARC organizations—because they do not prioritize LARC as a policy issue—I interviewed people (typically multiple people) in each of the categories in each type of categorization described above.

Origin Stories: Focused Passions and Personal Commitments

Career choices feel very personal and, although constrained by external factors, are often experienced as more individual and chosen than structurally determined. While people do have a great deal of influence over the specific positions they take, there are also important channeling mechanisms in place. These mechanisms are gendered, raced, and classed, and may guide career decision-making in ways both subtle and overt (for a longer discussion, see Charles and Bradley 2009). For educated women choosing a career, organizations that attend explicitly to gender and race can be particularly appealing. Other sectors may be more likely to be hostile to women or people of color, or to be indifferent to gendered or intersectional concerns. These factors may be compounded by a personal passion for gendered and racialized concerns. Indeed, nearly everyone I spoke with in Texas originally entered this field out of a powerful personal commitment to (variously) women's health, reproductive health, reproductive rights, or reproductive justice. Although different people described that feeling differently, many used the word "passion" or words that reflected a similar level of intensity and emotion. Below, I provide some examples of how

interviewees describe this feeling, before elaborating on where they locate its origin and presenting data about those interviewees who do not evince such passion.

When asked how she got involved in reproductive healthcare work in Texas, Michelle, a white advocate with experience at Texas reproductive health and reproductive rights organizations, explained: "[I]t was an area I had personal interest in, so I just was invested in reproductive healthcare and reproductive justice generally." When I asked her to elaborate on where that interest stemmed from, she responded:

> [T]his is actually one where I don't always have—I don't know that I often verbalize why it is—it's more of a feeling. I just feel very strongly in bodily autonomy and the right of people to choose what to do with their bodies and the right to plan their pregnancies and their health, whether or not they want to have children. I think that that's essential.

Her voice nearly broke in this section of the interview, great emotion coming through. This kind of response was common in my interviews—interviewees commonly described their work as a calling or similarly rooted in a deeply felt sense of justice or personal investment, often longstanding. Many told me stories of their childhoods or adolescence, when this interest was reportedly first sparked. Shannon, a white reproductive health advocate, for example, shared the following with me in response to my question about how she entered this field:

> [W]omen's health is definitely a passion area of mine. It's something that I've always been really engaged in and interested in. […] I was this nerdy kid in high school who was harassing my friends about using condoms and stuff, even though I wasn't having sex, you know? But when I would find out that my friend was engaging in some maybe unsafe behavior, I was lecturing her about it and stuff. That's just always kind of been something to me […] you know, just my personal experience with LARC too, I've just found it's been something that has been very empowering for me, especially as a young woman, to know that I never had any failure in birth control and I've been very, very fortunate in that way, of never having an unplanned pregnancy, and my access to contraception was a big part of that.

As reflected in these quotes, interviewees based in Texas rarely reported working in this field simply because it was a job as any other. This theme may reflect the fact that advocating on the topic of reproductive healthcare in Texas is understood to be a particularly difficult job that is highly politicized. It is not, in other words, likely to be appealing to many people without a personal investment in the work. Advocates typically reported caring quite strongly about the mission of their work, often even in those cases where their formal job description touched reproductive health only peripherally. In these cases, advocates described having brought their passion for reproductive healthcare to the position to make it a bigger part of the job than it was intended to be when they were hired.

Many of my interviewees located the roots of their passion for this profession in childhood or adolescence, as described by Shannon above, or as a common thread running through their career. Amy, a Latina reproductive health advocate, put it this way:

> [I always had] this idea in my head that ideally, I'd love to work specifically on women's health issues. And so, when this opportunity came up [at my current employer] … I was like, "This is exactly what I've been wanting."

Several people I spoke with identified the origins of this "idea" in their family, including family commitments to this political cause or to politics more broadly. For instance, one reproductive health provider and reproductive rights advocate explained: "I was always interested in reproductive justice. […] My parents were very politically engaged, and so it was always something that I was aware of" (Laura). Others mentioned family experiences with the healthcare system generally or reproductive healthcare specifically, or their own experiences with reproductive healthcare, as the initial reason their passion developed. This group included people whose family members struggled to access needed healthcare, were not able to contracept as they desired, or experienced unintended pregnancies very early in

life. A white reproductive health advocate of Hispanic origin, Julia, described her passion as partially rooted in her desire to avoid the fate that befell her grandmother:

> I wanted two kids in my life. I started my period when I was thirteen. I'm still on it. I'm [now] hitting fifty, I'm going to be fifty next month. I'm still on it. My mom didn't stop [menstruating] until she was fifty-four. So that's over thirty years of me figuring out how to have two babies and twenty-something years of preventing pregnancy so that I don't have twenty-one [children] like my grandmother, and about six miscarriages [like she did].

Other participants reported memories of their parents' emphasis on avoiding adolescent pregnancy or described developing a keen interest in reproductive healthcare following their own experiences with reproduction. While the specific personal reasons for becoming involved in and passionate about reproductive healthcare varied, nearly everyone I spoke with emphasized that such passion was the reason they became involved in this field, and the reason they continued to work in it.

Origin Stories: Happy Accidents and Winding Paths

The few people I spoke with who wound up in this field for reasons other than the clear sense of purpose described above were primarily employed by more moderate (rather than progressive or radical) organizations. Some also worked in positions that dealt with reproductive health as only one part of a broader portfolio. They often described having "stumbled" into the position or "accidentally" finding their way to reproductive health, reporting professional backgrounds in other political work, clinical work, or policy work. They frequently explained, though, that at some point along their professional path, a personal interest in this topic slowly developed. In a representative passage, Christina, a Hispanic reproductive health advocate explained,

> [Women's health] wasn't necessarily the main policy area I wanted to go into right out of school or anything like that. But I saw this posting and just learned a little bit

> more about [this organization] and their approach, and I was really taken by their approach to women's health and the way they presented their issues and arguments. It was like, "That makes a lot of sense." [laughs]

Likewise, a Latina reproductive health advocate, Stephanie, reported:

> I had finished a [legislative] campaign and I was looking for a job, and I knew somebody that was like, "Oh, you should try this out." And then, I mean, I think with anything, you're sometimes—life takes you in weird directions that you're blessed to fall into, different areas where you're like, "Oh, I didn't realize I cared so much about this."

These two conversations captured the type of experience interviewees in this group reported. They did not deliberately seek out this field due to a preexisting passion for the topic, but rather fell into it and then developed a personal interest. Four others described much longer, more winding paths to these positions. Their narratives were highly specific, so to quote them risks their anonymity. Across the four, however, the same tenor was present: pleasure at their current position in the movement, but far less sense of purpose in their path toward it than people in the section above.

Origin Stories: State Government Experience

One additional aspect of my Texas-based interviewees' "origin stories" merits separate discussion here: nearly a quarter of them had been employed within the state government at some point in their careers before they transitioned into their current or most relevant positions. Their governmental experience included work at the state agencies that administer reproductive healthcare programs, in legislative offices, or in budget analysis, among other paths, and that experience seems to have inspired many to move into the advocacy space. As Erin, a white reproductive health advocate, explained,

> I really loved [my Texas state government work], but also along the way, I really started to put a lot of pieces together about how things could be done different. And when you work for a state [government], as you know, you're not really in a place

> where you can advocate for change. So, I took this position with [current employer recently], and I'm loving it.

In this case, the constraints on this interviewee's ability to advocate for change from within the system led her to look for a position outside the government, a transition she later reported finding most rewarding. She specifically pointed to her work for the state as the root of her interest in working in advocacy, connecting the two.

In addition to illuminating why some state employees shift into advocacy work, their prior professional work is important for understanding how they view, experience, and operate in their reproductive policy advocacy today. In some ways, two of which I discuss here, their prior professional experiences are clearly beneficial. First and perhaps most obviously, advocates previously employed by the state government have "insider knowledge" about how the Texas Legislature, relevant state agencies, budget offices, and related governing bodies operate. They are able to work with those state bodies more effectively than some other advocates can, because they know the state programs from a different vantage point. They are familiar with the ins and outs of how the systems work behind the scenes, and therefore can be quite precise in their advocacy. At least in some cases, they may even continue to do some work associated with their previous positions in their new roles. A white reproductive health advocate, Emily, described one way this works:

> Emily: [Current state agency staffers don't] really understand the big machine of it all. So, I do a lot of that from outside. [For a given policy priority] I kind of tee up and very clearly outline how it would get done, so…
> Anna: So, you're just doing your old job?
> Emily: Pretty much.

This quotation illuminates the fact that although some work is clearly "state side" and some is "advocate side," between the two lies some work that might be done by either side—the "teeing up." While this interviewee explained her work in this area with a wry tone and some

light frustration, she also noted that her prior experience allowed her to circumvent the difficulty she might otherwise have had working with current staffers who were not yet up to speed.

Second, advocates with recent experience within the state government have prior relationships on which they can build. In contrast to the difficulties reported by Emily above, they often enjoy higher levels of trust with current government staffers, their former colleagues, and in some cases continue to maintain close friendships with them. They therefore need to devote less time to building those relationships, and almost certainly are closer to key staffers than they otherwise could be. This is important because, in advocacy, smooth working relationships with state officials are critical to moving policy priorities forward. A Latina reproductive health advocate, Amy, reported:

> I have good relationships with some of [the agency] staff too, from my time working there, so it's like, "You know who I am, you know I'm generally not a crazy person, right? And you also understand that I understand the limitations that you're working within. And you don't have to explain things to me." So that's a good place to start.

In addition to working from a base of information about the system, as described above, this interviewee noted that state staff consider her to be a known quantity—they can vouch for her general reasonableness and her existing respect for their work and its constraints, which is a "good place to start."

While these are two ways prior state experience helps advocates, some of my interviewees with this experience also expressed ambivalence about their new role outside the system. A few suggested this employment history had the potential to hamper their advocacy work. Some who made the transition only recently spoke of still identifying with the state in some cases, including feeling some defensiveness about the programs they

worked within until just recently. Melissa, a white and Hispanic reproductive health advocate, for example, explained:

> [In my new position] you have to really be thinking from the perspective of the advocate. […] At first, I was real cautious on how I would speak, because I was basically talking about the state! [laughs] […] And all of these programs were my programs at one time [both laugh] […] so I had to make sure I could be objective enough to still talk about […] the weaknesses or the challenges of the programs. Which on one hand was good because I knew what those were. [both laugh] […] But then it was kind of interesting to hear sometimes from the advocacy side, "Yeah, they're not—those programs are not, you know, client-friendly, or they're hard to manage, or the paperwork, or the contracts," and stuff like that. Most of which I think I knew, but it was just kind of different hearing it from [this perspective].

Here, as a former state staffer, Melissa gestures toward the process of becoming acclimated to the transition from state worker to advocate.

Another recent state staffer, Amy (Latina; reproductive health advocate), described how other advocates seem to *receive* advocates newly hired from the state agency system:

> I know a lot of people were, I heard anecdotally, nervous about [a new hire] because she was coming from the state, and I was like, "Well, so am I; I don't know if that's also troubling to people." Which I also think is really interesting. […] I don't really think of it like "us versus them" in any way shape or form. It's, I think, in this world it's—because […] it's so partisan in Texas—and especially women's health is such a nonstarter for the Republican Party—and therefore we have a very conservative government and conservative state agency. But none of that is a personal thing. It's just what you're able to do or not [as an agency staffer] based on [state governmental] leadership. But I think at the end of the day, everyone that's working—no one goes to work for the state because they really just want to slash the safety net. They're all generally people who want to do good, and that's why you're in that job.

Amy expressed concern about other advocates not yet trusting recent state employees fully because they were so recently "on the other side," and suggested that the "different sides" mentality was not shared by state agency staff. From that perspective, she noted, agency and advocates seem to be on the same team—but she has realized that longtime advocates may not share this view. Although this tension seems to fade as new advocates build trust and experience in their new roles, it is a notable concern at the beginning and serves to highlight

how much advocates distrust state government in this area. It is also another important implication of the ongoing influx of former state staffers into advocacy work. While the regular infusion of fresh energy and knowledge of the state brings benefits, it may also heighten mistrust among advocates and slow the building of a firm coalition of trusted colleagues.

The people I interviewed in Texas generally work in reproductive policy advocacy or leadership roles because they care deeply about this topic. Yet despite that fact, they explained that there were a range of reasons that it is difficult to build trust at the movement or inter-movement level, including high turnover: on average, the advocates I spoke with are quite young, with many in their twenties and thirties. After that stage of career, many move on to comparatively less stressful employment. In a state with a less conservative government, personal passion may be less necessary, and turnover could be slower. In the next section, I explore these possibilities as I describe the backgrounds and histories of the people I interviewed in California—a very different state context.

The "Farmers" in California

Although similar to advocates in Texas in some ways, the people I interviewed in the reproductive policy advocacy field in California were quite clearly a different group of people. Their motivations were different, their demographic characteristics were different, and even their "origin stories," or their routes to working in this field, were different. Some of these differences are particularly meaningful for policy advocacy and, more specifically, for the ways different advocates frame long-acting reversible contraception. One's professional background, personal passion for the work, and duration of tenure in a given position all influence how effective one will be as an advocate. In Texas, the high turnover

rate among advocates lowers the average level of expertise among people in this field, but it also provides a steady influx of fresh energy from people new to their positions. Further, the many people who come to advocacy after a stint working within the state government may act as a countervailing force. This kind of experience can translate to strong relationships of trust with former colleagues who remain in state government, and necessarily includes expertise in how state programs work. This "inside knowledge" is very useful in advocacy, which often turns on one's ability to accurately predict how quickly moving events will unfold. In California, in contrast, advocates' long tenures carry great benefits—notably including long relationships of trust among advocates in the field—and lower risk of fatigue than in Texas, given the less hostile environment, and their minimal experience working within state government is less important in a more collaborative state government context.

In this section, I describe the demographic characteristics of the people I interviewed in California, present some basic information about the organizations they worked for, and discuss their paths to their position at the time of the interview (or the position on which the interview focused, if different).

The Participants

In California, like Texas, the vast majority of people I interviewed identify as women, a distribution roughly representative of the gender breakdown of the reproductive policy advocacy world more broadly. In Texas, my interviewees were primarily white, while in California roughly half the people I spoke with were white and half were people of color. I interviewed a much higher percentage of Black people in California than in Texas, and a much higher percentage of Latinx people in Texas than in California, and the average age of my interviewees in California was higher than in Texas. This latter point perhaps reflects

lower turnover in those positions, as interviewees reported that people stay in reproductive policy advocacy positions for decades.

Org. Type	Pseudonym	Age	Gender	Race/Ethnicity
All	Helen	40s	She/her pronouns	East Asian
Reproductive rights	Pamela	40s	Female	White
Reproductive justice	Audrey	30s	Pronouns: they and she	White; Latinx
Reproductive justice	Marisa	40s	Female	Chicana
Reproductive justice	Summer	30s	Female	White
Reproductive justice	Susan	60s	Woman	Black
Reproductive justice	Valerie	40s	Woman	White
Reproductive health	Casey	40s	Woman	South Asian
Reproductive health	Eva	Declined to state	Declined to state	Declined to state
Reproductive health	Linda	Declined to state	Declined to state	Declined to state
Reproductive health	Maria	50s	Female	Hispanic
Reproductive health	Samantha	40s	Female	White
Reproductive health	Samuel	70s	Male	White; Jewish
Reproductive health	Sharon	40s	Female	African American
Reproductive health	Shirley	50s	Cis leaning	Black
Reproductive health	Travis	Declined to state	Declined to state	Declined to state
Other	Natalie	40s	Female	White
Multiple	Kathleen	40s	Female	Chinese; Jewish
Multiple	Veronica	30s	Female	Latina

Nearly all my nineteen interviews in California were with people who identify as women, identify as female, and/or use she/her pronouns. One person uses they/their pronouns, and one identifies as male. The majority was in their forties; a few were in their thirties, a few in their fifties, and one each in their sixties and seventies. None were younger than thirty years of age. Roughly half the people in the sample identify as white; two

specified European Jewish heritage. Three people identified as Black or African American, four as Hispanic, Latina, Latino, or Latinx, and three as racially or ethnically Asian, Asian American, South Asian, Indian, Chinese, or Taiwanese. One person specifically identified as "mixed."[19] Two people declined to answer demographic questions. Over half the people I spoke with were in a position of leadership within their organization at the time of the interview and were also responsible for policy and advocacy work. Five people were in relevant research, policy, or combined research and policy roles; four were in other positions such as public affairs or clinical roles.

The Interview Organizations

The range of organization types represented in my California-based interview data was very similar to those in Texas: non-profits, membership organizations, medical providers, and research organizations made up the vast majority of the organizations from which I interviewed a staff member. In California, however, the organizations were roughly evenly split among these categories, while in Texas, most people I spoke with worked at community organizations or non-profits. This difference in organizational distribution may reflect my professional network in each state. In Texas, I had an existing professional network among non-profits as a former policy advocate, while as a graduate student in California I had more contacts among research organizations and medical providers.

Nearly half the organizations that employ the people I interviewed in California are categorized as "reproductive health" organizations, per their websites descriptions and their

[19] All demographic information presented in this study was elicited through open-response questions (e.g., "What is your racial and/or ethnic identity?", "How old are you?", "How do you identify for gender, or what pronouns do you use?") so as not to artificially limit interviewees' responses. Note that because racial and ethnic identities are not mutually exclusive, some interviewees fall into more than one category.

approach to organizing on the topic of reproduction. Five were reproductive justice organizations, and one was a reproductive rights organization. Four are not easily categorized under this rubric, either because they could be understood as fitting into more than one of these categories or because they are outside this type of categorization altogether. The organizations were split fairly evenly among non-profit organizations, membership organizations, research organizations, and medical providers. In addition to these categories, a scattering was in other types of organizations such as lobbying firms, funders, and coalitions. As described in more depth above, these organizations could be categorized in several other ways, any one of which would reveal different nuances among them. Unlike Texas, though, the (relative) lack of political tension around the topic of abortion means that orientation toward it is a less salient dividing feature. This difference also means that in California, organizations that advocate on the topic of LARC but not the topic of abortion were difficult to find, LARC took up less political airspace across the board (including on the organizations' websites), and there was far more collaboration across the spectrum of organizations oriented differently to abortion.

Origin Stories: More Happy Accidents than Driving Passions

In both states, people tend to do reproductive policy advocacy because they love it—in Texas, where it is very hard work, and in California, where it is relatively easier. In Texas, though, most people I spoke with told a highly personal "origin story," or path to their current position, while in California, many more reached it by way of a circuitous path. This may be because in Texas, advocacy on the topic of reproduction is difficult and politicized enough that one is unlikely to simply stumble into it. Most people who work in this field in Texas arrived in the field while consciously navigating its pitfalls. In California, by contrast,

the people I spoke with generally reported spending their entire career in advocacy—albeit often in a range of advocacy issue areas over the course of the years.

Although the "passionate origin story" was less common in California than in Texas, it still ran through several of my interviewees' life stories. In my California-based interviews, roughly half the people I spoke with originally entered reproductive policy advocacy out of a personal passion for the issue. Many people in this group traced the roots of that passion back to one of three types of experiences: their childhood or early life experiences, personal experiences with reproductive healthcare, or less personal adolescent or young adult experiences. In an example of the first theme, Audrey, a white and Latinx reproductive justice advocate, explained:

> I really grew up in a family that was very vocal around social justice issues and was very engaged and active in [a particular kind of] justice specifically. […] The women in my family have been very open about their reproductive health and their experience with reproductive life planning. And I've always known the number of times my mom has been pregnant and her number of miscarriages and her own experience with abortion, as well as my sister and my aunt. […] So just having grown up in that family, a family that was often just very in tune and aligned with social justice things, that really shaped my own interests.

This approach to social justice as something of a family affair was fairly common, and it extended to stories from outside the United States. As reproductive health advocate Eva described, her concern was not simply for reproductive healthcare. Rather,

> … it's all about equity, equality, and justice. And so, no matter what it is […] I take it very seriously if one group has access and the other doesn't, or especially lower socioeconomic groups. And it all comes from advocacy and it all comes from the political process. And it all comes from the fact that [when] I was a kid I was part of [a revolution outside the United States]. So, I did [a] revolution when I was like 17. And so, you know, I actually did it and you know, me and my family, we were really involved in it.

These types of experiences seemed to provide long-burning fuel for the care my respondents bring to their careers, and they appeared across the range of reproductive health, reproductive rights, and reproductive justice organizations in my sample.

Asked about the roots of their current careers, many people told me about a second type of personal experience that generated a passion for reproductive policy advocacy: their own reproductive life experiences. Specifically, the experience of an unplanned (though not always unwanted) pregnancy emerged in multiple interviews. Summer, a white reproductive justice advocate, eloquently explained:

> I'm from [a rural area] of California and growing up here I definitely knew that there were a lot of barriers and disparities when it came to reproductive health access, but I didn't really have the framework to be able to do anything but think about it at the time. And so, I went away to college as a young person. I was 20 when I left [my hometown] and I got pregnant at the age of 21 and I ended up having a child at 22 and then another one at 23. So, I ended up with these two children who I love dearly. They're great. Really just, I took a really different path, I think, than what I had planned. And I ended up coming home and realizing that there was so many barriers in my area to women's access to abortion and health services and contraception. I mean, it just—there were *so* many barriers.

In Summer's experience as for others in my data, unexpectedly becoming pregnant revealed common barriers to reproductive health, reproductive rights, and reproductive justice for the person in question. Unexpected pregnancy was also described to me as the raw material out of which a life and career were built. Kathleen, a mixed-race, Chinese, and Eastern European Jewish reproductive health and rights organization representative, walked me through how this process unfolded for her:

> You know, we are what we make out of what we're made of. So, I started in this movement as a patient who had an unintended pregnancy and was not ready for the pregnancy to continue. [... M]y personal experience [allowed me] to see how access to reproductive health or reproductive choices or reproductive lives really has an impact on individual families, and communities. And now as a mother I also… even more. I basically, when I had my personal experience, I was very committed to turning my experience to making sure that anyone who was in my position would be

> able to have access to the care that they wanted and needed with dignity and respect and were able to, you know, with affordability and true access in their local communities. All of that. And that has stayed with me.

For Summer and Kathleen, along with many others in my sample, personal reproductive experiences were the root of a lifelong passion for this work.

In the final theme in this category of origin story, less deeply personal but nonetheless profoundly moving young adult experiences came up frequently in response to my questions about how respondents wound up in their current position. Helen, an Asian and Taiwanese reproductive rights advocate with additional experience in the fields of reproductive health and reproductive justice, explained,

> [W]here I ended up currently, where I am currently and the pathway [by which] I got there, was initially finding a lot of interest in wanting to be an advocate on women in particular. Coming out of college I worked at a domestic violence shelter, […] and through that experience working at the shelter, observed, and in talking to some of the women there, how all the different ways that the law intersects with their lives in particular, the lives of the families I was working with, and I ended up going to law school thinking I'd be a domestic violence lawyer, and then […] kind of found my passion in that intersection between gender and race, and later on immigration. So that's kind of been the ongoing theme throughout my career.

She used the word "passion" here to emphasize that her school and early career experiences helped her find her motivating energy for doing the reproductive health and rights advocacy she continued to do at the time of the interview. Similarly, Valerie, a white reproductive justice advocate, spoke movingly about seeing the contrast between her hometown in the United States and a Scandinavian country when she studied abroad in college:

> Well, I got interested in repro work in general just from growing up in rural Pennsylvania, small town Pennsylvania maybe, and just seeing the differences in who has access to what and who has information about what and how that plays out. And then I studied in my junior year abroad in [Scandinavia] and just was really interested in how totally different all of their policies are about everything. And birth control was free the whole time, you know, even for me as a noncitizen. […] It got me more interested in pregnancy decision-making and how we support or don't support people around that.

As she mentioned here, Valerie's original interest in this field was closely tied to where she grew up, but it blossomed only when she left the United States for Scandinavia and observed the stark contrast in reproductive health accessibility between the two.

In contrast to the three types of highly personal sources of passion for this work in the data described above, roughly half the people I interviewed in California reported a more circuitous or incidental path toward their current work. Frequently, that path led them through a variety of other political or advocacy positions—always on the political left—before arriving in this field and in their current (or most relevant) positions. Although they described great care for their work and energy around their organizations' political aims, they emphasized the relevance of their state surroundings less, and differently, than advocates in Texas did. These quotations are more difficult to include parsimoniously, in part because they are by nature winding stories, and in part because they are often highly specific and therefore could jeopardize respondents' anonymity. As a general rule, however, they often presented a path toward their current position that one Chicana reproductive justice leader described succinctly: "I kind of fell into what I'm doing a little bit in some ways" (Marisa). In a story representative in its several stages, if not in its brevity, one white reproductive health advocate reported:

> I have a master's in social work, and I worked previously in community-based settings doing direct care with clients. I always worked primarily with women and children involved in the child welfare system. And I was laid off from a community-based job that I was doing [be]cause it was grant-funded, and found a job at an organization that was more closely related to women's healthcare issues. And then from there I moved into my current position. (Samantha)

In these origin stories, interviewees emphasized both that they cared deeply about their work (as one stated, "Healthcare is my passion" [Maria; Hispanic; reproductive health advocate])

and that they did not deliberately seek a career in reproductive policy advocacy. This viewpoint was far less common among my Texas-based interviewees, who were more likely to report a guiding passion for reproductive healthcare or a targeted interest in finding a job in this area.

Origin Stories: Career Longevity

Most people I interviewed in California had been in the progressive policy, research, and advocacy space for most or all of their professional careers. Although they reported moving among issue areas (e.g., from LGBTQ+ advocacy to immigration justice advocacy to reproductive healthcare advocacy) over the course of their careers, they only rarely reported any experience working within the state government or in other industries. As Pamela (white; reproductive rights advocate) captured, moreover, once in the reproductive policy advocacy field, people tend to stay in these positions for a long time:

> I think one of the things that is also important to note about California is that for a very, very long time it was the same people. So, I was [in a relevant role for more than a decade] and when I started, there were already giants in the field who [have] only have retired in the last two to five years […] For the most part, you have had a lot of steadfast consistency amongst the people who are doing this work.

As a result of this career longevity, advocates have years or even decades to build trust with one another. This point is important when tensions arise within reproductive health, reproductive rights, and reproductive justice movements, as it means there are relationships, trust, and assumption of good faith to fall back upon—and, critically, to build upon. Pamela went on: "And when you know people that well, whether you always agree with them or you disagree with them, you like them or you don't like them, it makes things so much easier when everything is relationship-based." These relationships are a notable contrast to their

parallels in Texas, which are typically much shorter due to the relatively brief tenure people spend in each position.

Conclusion

In both Texas and California, the "farmers" in the reproductive health, reproductive rights, and reproductive justice fields were excited about and invested in their professional responsibilities and the priorities of the organizations for which they worked. In our conversations, participants often reported arriving at their current positions through a personal connection to progressive causes, rather than through a simple need to earn a living or fill their days. Relatively few framed their professional journey as entirely disconnected from their personal and political beliefs. Rather, in interview after interview in both states, I heard how a deep connection to progressive organizing—often though not exclusively to reproductive policy work—played some role in the path advocates took to their current job. This point held regardless of how meandering or seemingly aimless that path might have been. Many participants also reflected at length and movingly on the roots of their careers in their personal reproductive life experiences, or in their upbringings in their families of origin.

With this background information, one might envision that advocates arguing for increased access to reproductive healthcare broadly, or long-acting reversible contraception specifically, might draw only on values-based reasoning to gain legislators' support. They might argue, for instance, that every individual person deserves access to reproductive healthcare, including long-acting reversible contraception, or that health care more broadly is a human right. Indeed, in interviews many advocates did describe these approaches as closest to their hearts, and as their preferred advocacy arguments in an ideal world. The tactics they report using when push comes to shove, however, are not freely chosen in such an ideal

world, and the decision-making process advocates undertake to arrive at those tactics is complicated and often tense. In the next chapter, I turn to a consideration of the advocacy decisions that advocates make, on the ground and in their respective capitol buildings.

Chapter Three: "When […] the Ground Is Ready for Plowing"[20]

> *LARC is really interesting right now because it seems like a lot of people are interested in it. Which is, I mean, I don't kn- it's like, contraception is contraception—but if you say LARC, it's like people get more excited about it. Which is—sure, we'll tap into that excitement.*
>
> ~Amy, Latina, Texas reproductive health advocate

In this chapter, I consider how, precisely, advocates make the case to legislators for increased state investment in long-acting reversible contraception. What "crops" do they "plant" as they choose which arguments to use? What are the similarities and differences between Texas and California? First addressing Texas and then California, I briefly describe the kind of work my interviewees do in their day-to-day professional lives, with particular attention to their advocacy work. Drawing from interviews and website data, for each state I next describe the kinds of rhetorical arguments used to make the case for increased access to long-acting reversible contraception at the state legislature. I argue that while a range of arguments for increased access to LARC are deployed in each state, the cost-savings argument is notable in both these campaigns to increase state support for LARC. I also show that despite the stark political differences between California and Texas, there is more variation of approach in the reproductive justice, reproductive rights, and reproductive health advocacy ecology *within* Texas and *within* California than *between* Texas and California.[21]

Texas Advocacy: The "Bread and Butter" Work

[20] (Wright 1941:38)

[21] I draw more from my interviews with reproductive health and reproductive rights advocates in this chapter than from those with reproductive justice advocates. This difference in part reflects the fact that reproductive health and reproductive rights advocates reported substantially more advocacy for increased access to LARC. It was a comparatively large part of their advocacy portfolios, and they had comparatively more to say about it than did reproductive justice advocates.

The Texas Legislature meets in the center of Austin, in an Italian Renaissance Revival building modeled on the United States Capitol and dating to the late nineteenth century. Its outside walls are covered in a light red granite which, along with the building's distinctive roofline, leads to one of its semi-affectionate nicknames: the "Pink Dome." Most state legislative work unfolds in this building or in a connected underground labyrinth of newer legislative offices ("the extension"). During the legislative session—when legislators are in Austin, rather than their district offices—much of the in-person advocacy described in my interviews takes place in one of these two locations.[22] This work falls into two main categories: meetings or communication with legislative offices and testifying in front of legislative committees. Both types of work are carried out both by those with a specific policy or advocacy title and by people in leadership positions.[23]

Meeting with legislators or their staff, the first type of advocacy work frequently described in interviews, means a trip to the Capitol building—in Texas advocacy parlance, "downtown." One white reproductive rights advocate, David, gave an overview of his daily activities:

> I do what most people think of as traditional "lobbying work" at the Texas Legislature. […] That involves, you know, talking and educating the lawmakers and their staff, but also reading the proposed bills and policy and that sort of stuff and providing our organizational input.

[22] This section describes advocacy as experienced by my interviewees before COVID-19; at the time of data collection, there had not yet been a legislative session during the pandemic.
[23] In addition to interviewing lobbyists and organization leaders who conduct some lobbying, I also spoke with a wide range of other types of staff at organizations that take a position on LARC policy (described further in Chapter 2). These include medical providers or staff at provider offices, pharmaceutical company representatives, and state agency staff. Their daily work is less relevant to this chapter than advocates' and leaders' work, but I draw on it elsewhere in the project to sketch the backdrop against which other data are best understood.

David focused here on meeting with legislators and aides, as well as providing feedback on policy. These themes came up often as part of the core work done by advocates, both with "friendly" legislators (who might seek an advocate's opinion on a proposed bill) and with neutral or hostile legislators (who might need the education and direct advocacy more critically).

Each of these aspects requires that advocates have organizational legislative priorities and concerns (their "legislative agenda") developed before session begins, including folders of educational materials and the agenda itself to distribute in legislative meetings. During session, advocates must be prepared to pivot in response to changing conditions and to coordinate with legislative offices as needed. Asked about her daily activities during session, a Hispanic reproductive health advocate, Christina, described:

> Bill tracking, meeting with different offices. We've already developed our legislative agenda [by the time session begins]. We're talking strategy and stuff like that […]. So, it'll be a lot of that, a lot of monitoring progress of different bills. Seeing what [legislative members'] offices have interest in, seeing if they need any help or research assistance or things like that, talking points, monitoring what happens at the state [agency]. Just hearing different things that come up and then seeing their validity or to the extent of how it's actually going to impact providers.

This interviewee drew out the responsive element of advocacy, focusing on the need to monitor and respond to what happens during session, and on the relational component—supporting "friendly" legislative offices with their developing needs relating to reproductive health policy. Expanding on this kind of support and other interactive work, April, a reproductive health advocate, reflected on a previous advocacy position:

> [My work] was meeting with stakeholders. It was making sure that our organization's thoughts, opinions, viewpoints, stances were out there. And then also just getting to meet with other organizations, with people at the Capitol, with people in the [state health] agency to be a resource to help answer questions, to connect them to experts.

She also elaborated on an important aspect of advocacy work mentioned above: connecting legislators and state agency staffers to experts who can provide critical information about how potential policy might unfold on the ground. Those experts might include medical providers, academic researchers, or individual constituents with experiences that illustrate why a particular bill is necessary, and they are an important resource advocates can offer to legislators.

Yet of course, resources and information flow in both directions in these relationships. The reproductive health advocate quoted above, Christina, described that back-and-forth in meetings with legislators or their staff:

> We'll go to the office, and then meet with whoever we decided with and then, either go through a particular issue or—lately it's been a lot of our legislative agenda and just our priorities and things that we're going to be looking out for, stuff we've heard from the state [agencies] […] Either we're bringing information to them—most of the time it's that we're bringing information to them. Hopefully during session they'll share stuff with us too, and see where we might be able to help, if it's working out some language in a bill or a rider or doing some research or whatever to support talking points or things like that.

In other words, not only are advocates a font of information for legislators, but legislators also share information with advocates—information that might not otherwise be available to them. Later in the interview, Christina elaborated on another place that exchange of information happens: helping legislators strategize before committee hearings.

> When things start moving at the Capitol [as session gets underway], we can see if we can maybe develop questions for legislators to raise during hearings or on the floor. […] If there are hearings going on that are relevant, […] we'll just sit in on those and if we're testifying with it, drop a card or deliver testimony and then just monitor and watch and see what questions get raised, what different points advocates bring up, if there's unexpected opposition or unexpected support—just sit and wait and take notes through all of those too.

Christina here also described a second important part of advocates' in-person work: testifying in front of legislative committees. In contrast to communicating or meeting with individual legislative offices, which can be formal or informal, hearing testimony is always formal and highly ritualized. The legislative committee sits at a dais at the front of a hearing room in the Capitol building, and the audience—primarily people who plan to testify—sits in rows facing them. As Christina explained, advocates and others who intend to testify on the topic the committee is discussing must do so formally, either by signing up to deliver full spoken testimony at the microphone, or by "dropping a card" (literally, filling out a form on cardstock indicating the organization or person they represent and their opinion on the issue being discussed). When the committee opens the floor for testimony, people who have signed up to speak are called by name to deliver their remarks. The written comments of those who have dropped a card are recorded separately. Similar to meetings with staffers, testimony is not easily delivered without in-person attendance.[24]

There is no doubt that in-person advocacy during session is the "bread and butter" of advocacy (as pointed out by Sara, a Latina reproductive justice advocate)—most of my conversations with advocates about their daily work focused on this type of work. Direct advocacy during session cannot happen, however, without a great deal of preparatory work before session begins. One reproductive health advocate with decades of experience, Rob (Caucasian), explained one reason such preparatory work is necessary:

> [O]nce the session starts, it is exceedingly difficult generally to get [legislators'] attention, because they're juggling so many balls, whether it's committee hearings or hearings on their bills or time on the floor or constituents coming to see them or receptions that they have to speak at. Their time is very limited in terms of bandwidth. So, a lot of times [during session] it's just working with [legislative] staff, you know, providing the policy workup that you've spent the interim working on,

[24] See note 7.

> meeting with stakeholders on issues that may be of concern to them and trying to work through those.

In addition to "going to hearings and talking to legislators and advocating for policy and getting very involved" (Sara; Latina; reproductive justice advocate), the people I interviewed described a great deal of additional background work to be done during the time between sessions (the "interim"), as well as specific legwork necessary before any particular meeting or testimony—that is to say, any direct advocacy—can take place.

Leslie (African American; reproductive justice advocate) described what that interim work looks like for her: "providing education to our communities, through educating our staff that actually go out door to door and have conversations and engage with folk on the ground, and education that informs our legislative partners." Likewise, Sara, a Latina reproductive justice advocate, expanded on the specific effect of advocacy in Texas:

> In Texas we have to get a little more creative than [advocates elsewhere]. So that means getting involved in grassroots advocacy, and talking with the directly impacted communities. [… I]t also looks like living in the RGV [Rio Grande Valley], because I do live in Austin *and* the Rio Grande Valley, and talking to the communities that have been directly impacted, talking about what reproductive health issues that they have, and trying to advocate for those advances to happen at the local level.

These and other preparatory activities are as time-consuming as they are critical, and they must be slotted into the months between legislative sessions.

Luckily, the legislative session in Texas lasts only a short span of months every two years, leaving plenty of interim time to lay that groundwork. Asked about what it looks like to do advocacy at the legislature, Rob explained the structural context and the type of interim activities that must be completed before session begins:

> [I]t's all about the setup, right? The work doesn't really occur during the 140 days the Legislature's in session. It generally occurs before that, in terms of doing your policy workup, in terms of getting out and identifying supporters, meeting with opposition, identifying and educating legislators back in their home communities. Texas is a little

> different in the fact that we only meet 140 days every two years, whereas some states like California are […] full-time legislators. So, there's some benefit to that: a part-time legislator has to go home, live in the community, generally has a job, generally has a physician, and [we're busy] utilizing that time when they're away from the Capitol to develop the relationships and provide information to them on things that are important.

In addition to explaining the significance of the legislative calendar for who legislators are, he emphasized that the session is only the finale in a much longer production. A white reproductive rights advocate, David, also explained how the ratio of session to interim time influences his work:

> [A] lot of the work I do is also very process-heavy because of the nature of how the Texas Legislature works, because it meets [for] six months every two years. And so there's more than knowing what's a good idea and what's a bad idea, […] my role is really a procedural one, knowing how to either stop bad things from happening or trying to get good stuff to happen.

As David described here, the short legislative session in Texas affects not only the timeline on which advocacy unfolds but also the work itself. In addition to content expertise, he needs a commanding grasp of how the legislating process works and how and where to exert influence. This knowledge is particularly important because of the condensed legislative calendar—a longer timeline would give advocates more "wiggle room" to err and adjust, while this shorter timeframe requires a fine-tuned sense of legislative procedure.

Texas Advocacy: Arguments for LARC "Under That Damn Pink Dome"

> Anna: What's the argument for access to contraception, for long-acting contraception in Texas?
>
> Lisa: […] It's cost effective, preventing unplanned pregnancy's a good thing, we save money to the Medicaid program with reduced unplanned births and reduced complications, reduced preterm labor or blah, blah blah. So, there are the *cost arguments*. Then […] there are the *outcome arguments*: […] contraception allows you to plan for your pregnancy and then it's a healthier pregnancy, a healthier kid. (Hispanic; Texas reproductive rights advocate; emphasis added)

Advocacy is, by definition, a balancing act. To be successful, advocates must hold the tension between their need to get things done and their sense of what is right and ethical. This tension results in a series of choice points, one set of which is deciding which arguments to use when advocating for a particular policy priority. In this section, I explore the range of arguments advocates commonly deploy when advocating on the topic of long-acting reversible contraception in Texas. Although there are many arguments mentioned only once or twice in my interviews or on organizational websites, three arguments—each mentioned in the widely representative quote at the beginning of this section—rise above the rest as far more common. Advocates argue that (1) LARC is an incredibly effective means by which to prevent unintended pregnancy; (2) because it is so effective at preventing pregnancy, LARC saves the state money by lowering the birth rate; and (3) because it is so effective at preventing pregnancy, LARC saves lives by reducing maternal and infant mortality.[25] On its face, LARC appears to be a silver bullet with the capacity to address three corresponding "social problems": unintended pregnancy, state budget deficits, and maternal and infant mortality, respectively. In this chapter, I present and analyze the complexities of the three arguments.

Pregnancy Prevention

The most general argument that advocates reported making to increase state support for LARC access is that IUDs and implants are extremely effective at preventing pregnancy.

[25] I focus here on the arguments that came up in the data more than once or twice. One additional way of making a case for increased access to LARC came up a few times but is not, strictly speaking, an argument: explaining the basic science behind how it works to skeptical legislators. For legislators who did not previously understand how LARC works (and may have assumed it was, for instance, an abortifacient), this approach was reported to be persuasive.

This argument is foundational to the other two, and rests on the implication that preventing pregnancy is a central goal for legislators and for individual women. It appeared in my data in a few forms. First, some respondents very simply explained that the best argument for increasing state investment in long-acting reversible contraceptive methods was that these methods are very efficacious (that is, highly effective at preventing pregnancy). In an exchange with Amy, a Latina reproductive health advocate, I asked, "What's the easiest pitch for LARC if you're trying to explain it to agencies or legislators or other partners? How do you argue for LARC or for LARC access?" She responded:

> I mean, I think we can point to a lot of, all of the data showing that it's the most effective form of contraception. […] I think that's the biggest sell, is like, if we're really serious about preventing unintended pregnancies, or giving women the ability to decide if and when they get pregnant, then we want to be able to make the most effective forms accessible.

Here, she emphasized that because LARC is the most effective form of contraception—implicitly, the most effective *at preventing pregnancy*—it must be part of the state's solution to "preventing unintended pregnancies." This presentation is the "biggest sell" for state representatives, suggesting that the sheer capacity for LARC to prevent pregnancy so successfully makes it attractive to legislators and other stakeholders.

Recent advances in IUD technologies mean that its efficacy is often framed as hyper-modern and cutting-edge, and thus desirable. Michelle, a white reproductive rights and reproductive health advocate, for example, explained:

> LARC [methods] are effective and long-lasting. So just stating the facts of, the fact that like, "Look at these kind of miraculous devices that that can last for seven years and that they're really, really effective. Like whoa, look at these percentages [of pregnancies prevented]." So, I think there's a certain element of just like, "Look at this miracle of modern medicine and what it can do!"

Michelle, in this quotation, also directed attention to how effectively (and for how long) long-acting reversible contraceptive methods prevent pregnancy, highlighting their "modern" and "miraculous" nature. She also began to gesture toward the next way interviewees communicated efficacy in pregnancy prevention as a central argument for LARC: "these percentages." This phrase references the particularly low percentage of people using LARC who will become pregnant during that use. Several interviewees emphasized this rate. This description by Jeff, a white medical provider and reproductive health advocate, was common: "We've got an IUD that's whatever it is, 97.5 percent or something effective, and an implant that's 99 percent effective. You've got tremendous efficacy with those two products." Throughout the course of their interviews, several people explained that LARC is more effective at preventing pregnancy than is tubal ligation. Alongside highlighting just how well LARC prevents pregnancy, this approach gestures toward another theme in this category: comparing LARC to other contraceptives.

The comparison between LARC and other contraceptives often rhetorically emphasizes how well LARC prevents pregnancy (as in the quote above), in part by emphasizing its low rate of user error and low ongoing logistical demands on users. User error, or how often contraceptors "make mistakes" that lead to pregnancy, is an oft-discussed aspect of a given method among people who work in the field. That LARC has almost no user error was frequently described in interviews and in website data as a key benefit. For example, Rob, a white reproductive health advocate, said,

> The results [of LARC] compared to other contraceptives clearly stand apart—and you're not relying on somebody to remember to take a pill or having another issue arise that could result in an unplanned pregnancy.

In this description, the person contracepting is implicitly unreliable, though not necessarily at fault, and LARC is a solution to the unplanned pregnancy risk such unreliability generates. Other interviews filled in the details of that picture, explaining how in comparison to methods with more user action required for continued work, LARC is an improvement. Amy elaborated on this point when I asked why people seemed excited about LARC.

> Because it's more effective, right? You can almost make a better argument, like, "Look at this, it's like, you don't have to keep coming back [to the doctor's office] or like [compared to] a pill, you don't have to remember to take it properly. It's just an insertion and then it should work." And so out of sight, out of mind.

Here, the specific benefits Amy highlighted are the facts that LARC works without visits to the doctor's office and without any need for the user to remember to take daily action. Often described as "set it and forget it," this view of LARC's benefits is common among physicians and some patients. Yet it is a drawback for some patients, disproportionately low-income people and people of color. For many, the fact that these methods are "opt-out" rather than "opt-in" once inserted represents a significant concern (Gomez et al. 2018; Jackson et al. 2016).

Jeff, the medical provider and reproductive health advocate quote above, highlighted the fact that doctors and patients are not the most difficult audience to convince of LARC's benefit. In this, he exemplified another theme within the data about LARC's efficacy: its connection to the argument that it is worth the money the state invests in it. In this interview and in others, interviewees made clear that the high rates at which LARC prevents pregnancy were key to convincing legislators to invest in it financially. The exchange below captures how the two are intertwined:

> Jeff: I don't think [LARC] was that hard of a sell for doctors and patients. The legislators are paying for a lot of it, so they had to be convinced a little bit differently.

> Anna: And how do they have to be convinced?
>
> Jeff: Well, there are lots of people wanting the money that they're handing out, so I think we had to, not convince [them], but… show the data, that this really did prevent pregnancy. It's a very effective way to do it.

Here, Jeff emphasized that as a rhetorical strategy, the efficacy with which LARC prevents pregnancy is intimately connected to its ability to save the state money. In other words, legislators might be less likely to fund LARC provision without understanding how well it prevents pregnancy. In this, the advocacy argument that LARC is exceptionally effective at preventing pregnancy connects to the second major type of argument advocates report using: LARC's potential to save the state money.

Cost Savings: "Unborn Baby Money"

> [T]hat was how the Legislature would justify other [expenditures:] *unborn baby money*. It's just… that math, it's just weird. […] They'd be like, "Well, we saved this much and so we'll just reinvest it in this [other expenditure]," which is mathematically probably accurate-ish. It's just a weird approach.
>
> ~Michelle; white; Texas reproductive health and reproductive rights advocate; emphasis added

The argument that LARC prevents pregnancy extremely effectively is the foundation on which rests a second argument: investing in long-acting reversible methods is a responsible fiscal investment for the state government. At its most basic level, this argument explains that for each dollar invested in providing LARC to low-income residents of Texas, the state will see a "return on investment" (Jennifer; Hispanic; reproductive health advocate) of several dollars. That return on investment is understood to come through "averting Medicaid births" (Emily; white; reproductive health advocate), meaning that the state will avoid paying for low-income people's reproduction and children. Most typically, the total amount "saved" includes costs associated with the pregnancy, labor and delivery, and first

year of the baby's life, and equals between seven and thirteen dollars returned to the state per dollar invested in LARC. This financial approach was commonly described in my interviews and in website data as some variation of "literally investing in the future" (Christina; Hispanic; reproductive health advocate). The saved money was seen as particularly important in advocating for increased access to LARC (compared to other kinds of contraception) because the contraceptive devices themselves have a high price tag compared to other methods. However, because they are particularly long-lasting and effective at preventing pregnancy, they are more likely to prevent an unplanned pregnancy than are other methods. Therefore, the argument goes, legislators need to understand the financial benefit of investing in the devices to increase the chance that they will do so.

The cost-savings argument for increasing access to long-acting reversible contraception, at the most basic level, explains how many dollars the state budget office will note as being saved for each dollar spent on this kind of contraceptive device. Nicole, a white reproductive rights advocate, walked me through the math in this way:

> LARC, to my knowledge, […] has a higher upfront cost than say birth control pills, patches, rings, condoms, nothing—that can be a thousand dollars even, and […] a thousand dollars up front is a lot for a public health program that could be paying fifteen bucks a month for pills instead. But they last for three years or five years or ten years—so the cost, if a woman is happy with her method and it's working and she leaves it that long—the cost to prevent a pregnancy is much lower per month […] It's also so much more effective, so the chance of somebody accidentally getting pregnant while using LARC is so much less.

As described in more detail above, the efficacy with which LARC prevents pregnancy is a pivotal part of the argument, but so is the duration of use, as seen here. Shannon, a white reproductive health advocate, expanded further on this point, elaborating on precisely how the dollars saved are calculated:

> LARC has a huge upfront cost. On average the devices [cost] about a thousand dollars apiece. So, you really have to have good, strong evidence—and there's a lot of great evidence—on the cost savings from LARC. […] We have really good data on how much the average cost of a birth is, how much the [state pays for] every Medicaid-paid birth. The newborn gets twelve months of coverage in Medicaid under federal law. So, we have really good data on, okay, this is how much we pay for birth. And this is how much our average newborn costs are, […] birth, fertility rates, medical costs. […] We can have some assumptions around how increased access to LARC and increased utilization of LARC is going to offset costs for unplanned pregnancies basically, and reduce the number of unintended pregnancies and unplanned births. That will be a cost savings down the line.

As described here, the "dollars saved" are understood to include not only the delivery process itself, but the first year of the newborn's life. Critically, the babies in question are explicitly described as Medicaid-eligible, making visible the fact that the publicly funded programs these participants are describing only cover the lowest-income Texans. Notably, this eligibility influences the savings the state calculates.

Julia, a white reproductive health advocate of Hispanic origin, elaborated on this point, directly describing the possible costs of a low-income state resident's unintended pregnancy. She spoke with the knowledge of somebody intimately familiar with how a medical provider's office works, but used the pronoun "we" to indicate her identification with the state in this instance:

> Either we're going to pay on the front end or the back end. It [a pregnancy] costs about, what, $16,000. And then that kid could be in Medicaid for the next 18 years. That mother may need another public room in public housing. She had maybe a two bedroom. She's going to need a three bedroom. You know, it's going to cost the state big, big money on top of the fact that all the preventative work that we do—the hematic grids, the checking your urines and checking for cancer—it's preventing them from getting pregnant and having a million-dollar baby […]: those that are very, very sick.

As Julia explained, common calculations of the cost savings of LARC include not only the direct medical costs of labor and delivery for an unintended pregnancy, or even the first year of medical care for the baby. Rather, those cost savings are often assumed (if not

mathematically calculated) to include the associated cost to the state of having an additional person using publicly funded state programs for low-income residents, from Medicaid to public housing. She further elaborated that unintended pregnancies can be particularly medically complex and therefore particularly expensive, rendering those infants "million-dollar babies."

Shannon, a white reproductive health advocate, added more detail to this picture. She described the associated state and federal programs and systems that are framed as being strained by low-income people's unintended pregnancies:

> If women are, and families are, able to plan when they want to have children, whether they want to have children, that's going to reduce the strain on all different aspects of the public system: the school system, food, WIC [The Special Supplemental Nutrition Program for Women, Infants, and Children], TANF [Temporary Assistance for Needy Families], all of those things. If someone said, if someone really wanted to have two kids and now they have five, because they didn't have access to contraception or other services, then that means that they're needing some additional assistance to be able to take care of those children. And it's not because they were irresponsible and they just—it was because we didn't do a good enough job of giving them the tools that they needed to plan their families.

She emphasized that low-income people are not to be blamed for unintended pregnancies that result from a lack of access to effective contraception; rather, the state has a responsibility to provide them with "the tools that they needed to plan their families." While she did name the school system, which is utilized by all residents of the state, most of the systems she named are designed solely for use by low-income people.

Melissa, a white and Hispanic reproductive health advocate and former state staffer, delved more deeply into how precisely these costs add up, and whose unplanned pregnancies in particular are targeted for prevention.

> The cost of LARCs can be offset by the prevention of unplanned pregnancies. So, in Texas about thirty something percent of pregnancies are unplanned, […] but […] seventy percent of Medicaid births are unplanned. […] So, if you think that you can

> get LARCs out there and prevent the unplanned pregnancies, then you look at the state's cost for the first year [of the infant's life], the way HHSC [the Texas Health and Human Services Commission] captures that cost, it's the delivery and the first year of care for the infant. And that's about $13,000. […] So, if you think of the number of unplanned births that you're preventing, then it can be a cost savings to the state.

Here, Melissa explicitly noted that a much higher percentage of publicly funded births than privately funded births are unplanned, specifying that this is the unplanned pregnancy rate the state is seeking to reduce. She went on:

> […] And that's not including that when you look at [the] data, unplanned pregnancies have a higher incidence of less prenatal care, more women smoke if they have an unplanned pregnancy, more women have medical issues because they weren't planning on the pregnancy so they weren't taking [on] some of those healthy behaviors that some women do when they know they're planning to get pregnant, they'll stop drinking, they'll stop smoking, they'll lose weight, start exercising, taking vitamins, etcetera. So, on the unplanned [pregnancy], you lose all that protective stuff. And so there's more incidence in unplanned pregnancies of [strained, worried tone] lots of things like, you know, child protective involvement, juvenile justice, things like that. So those costs are not even in that $13,000. That's only the medical cost of delivery and the first year of the child's—of the infant's care.

While noting the costs included in the $13,000 the state anticipates spending on each unintended pregnancy by a low-income woman, she expanded beyond that to describe what is *not* included in that figure. She explained the health risks associated with unintended pregnancies, tracing a line between those risks and the possible later involvement of the child in the child protective system and the juvenile justice system—also very costly systems for the state to maintain.

Implicit in this framing is the understanding that state funds are limited and that state legislators are reluctant to cover low-income people's care or structural support. This approach characterizes much of the neoliberal era, and it is particularly associated with conservative governing ideologies. Yet it is not limited to Republicans. When asked about the most effective arguments for increasing access to LARC for low-income Texans, many

advocates emphasized the broader fiscally conservative environment in Texas. For example, Amy, a Latina reproductive health advocate, explained:

> Texas is very fiscally conservative and so it's really hard to get money allocated to anything. […] People really scrutinize where those dollars are going, so any way you can show, "Well, if you invest here, you're actually saving money in the long run," it's kind of a better selling point.

Shannon, a white reproductive health advocate, echoed this general point before connecting it to reproductive healthcare more specifically:

> A bill that has a cost savings is way more likely to move [through the legislative process] than one that has a cost. So anytime you want to get any policy [passed], you have to look at the cost. […] You have this thing you want to do because it's the right thing to do, right? And then you have to sell it to the decision makers who probably have a different opinion of what might be the right thing to do, or maybe you have the same end goals, but very different reasons for getting there. Right? […] Someone who has no interest in reproductive healthcare probably would be swayed more of just a fiscal thing.

As these two quotations illustrate, advocates reported that in Texas' legislative environment, policies that save money are much more likely to gain traction than those that cost money. While legislative bodies are of course responsible for spending taxpayers' money carefully, the quotation from Shannon above begins to point to one of the possible outcomes of this advocacy approach: working alongside and in collaboration with powerful people who have similar goals to advocates, but different motivations.

Heather, a Caucasian reproductive rights advocate, expanded on this point when I asked what she had experienced or been taught regarding the most successful arguments for increasing access to LARC. She responded:

> Yeah, so, there's some odd bedfellows that definitely form around reproductive health access and LARC access. So, on one hand you have a lot of advocates who, I think, are operating from this sort of human rights framework where they think that access to reproductive healthcare is a fundamental human right that they support, and they want everyone to have access to that and remove the barriers to it and—end of

> story. On the other hand, you have some stakeholders who are—*very* interested in cost savings.

To this point in her answer, she seemed to be simply repeating the point Shannon and several other interviewees made above. However, immediately following this, Heather went on to explain where her areas of concern lie in this approach. I quote it at length here because of how neatly it captures the concerns I heard others express as well.

> [A]s a general rule we know that preventing unintended births saves the state money, because they're not funding those births through Medicaid, they're not funding some of the outcomes of those births, and [sigh]—you know, to some degree there's some racial undertones, as well. I think among some stakeholders there's a sense of who we want to be having babies and who we don't want to be having babies. And that can get—pretty troubling. […] And also, you know, citizenship, because we do have birthright citizenship, I think that for some policymakers, preventing undocumented women from having babies is a driver. It's something that you hear interest in, so—from an advocacy perspective it's different because the reasons why you're doing it, these like fundamental human rights reasons of reproductive healthcare access, may not line up with the reasons why some of the policymakers agree to it. […] So, there's a real disconnect there, to some degree. A lot of advocacy work involves making *deals with the devil*. (emphasis added)

Although this quotation begins with the more general point others make above, Heather moved quickly to identifying one key problem with this approach: the population whose unintended pregnancies are understood to be undesirable and targets for elimination is neither race-neutral nor income-neutral.

In fact, alongside the explicit desire to reduce poor people's unintended pregnancy rates described above, Heather identified both "racial undertones" in the assessment of "who we want to be having babies and who we don't want to be having babies" and particularly drew out the fact that birthright citizenship leads some government representatives (here coded as "stakeholders") to seek to prevent (not simply unintended) pregnancies among undocumented people. Emily, a white reproductive health advocate, reported a similar concern:

> The focus has really been on Medicaid women, and I have concerns around that, because I don't want this to be population control, I don't want this to be about less poor brown babies, and I think for many of us working on this that is *not* the aim, but I think that there can be, the optics can… not be great sometimes. And when you talk about some of this stuff in a cost savings term, we have to think about *how* we're saving those costs, and it's essentially through averted births, and if you're only doing this in Medicaid, it can be problematic.

These instances were far from the only times advocates raised this point in the course of describing the cost-savings argument. Rather, descriptions of the tension inherent in "making deals with the devil" frequently followed close on the heels of a more basic overview of the cost-savings argument, and many advocates quite explicitly identified the racist and classist assumptions and, in some cases, motivations of state legislators and other "stakeholders."

Underlying the cost-savings argument is the question of how well it works. After all, compromising one's values to gain buy-in from state legislators may be unpalatable, but perhaps even more difficult would be compromising one's values and *failing* to gain buy-in. Many advocates explained that in their experience, the cost-savings argument works exceptionally well. As white reproductive health advocate Erin reported, "I think anytime you can demonstrate to the Legislature that there is cost savings—and you do that by your 'projected births averted' data—they listen." Likewise, when I asked Jennifer, a Hispanic reproductive health advocate, about the most effective arguments, she replied, "the return on investment."

> Jennifer: And also arguing [that] for every unplanned pregnancy or every birth… and the kid's on Medicaid, you're going to spend a lot of money so like, look at it as spending a few hundred dollars on a LARC up front versus several thousand on like continuous care once the child is born.
>
> Anna: Mhm. So that's, like, a persuasive argument for legislators?
>
> Jennifer: I think making any sort of return on investment, economic impact argument is typically the best.

In both of these instances, my respondents argued for the most common perspective in my data: that the cost-savings argument works. The implication, both in my question and in their answers, was that this argument works specifically to secure funding to increase access to LARC in publicly funded reproductive healthcare programs in Texas.

Not every advocate I spoke with, however, agreed with this point. Asked about the cost-savings argument, for instance, Scott (a white reproductive rights advocate) replied:

> It's an argument that's deployed in the Capitol with lawmakers that need a reason to do the right thing, and it seems like a very safe position for the opinion leaders to stake out. It certainly doesn't—I don't—I haven't ever seen anybody be like, "What? We save money? Then I'm going to completely rethink my position on it," even at a policymaker level. I think it's a safe argument to make, it's a safe argument to say out loud, if you don't want to talk about the—if you want to sidestep the values debate.

While this view was less frequent in my data, it did come up periodically. As Scott explained here, the possibility that the cost-savings argument works more by giving cover, by being a "safer" argument than others, or by allowing listeners to "sidestep the values debate" than by convincing a given legislator was raised by a few advocates. The potential for the cost-savings argument to change hearts and minds, in other words, did not go unquestioned.

Improved Health Outcomes

The third key argument that legislative advocates in Texas reported drawing on to advocate for increased access to LARC is that these methods will improve maternal health and infant health, reducing maternal mortality and in some cases saving infants' lives. Building on the argument that LARC is exceptionally effective at preventing unintended pregnancy, as discussed above, this approach discursively constructs unplanned or unintended pregnancies as dangerous and potentially fatal to pregnant people (who might

suffer adverse health effects of the pregnancy or die as a result of it) and babies (who are more likely to experience a range of negative effects if they result from an unintended pregnancy). In this section, I first discuss the central argument—that unplanned pregnancies are dangerous, but LARC can help—before presenting the two points underlying it: that LARC allows patients to get healthy before getting pregnant, and that LARC allows patients to space their pregnancies over a longer period of time, with longer inter-pregnancy periods. Finally, I discuss the logical gaps in this framing, with particular attention to the fact that while seemingly race- and class-neutral, in fact it is implicitly deeply raced and classed.

The argument that long-acting reversible contraceptives are life-saving technologies rests on the idea that unintended pregnancies are dangerous to the health of patients (presumed to be cisgender women) and their babies. Specifically, the argument suggests that unintended pregnancies are much more likely to injure or kill women and produce sickly babies or even result in infants' death, and that LARC is a means by which to prevent these events. These arguments implicitly or explicitly respond to the fact that Texas has exceptionally high rates of maternal mortality and morbidity (defined as the rate at which women die by pregnancy-related complications, during labor and delivery, or in the weeks following the birth)—rates that are particularly high among Black women (MacDorman et al. 2018). It is true that LARC can reduce unintended pregnancy, and that unintended pregnancies are more likely to result in poor health outcomes for pregnant people and babies than planned pregnancies. Black maternal mortality, though, is a problem that is as much about racism in the healthcare system as about pregnancy intentions (for recent considerations of this topic, see Owens and Fett 2019; Taylor 2020). This contrast reveals both that this argument individualizes what is at its root a system problem, and that LARC as

a solution to maternal mortality leaves a gaping chasm regarding how to address intended pregnancies among low-income Texans.

In recent years, however, these rates—specifically the high rates among Black women—have captured national and international attention. In the process, they have become a source of embarrassment and consternation among some Texas state legislators. As a result, at the time of my interviews, maternal mortality and morbidity was considered to be the rare reproductive health concern that legislators on both sides of the aisle wanted to address. Advocates took notice of the bipartisan desire to address this issue, reporting in interviews that the potential to reduce high rates of maternal mortality and morbidity in Texas were an important part of advocacy for increased access to LARC. Christina, a Hispanic reproductive health advocate, explained perceptions of the political momentum around maternal mortality:

> Maternal health has been a really big issue in Texas, and has been a buzzy thing that we're… trying to… not—not capitalize on it [laughs], but just, yeah, it is an issue, so let's think of ways that we can address it.

The "buzziness" of maternal health in Texas provides an opening, in other words, for advocates to make the case for expanding access to reproductive healthcare and, specifically, to LARC. Although Christina shied away from claiming to "capitalize on" this concern, she emphasized that the common understanding of maternal mortality as a "big issue" is an opening for making progress on policy priorities her organization had previously identified as important, including LARC. Jennifer, a Hispanic reproductive health advocate, elaborated on this point:

> Maternal mortality has been a huge thing, so I think anytime that we can make the connection between planned pregnancies and how generally those are going to provide better health outcomes than unplanned pregnancies, that might be a

> persuasive argument. Because I know, I mean, Republicans, Democrats, men, women—*everyone's* concerned about Texas's high maternal mortality rate.

Describing the broad base of support for reducing maternal mortality rates, Jennifer here highlighted how unplanned pregnancies have become a concern for all types of legislators in Texas. Expanding on this point, reproductive health advocate April (race not disclosed) more specifically addressed how the maternal health crisis allowed policy to transcend the usual political tensions around contraception, typically a "blue" issue under attack by the political right in Texas. She noted a broad realization that,

> [W]e've got a much bigger problem [than the typical contentious politics of contraception], which is people dying, and if approving LARCs or making LARCs available on public assistance programs, or making them more available in doctor's offices or hospitals, is an easy solution, then we should do it.

Here, April highlighted the "ease" of making LARC more available as a way to reduce maternal mortality. While it is true that preventing conception may be considered easier than addressing the health complications that may attend an unintended pregnancy, it is noteworthy how complex in fact it is to make LARC more accessible through the routes she references, as described in Chapter 1.

None of the participants quoted on this topic addressed the fact that the maternal mortality crisis in Texas is very clearly raced: Black people in Texas are dying of pregnancy-related complications at rates more than two times higher than white people (MacDorman et al. 2018). The seeming race-neutrality of maternal mortality in these quotations functions to obscure which pregnancies, precisely, are being prevented in order to save mothers' and babies' lives. This omission is important for understanding the specific ways LARC is understood to save lives.

Participants described two interwoven ways that LARC specifically helps protect mothers' and infants' health relating to unintended pregnancy: by giving women time to achieve an "ideal" state of health for themselves before becoming pregnant (getting treatment for chronic medical conditions, losing weight, and terminating habits such as smoking or drug use, for example), and by helping patients achieve "ideal" interbirth timing (commonly understood to be at least eighteen months between pregnancies) to increase the likelihood of healthy pregnancies. One Hispanic reproductive rights advocate, Lisa, explained the general argument:

> Planning your pregnancy means it's a healthier pregnancy. We have that maternal mortality crisis in this state. We want to ensure that a mom is healthy when they decide to have a baby and then [there are] the outcomes for the child [of a planned, as compared to an unplanned, pregnancy]: fewer preterm births, fewer developmental delays or disabilities that have long term issues—blah blah blah.

Here, Lisa sketched out how planning a pregnancy (by means of LARC) influences both the mother's and the baby's health, with particular attention to the latter. Melissa, a white and Hispanic reproductive health advocate, provided some background to this argument, describing how women are presumed to be spending the time before they become pregnant if that pregnancy is planned:

> LARC is very [important]—and other contraception too, but LARC in particular [be]cause it's longer term—is as it relates to maternal mortality. Women who die during their pregnancy or within the year after their pregnancy ends—a lot of it is opioids, of course, that's the top [cause of death], but then you have other issues that have to do with hypertension, diabetes, cardiovascular issues, and the longer acting contraceptive method allows the woman and her physician or clinician to have more time to work on those issues so that she can be healthier when she does decide to get pregnant. And those issues sometimes take a while to work through. If you're diabetic, it takes a while to modify your diet […] and so it can help when people [at the state] worry about maternal mortality, because a lot of those issues impact that.

Melissa in this excerpt emphasized the work a potential mother can do with her medical provider to become the ideal "pre-pregnant" self (Waggoner 2015), thereby lowering the

health risks of a pregnancy both for mother and fetus/baby. She began by revealing that opioids are the leading cause of maternal death. She moved quickly, however, to explaining how a host of other problems are also relevant, including many that are imagined to be eliminated if a pregnancy is planned.

Jessica, a white reproductive health advocate, elaborated on the details of the argument itself, elucidating three related ways that contraception can be lifesaving:

> [T]here's several different ways that [contraception] saves lives. First, you're much less likely to have an unplanned pregnancy, so that's a pregnancy you're not going to die from, so that's one way. And secondly, if you have a condition that needs to be treated, for someday later [when] you might get pregnant, then that is more likely to be entered into the system, [you can] find [redacted hospital name] or whatever's available to you as usually an urban or suburban woman, and get those things addressed so you can take the best care of that thing you can. And then third if you want to have a baby, to be able to get things under control, and make sure your medicines are okay, stop smoking, all the kinds of things you can do to get yourself really healthy, have a good spacing, get that sort of pre-conception care done so you have the healthiest pregnancy possible. So those are several ways that that can help both maternal and infant health and even mortality. […] Contraception access is not the whole thing, but without that, how are you going to do preconception care, if "Oops! I'm pregnant when I come to the doctor!"? So, it's an important component.

Jessica distinguished three potential causes of death via unplanned pregnancies, which she suggested can be averted by planning pregnancies: first, pregnancies are inherently dangerous and an unplanned pregnancy may kill a woman; second, preparing for a pregnancy might push a woman to work with a medical provider on other health concerns; third, planning a pregnancy allows a woman to have "the healthiest pregnancy possible"—possibly saving the life of the baby, by implication, since this reason is distinguished from the first.

Reducing maternal and infant mortality is an admirable goal. Connecting LARC to this goal, moreover, is clearly politically useful, as these are areas of particular political concern in Texas today. The argument that LARC is a solution to maternal and infant mortality rests on the idea that unplanned pregnancies are particularly dangerous, even lethal,

to mothers and babies, and ought to be avoided. People ideally, these arguments suggest, should space their pregnancies at least eighteen months apart and use their pre-pregnancy (planning) time to "bring their own health under control." Despite the apparent commonsensical nature of these arguments, they rest on a shaky foundation. Maternal mortality in Texas is dramatically higher among Black women than among other women (MacDorman et al. 2018). Although none of the participants quoted above mentioned race directly in the included excerpts, therefore, "maternal mortality" is implicitly racialized—it is not simply "maternal mortality" that is to be prevented, but "[Black] maternal mortality." Additionally, "unplanned/unintended pregnancy" is a highly raced and classed concept, as rates of unplanned *but desired* pregnancies are much higher among low-income women and women of color (see, e.g., Aiken et al. 2016; Aiken, Dillaway, and Mevs-Korff 2015; Blake et al. 2007; Edin and Kefalas 2011; Hartnett 2012). Below, I briefly describe how these facts throw into relief the precarious logical and moral foundations of LARC as a means to improve infant and maternal health.

First, while it is true that unplanned pregnancies are medically riskier than planned pregnancies, maternal and infant mortality are not race-neutral public health problems in the United States. They do not occur equally in all populations, even holding the "plannedness" of pregnancies constant. Rather, they are deeply raced. People of color face substantial racism in obstetric settings (like other medical systems), which is profoundly "risky" for their own health and that of their pregnancies, and dramatically lower access to pre- and post-natal care (Adams, Gavin, and Benedict 2005; Andaya 2019; Bridges 2011, 2020; Davis 2019; Green 2018). Although spacing pregnancies and becoming healthier before becoming pregnant are also likely to improve the health of a birthing parent and baby, racism in

healthcare is a tremendous health risk—and LARC as a solution to (implicitly Black) maternal mortality cannot address this concern. Framing LARC as a solution to (implicitly Black) maternal mortality, further, suggests that rather than the state taking responsibility for addressing structural and interpersonal racism in healthcare, Black women ought to take responsibility for avoiding the fate of maternal death by becoming pregnant less frequently and more "planfully."

Second, these advocates are arguing for increased access to LARC *specifically in state-funded programs for low-income women*. As a result, these interventions would only reduce unplanned pregnancies among low-income women. Unplanned pregnancies are disproportionately likely to occur—and be welcomed, not grudgingly borne—among low-income women of color. Therefore, reducing the unplanned pregnancy rate would have a disproportionate effect among these women, reducing their pregnancy rate more than that of other populations. While LARC as a means to reduce unplanned pregnancy and thereby maternal and infant mortality might seem straightforwardly positive, in fact it would mean reducing the pregnancy rate among women of color and low-income white women more than the pregnancy rate among other women—a sharp concern in a country with a deep and long track record of state-sanctioned eugenics.

Some of these rhetorical threads also run through advocacy for increased access to LARC in California. The cost-savings argument, in particular, came up in both states—albeit in different ways. Yet advocates' lobbying work itself, and the other arguments they use for increasing LARC access, are quite different in California than in Texas. Below, I compare how advocates in the two states describe their work and their advocacy arguments for increased access to LARC, highlighting the surprising similarities among many differences.

California Advocacy: "The Real Crux" of Lobbying Work

The California State Capitol is a neoclassical building located in Sacramento that dates to the mid-nineteenth century. Like the Texas Capitol, its architecture is loosely based on the United States Capitol, and both the State Senate and the State Assembly meet here. In interviews, participants reported that much of their direct advocacy work takes place in the Capitol building (often referenced by people based elsewhere in the state simply as "Sacramento"), including both one-on-one advocacy in particular legislators' offices and testimony in front of legislative committees. As in Texas, the state legislative calendar strongly influences advocates' work: the year-round legislative session in California provides advocates more breathing room than that afforded their Texas counterparts. While I spoke with fewer registered lobbyists in California than in Texas, many interviewees who work in other positions related to advocacy also reported spending time at the Capitol, educating legislators, meeting with their representatives, or staffing lobby days. The range of organizations I interviewed in California represented some that engage only in education at the Capitol, some that do only some lobbying and hire contract lobbyists for additional work when needed, and some that employ full-time in-house lobbying staff.

There are multiple reasons that advocacy organizations might not employ full-time registered lobbyists. Some people I interviewed in California work at smaller organizations with more limited budgets than many of the organizations I spoke with in Texas, and therefore contract out for formal lobbying services rather than maintaining full-time registered lobbyists on staff. A reproductive health advocate, Linda (race not reported), for example, explained, "I will sometimes do general education for legislators around family medicine, or on a sponsored bill I might go with our lobbyist—but none of us [on staff] are

registered [lobbyists]. We contract out for a lobbyist." Likewise, reproductive health staffer Travis (race not reported) noted,

> I'm usually only brought in on certain things where I have a particular advanced knowledge of an issue, more than our lobbyists, and I can be really helpful on background information for a particular issue… I [also] work to build stakeholder groups and stuff like that on legislation that we're sponsoring or supporting.

In this kind of situation, the organization staff often does substantial legwork on a particular issue or bill. In-house lobbyists or other staff members can do much of the preliminary work, only calling on contract lobbyists when the work shifts to direct lobbying beyond their capacity or time constraints. The following exchange took place during an interview with Natalie, a white contract lobbyist who works with some of the other organizations represented in this study:

> Anna: The policy unit of [contracting organization]—that's an in-house part of the organization that puts together their policy priorities and then they contract with you to carry out those aims, is that right?
>
> Natalie: Correct. They have in-house lobbyists and policy analysts, and they reach out to contract lobbying firms like ours to represent them when we're doing a broad brush and we need as many votes as we can [get], and we need to have exposure with legislators and educate them.

In this case, the organization that hired Natalie as a contract lobbyist does employ some staff members who are registered lobbyists, but at times needs additional capacity for a particularly large push. Natalie's firm provides that additional muscle.

Another reason some interviewees reported doing only limited direct lobbying themselves is the tax status of their organization. Registered 501c3 organizations are non-profits that, as part of their tax status, are required to refrain from engaging in any candidates' political campaigns and to limit their direct lobbying.[26] However, they often do

[26] While this is true in both states, California-based advocates brought it up much more frequently than those in Texas.

still conduct some lobbying, which is legal so long as it is not a large portion of their work. Describing a previous position of employment, Sharon, an African American reproductive health advocate, exemplified that balance:

> We were a 501c3: we couldn't do—well—no work that particularly related to candidates, but of course we could sign on for different policies that were coming up. So, I did a lot of lobbying at the Sacramento and DC capitols around different initiatives and different policies that were coming up… [in my current position] I actually will be going to the Capitol on the 25th to do some lobbying with them and possibly in September going to DC to do some lobbying on some of the different initiatives that they are following right now and bills that they're following. So, I've done a little bit of policy, not like writing policy but more of lobbying for different policies and stuff like that.

This mix of advocacy at the state and federal level came up in other interviews, as well, although this participant emphasized it particularly heavily. As she mentioned, the organization's 501c3 status is specifically related to the types of advocacy work she is allowed to do.

Two people I spoke with exemplified the type of work done by full-time, non-501c3 lobbyists. Eva, a reproductive health advocate, described a wide range of ways her work and her organization's work touch advocacy:

> We are involved in legislative advocacy, […] regulatory advocacy, policy change, policy development, direct lobbying, […] we are a lobbying organization. We have a lobbyist. And so part of my job is to be educating public, educating elected officials, educating regulators, educating interested stakeholders, but that's kind of all part of my job. And so it's really interesting that, if you want to advance this one aspect of this one topic, you have to figure out a different way of communicating and different ways of relaying your information based on your audience.

In addition to highlighting "education" of various stakeholders, she specifically identified the organization she runs as "a lobbying organization" and listed the various kinds of advocacy she and her staff do. She also gestured toward the need to carefully choose how to message her organization's priorities differently to different audiences. I explore this dynamic further

in the sections below, but I include it here because it indicates a critical part of lobbying work and an important part of how she reported spending her days.

Natalie, the white full-time contract lobbyist quoted above, elaborated on what it looks to like to do direct lobbying at the California Legislature, particularly emphasizing the importance of in-person meetings and the role of affect in the relationships she builds. Natalie was unusual in my sample in that lobbying is her exclusive professional work. She provided a very helpful description, though, of the kinds of advocacy activities in which a much broader range of my participants also mentioned engaging: meeting with individual legislative offices and testifying at legislative committee hearings. Her descriptions therefore usefully fill in a textural sense of the activities and feelings associated with lobbying work. She spoke with energy and enthusiasm as she explained,

> [T]he real crux of my advocacy is talking with people in and around the Legislature. […] there's no replacement for that human connection and that eyeball-to-eyeball conversation and the relationships you build around that and the trust that evolves over time. I think that the most satisfying aspect of my job is developing and maintaining those relationships. And sometimes it can be tough, especially if you don't agree and if you're trying to kill a legislator's bill. But I think in order to be successful in this business and thrive and enjoy it, you have to, there's an art of negotiation, there's an art of disagreeing. There's an art of confrontation that I certainly learned over time, that leads to a non-bridge-burning scenario. […] All you have in this business is your integrity and your word. And I think that's what gives me a tremendous amount of enjoyment, because it's constantly challenging.

As Natalie highlighted, lobbying is at its core about building relationships and being able to preserve them through one's "integrity" and particular manner of engaging, even when the alliances among legislators and lobbyists may vary from bill to bill or even day to day. While some other participants described those tensions as especially difficult parts of their job, she highlighted it as one of her favorite aspects, a notable difference since lobbying is the entirety

of her job—as distinguished from some interviewees for whom lobbying is only one part of what they do.

In the excerpt above, Natalie emphasized interactions and relationships with individual legislators and their staff as one of her favorite parts of her work. Asked about the parts she likes the least, she distinguished between the work done behind the scenes and the work done in the public's eye, and particularly highlighted the procedural delays inherent in publicly weighing in on legislation at committee hearings. In this, she explained a second type of lobbying activity: committee testimony:

> [T]he thing I probably dislike most about it is the waiting around. When I have a bill up in committee, I have to wait until the author shows up in order for [us to act]—we either present [information to the committee] or provide some testimony for the committee. But I love—a good lobbyist does his or her work ahead of time. So the actual policy committees are, for lack of a better term, dog and pony shows, [be]cause you know how it's going to turn out. You know if you have the votes to get your bill out of committee, you know if you have the votes to kill a bill.

She did note that committee hearings are important because they are a way for the general public to weigh in on and understand possible policy changes that could affect them, and she described two different ways advocates weigh in at committee hearings. After the statements excerpted above, Natalie went on:

> [Committee hearings are] important because it's in the public and […] it's important to provide access to everyone in California on certain policies that could affect them if they were to pass. It's just the way, the sitting and waiting around for an outcome I already know is going to happen. Just so I can go up before the committee and make some sort of compelling statement as to why they should vote for a bill or even a step or two less than that, just doing, providing "me too" testimony, where I go up and say my name, the organization I'm representing, and what my position is. That gets frustrating because I feel, I don't, I have to, you know—just, the fun part is going around talking to [legislative] members and their staff and getting the votes, or trying to convince them that they should see the world the way I'm conveying on behalf of my client or myself.

In the "fun part" of her work, that is, she convinces legislators to vote for the bills her clients support. After that point, when a bill has reached a committee hearing, weighing in publicly on it—either with a full testimony or a "me too" statement—is in her telling closer to theater than true lobbying.

California Advocacy: Arguments for LARC "in Sacramento"

In Texas, the arguments advocates reported using to make the case for increased access to LARC to state legislators bubbled forth in my interviews with scarcely any solicitation. In conversation after conversation, people could recite a litany of such arguments, clearly speaking primarily about points they used regularly. In California, in contrast, my questions about arguments for increased access to LARC elicited a quite different response. People often hesitated, asked clarifying questions, and ultimately many referred me to other people for the answers—people who frequently, in turn, referred me to still others. The picture that emerged was that of a movement to increase LARC funding that had largely concluded by the time its parallel in Texas began, and certainly by the time of research. As a result, the need to make the case for LARC was far less present for the people I spoke with in California than it was for Texas-based advocates. By the late 2010s, when I conducted most of the interviews, LARC was a widely accepted component of publicly funded reproductive healthcare programs in California. Many legislators in the state additionally support contraceptive access more generally, so it was a quicker and easier movement to fund LARC there than in Texas. Over the course of many interviews, however, two arguments for increased public funding for LARC emerged as salient for California participants, in both earlier and contemporary advocacy: cost savings to the state, and a "values-based" argument rooted in individual contraceptors' rights. Below, I provide

examples of each type of argument, and briefly discuss their implications and connections to the arguments in Texas.

Cost Savings

When asked about effective legislative advocacy arguments for increasing access to LARC for low-income Californians, participants often identified contraception's capacity to save the state money. About one-third of those who mentioned this argument noted that while it had been used in the past, it was no longer necessary or useful in their work. The remaining two-thirds described its use either as contemporary or unspecified. A few participants specifically or even pointedly emphasized that they did not use the cost-savings argument at any point in their work, either because they had concerns about its implications or because it simply had not been relevant or necessary. In this section, I examine some examples of typical descriptions of the cost-savings argument in this subset of my data, before presenting a few of the critiques of the argument people leveled.

Pamela, a white advocate from a reproductive rights organization, described the range of economic arguments for increasing access to LARC that she had experienced or used herself, providing a sense of the typical arguments highlighted in interviews with participants in California:

> [T]he economic argument is […] that where women have access to the birth control of their choice, they are going to be more active in the economy. They're going to have more opportunities and they're going to be more successful. And when they are successful, their companies are successful, their families are successful. There are a lot of studies out there that demonstrate that access to birth control has diminished the amount of welfare and social services that people require. So, those are the types of economic arguments. It's not only about women in the workplace, but it is also about overall societal—we do better. And I mean we have statistics, and I have to brush off the cobwebs now, but it's like for every dollar we invest in Family PACT, we save $10 to $15. It's a huge savings over the long haul.

As Pamela described here, the economic argument for increasing access to LARC in California revolved not simply around the cost to the state of unintended pregnancies but around a broader array of economic benefits to the state when individuals use the contraception of their choice. She made a clear point of how individuals "do better" when they have such access. By the end of the excerpt above, however, she moved from focusing on benefits to individual contraceptors to focusing on the benefits to the state as a whole. She also specifically noted the lower strain on social services when contraception is readily available to those who desire it. Later in the interview, she emphasized that these arguments are primarily useful with more conservative lawmakers, who are not as receptive to the "values-based" arguments (described further below) as are Democrats.

In response to my question about whether reducing the cost of unplanned pregnancy among low-income Californians was part of the LARC policy discussion in his experience, Travis (reproductive health advocate; race not disclosed) answered without hesitation, "Yeah, that's definitely part of the conversation." He went on immediately to identify where he suspected that rhetoric stemmed from, providing some background to Pamela's thoughts above:

> You know, Medi-Cal, I think, is responsible. I don't know what the latest numbers are, but last thing I heard was [they pay for] at least 50 percent of the births in California. So it has a major financial stake in what happens with mothers and families, and certainly you can save money not only in the prevention of unwanted pregnancies, but better maternal health care leads to improved outcomes for children.

Travis here connected the dots between the number of unwanted pregnancies paid for by Medi-Cal, the state's "financial stake" in low-income Californians' reproduction, and the policy case for increasing funding for LARC. Making explicit what often was implied in other interviews in California, he highlighted these dynamics without raising concerns about

them. Several other interviewees, however, noted these dynamics as problematic or described tensions about them in the reproductive policy advocacy field.

Valerie (white; reproductive justice advocate), for instance, explained some of the arguments that unfolded within and among reproductive rights, reproductive health, and reproductive justice movements in California about economic arguments for contraception in general and LARC in particular:

> [S]o for example, when we would do something like Family PACT, there'll be huge arguments about that because some people are using the "Every dollar you spend on family planning saves $4 in welfare" [argument]. And then it was like, "Well, if you want to go to that argument, then you could just start arguing that people who would require welfare shouldn't be able to have kids.…'" How offensive some of that is. And I definitely think with LARC it's especially—I think that [for] some of the groups now, even though that's probably part of their actionable orientation, it may be more subconscious.

Moving in this excerpt from a general critique of the arguments used to advocate for Family PACT, the state family planning program, to a specific concern about LARC, Valerie drew a line from economic arguments for contraception to the potential for eugenics reasoning: "you could just start arguing that people who would require welfare shouldn't be able to have kids." Placing this quotation alongside that from Travis, above, makes clear that the line of thinking extends from Medi-Cal's investment in lowering the birthrate among low-income Californians to the idea that people who qualify for social services have less of a right to have children than do wealthier residents of the state.

Marisa, a Chicana reproductive justice advocate, provided additional background information, connecting this argument with racism, eugenics, and xenophobia in California. When I asked if the cost-savings argument was or had been a part of the LARC advocacy conversation in California, she replied,

> Yes. I do think it is still a part of the conversation here just because I don't think that even though California is "progressive"—there is still… I don't know if it's really intentionally eugenic thought, but I do think that that's what comes through a lot of times is like, "Yes, we're going to make sure contraceptive access is, everybody has access [...] I don't know that people are really clear that the "why" about it is very racialized, is very class-based, is very xenophobic at times, so, I think that that's just not really questioned really in public health departments. So, when […] we as advocates are advocating for increased access to whatever, the "why we do it" cannot be because teens are having too many babies or because poor people can't have so many babies. That's not a reproductive justice approach to that question. [… T]o me it seems metaphorical maybe to how we look at racism in this country. Right? […] California, there—it's racist also. It's just very subverted, right? It's under the surface.

In response to my fairly general question, Marisa quickly and neatly explained the backdrop: California is racist, albeit less obviously so than some other states, and the "accidental" eugenics thinking behind lowering the birthrate among poor people (and adolescents) goes unremarked in public health. Advocates, she argued, must not be drawn into that framing. The contrast between this response and Pamela's, above, illustrates some of the tensions within the field of California reproductive health, reproductive rights, and reproductive justice movements. Related specifically to contraception and LARC, some parts of these movements consider a cost-savings argument to be a useful tool, while others consider it deeply concerning.

Audrey, a white and Latinx reproductive justice advocate, elaborated on this tension with an expanded analysis of the potential damage she believes the cost-savings argument can do:

> [As a movement,] we frequently will […] boil something down to economics, and by doing so demonize whole groups of people. And I think that […] this is also part of why reproductive justice is different than reproductive health or reproductive rights—is that I think that health and rights are—they're quick. […] to not think through the consequences of arguments for things or to say [that] it's okay to basically discard a whole group of people with saying certain statements, and I think that we see that also not just in this argument around LARC, that it will save the state money, but also [elsewhere in reproductive healthcare].

In this analysis, Audrey drew out the potential for the cost-savings argument to "demonize whole groups of people" and even "discard" them, emphasizing that while reproductive justice advocates see this potential and, as a result, steer away from the cost-savings argument, reproductive rights and health advocates may not. Reproductive justice groups, they suggested, would be more likely to use a human rights frame to argue for increased access to reproductive justice, not simply for LARC. This framing echoed through my conversations with reproductive justice advocates in California. As Susan, a Black reproductive justice advocate, put it, "I wasn't an advocate for *LARC*. I was an advocate for *women being empowered with their birth control*" (emphasis in original).

"The Social Justice Argument"

The second type of argument advocates in California reported using to argue for increased access to LARC is rooted in an individual's right to contracept and the non-medical benefits they may reap from doing so, should they so choose. This approach, frequently described as "values-based" or "social justice-oriented" in my data, appeared in my interviews in a range of manifestations, such as explaining how LARC can help a contraceptor achieve their professional or family goals, how it can be a tool for an individual to achieve their broader goals, or how access to it is a matter of basic human or civil rights. In this section, I present and analyze a few examples of this argument as described by California-based advocates, comparing its use to the arguments used most frequently by advocates in Texas where relevant.

In the first interview I conducted in California, Pamela, a white reproductive rights advocate, gave me a quick primer on what she termed the "social justice argument" for publicly funded LARC for low-income Californians:

> [T]he social justice argument is [that] we are a state that has one of the most diverse and varied constituencies in the whole country. Nobody should not be able—health disparities and the ability to have or not have children should not be dependent on your zip code or on your income.

Tying this coverage to the demographic makeup of the state and invoking reproductive justice language ("to have or not have children"), Pamela emphasized that one of the best arguments for increasing access to LARC is that without it, different residents of the state have different levels of agency in making their own reproductive decisions. These points echoed through Eva's answer, as well, in which she noted that her argument for increasing access to LARC did not differ substantially from her argument for increasing access to any kind of medical care. Speaking as an advocate at a reproductive health membership organization, her voice reverberated with intensity as she explained:

> I always go back to the basics: access to care, equity, equality, and justice, and especially social determinants of health. Because it all goes back to access to care, no matter what the care is; it's access to care, it's access to timely, appropriate, relevant, and high-quality care. And if Californians do not have that, no matter what it [is] that we are offering, it doesn't matter. Because if they don't have access, they get nothing. So, I stick to basics—and it's access to care.

Specifically framing LARC as basic medical care, in our conversation Eva repeatedly pointed out that legislators are often surprised to hear that some Californians lack access to reproductive healthcare in their daily lives. Access is a foundational component of her organization's mission, and she clearly felt most comfortable with this argument for increasing funding for LARC.

Drawing on similar themes but placing them in their larger context, Veronica, a Latina advocate with experience in reproductive justice, reproductive rights, and reproductive health, explained how she had used the values-based argument this way:

> LARC is just another one of those tools that we can give people to be able to make the best choices for themselves and their families, so [in my advocacy] it was talking about that and talking about how when people are given all information about these services equally […] they choose what's right for them, that they choose what's best for them.

Although Veronica used the language of choice here—frequently used by the reproductive rights movement to refer specifically to abortion access—she went on to frame those choices in their larger structural environment, emphasizing that individuals do not make decisions in a vacuum:

> We also talked a lot about the ideal of fighting for or looking at the conditions that people have in all of their lives. And really pushing this issue of, we should think about the communities, the choice, the conditions under which people are making choices. And let's think about that too as things that we need to solve and work on to be able to support people. So I think we tried to introduce a little bit more about… there's a lot of conditions under which people make these choices, poverty, other kinds of concerns and […] we can't solve this all together, but we at least want people to make real choices, and giving them full information about everything that they have and actually giving them real access, making sure it's covered in their state coverage, is a way to give them that power and choice.

Veronica here placed the state's investment in providing LARC to low-income Californians in a broader agenda of supporting individuals' capacity to make "real choices" for themselves about their reproduction. She did not suggest that LARC is a panacea to addressing poverty. Rather, she considered it one tool among many that people can draw on in their decision-making.

Likewise, Natalie, a white contract lobbyist, spoke at length about access to LARC as a civil rights issue. She emphasized that in California, even Republican state legislators are receptive to seeing reproductive healthcare in the "rights" frame:

> Natalie: [Some Republicans in the state Legislature are] amenable to these overarching civil rights issues, I would say dealing with not only women's health, but also LGBT rights as it relates to health care, etcetera.
>
> Anna: So it's like the civil rights argument is a compelling one for them?
>
> Natalie: Yes.
>
> Anna: Can you tell me more about what you mean by civil rights in that context?
>
> Natalie: Civil rights, the larger umbrella of equality. Right? And you can paint a very broad brush. You could paint the broad equality brush over a whole host of demographic groups that, because of their socioeconomic, you know, background—they're, you know, they're women versus men. They're LGBT versus, you know, straight members of California. […] The Legislature acknowledges that women's health care and access to health care no matter where they are on that socioeconomic spectrum, that's a civil rights issue.

Focusing particularly, in this part of our conversations, on state legislators who might be less likely to support contraception than others, Natalie nonetheless identified "civil rights" and "equality" as compelling arguments for this audience. That the "social justice arguments" for increased access to LARC are more broadly useful in California than in Texas means that advocates experience less contention and less tension in this type of advocacy.

Conclusion

Advocates in Texas and California use or have used a range of arguments to increase legislative support for access to LARC, from saving mothers' lives to saving the state money. Within each state, in fact, there was great variation in advocacy arguments used in reproductive health, reproductive rights, and reproductive justice movements, and the tensions between the various arguments and different parts of the movements in each state were clear. Yet in both states, the potential for long-acting methods to save the state money, commonly termed the "cost-savings argument," was an important part of the conversation. In this, unexpected similarities between the two states come to the fore, including not only the

arguments used but the way advocates experience these arguments and their own use of them.

Framing LARC as a silver bullet in solving the problems described above obscures two critically important facts. First, not all unintended pregnancies are unwanted pregnancies. Rather, particularly among marginalized people, many pregnancies that were not deliberately planned are welcomed joyfully. Second, the recipients of publicly funded long-acting reversible contraceptive devices are by definition low-income and are disproportionately people of color. These pieces help bring the picture into clearer focus: the state in question is saving money, reducing pregnancy complications, and even providing patients non-medical benefits only by preventing or delaying pregnancies that may or may not be desired—without interrogating the assumption that all unintended pregnancies are unwanted. Reducing "risky" and "expensive" pregnancies rather than making the obstetric system itself more efficient, safe, and equitable, moreover, means that people who do become pregnant will continue to face unnecessary risk in their pregnancies and deliveries. The tensions in these points are all the more concerning because the pregnancies and pregnant people in question are not a random sample of the population. Rather, they are uniformly low-income and disproportionately people of color. Far from a win-win policy priority that helps citizens meet a desired health goal while "trimming the fat" from the state budget, then, LARC has the capacity to save lives and save the state money only at the risk of reducing desired pregnancies among the most marginalized Texans and Californians. Advocates in both states again and again emphasized their discomfort with "planting" these advocacy "crops," for reasons including these. I explore these reactions, and advocates' concerns about the "harvest" they might produce, in the next chapter.

Chapter Four: "At Harvest Time"[27]

I've, especially in the last year, really been making a concerted effort to always bring that [antiracist] language and that framework into my own work, making sure that I'm always operating from a human rights perspective, making sure to the best of my ability I'm operating from an anti-racism perspective, making sure that I'm always, always, always including the words "non-coercive" in any presentation I do. [laughs] […] I think that the more people who are aware of it and talk about it, the better off we are, but when you're under that damn pink dome and trying to get a bill passed… It can be hard to balance that out with what is the most effective for a senator from West Texas.

~Heather; Caucasian; Texas reproductive rights advocate

Anna: *A lot of the organizations that are talking a lot about LARC are using cost-based arguments. […] So, they're saying the state of Texas will save—*

Susan [interrupting]:
Sounds kind of like eugenics, doesn't it?

~Susan; Black; California reproductive justice advocate

In this chapter, I consider the outcome—or "harvest"—of the advocacy arguments described in Chapter 3. Picking up the thread of that chapter, I focus specifically on the concerns advocates raised about the racialized and classed implications of the cost-savings argument in particular. The picture that emerged across all fifty-five interviews was clear: the cost-savings argument is broadly seen to generate discursively what I theorize as *reproductive responsibilization* through the use of LARC. At the broadest level, this process unfolds in three stages of connected reasoning. First, the cost-savings argument suggests poor people (especially poor Black people and immigrants) are likely to have pregnancies and babies that are particularly costly to the state through their (presumed) use of publicly funded

[27] (Wright 1941:40)

services. Second, this group is understood to have the capacity to reduce that "burden to the state" by contracepting effectively, preventing unintended—presumed to be *unwanted*—pregnancies. Therefore, third, they are effectively responsibilized, expected to take on the state government's responsibility to balance the state's budget. Yet at this point in the process there is a logical stumbling block: the same women who are expected to contracept faithfully so as to preserve state funding are framed through controlling images as irresponsible both generally and reproductively. How, therefore, can they be trusted to effectively contracept? I argue that long-acting reversible contraception, which takes the need for "responsible" behavior largely out of individual patients' hands, has emerged as one answer to this question.

This discursive construction is rooted in eugenicist logic that argues marginalized people should not be reproductive agents. It is problematic on its own terms, as only the latest iteration of a long history of eugenics in the United States. It may be a neat and effective short-term argument for why state legislators should fund a policy initiative they might otherwise not fund. Nonetheless, it has the potential to damage the longer-term goals of the reproductive health, reproductive rights, and reproductive justice movements. Over the course of my interviews, nearly every advocate raised some version of these two concerns. This chapter explores what these concerns are, in two parts. First, I delve more deeply into the logic of reproductive responsibilization, detailing each part of its discursive construction and how they combine to make something more—and even more problematic—than the sum of their parts. In the second section, I take Texas as a case study, focusing on how advocates in that state described their concerns about the cost-savings argument, about the reproductive responsibilization it generates, and about its other possible implications. I attend specifically

to Texas in this chapter because, as described further below, the cost-savings argument and reproductive responsibilization discourse were still unfolding there at the time of data collection; in California, they were far less active.

Reproductive Responsibilization

I argue that the discursive construction of low-income state residents as both responsible for balancing the state's budget (by contracepting) *and* too irresponsible to be trusted to contracept effectively—while not surprising in light of historical constructions of low-income women and women of color specifically—is noteworthy in its internal contradiction. Theories of responsibilization in carceral systems highlight how the state makes individuals and community organizations accountable for managing criminogenic risk the state previously managed (Garland 1997; Cruikshank 1999; Rose 2000; Armstrong 2002). Building on these theories and those of reproductive justice research and organizing (ACRJ (Asian Communities for Reproductive Justice) 2005; Luna 2009; Silliman et al. 2004; SisterSong, Inc. 2017), I make sense of this contradiction by theorizing *reproductive responsibilization*. In this process, I argue, the state transfers its responsibility to manage public money onto its most marginalized constituents, placing that responsibility on low-income people's management of their fertility. Critically, "low-income people" operates as a pseudo-colorblind category in these discussions: the race of the people contracepting, and the babies their contraception prevents, goes technically unmarked. While purporting to be fully separate from race and racism, however, the term "low-income" is deeply inflected by racialized and racist ideas of Medicaid recipients and of immigrants, and of those who use

public services more broadly.[28] The people eligible for publicly funded healthcare services, further, are disproportionately people of color. Through the cost-savings argument for increased access to LARC, advocates and other stakeholders discursively draw on and re-entrench reproductive responsibilization. The various pieces of reproductive responsibilization have long been critiqued by women of color organizing and reproductive justice activists in particular (see, e.g., Crenshaw 1989; Luna 2020; Luna and Luker 2013; Silliman et al. 2004). I highlight how the pieces fit together as part of a larger process, which I argue unfolds in three stages.

First, reproductive responsibilization rests on the foundational idea that low-income people's babies are particularly financially (and logistically) burdensome to the state, compared to other babies. Taken for granted in my interviews and broader observations, this construction positions babies born into poor households as financial burdens for the state government, placing a dollar value on their lives. That value is measured by how costly their potential health care, education, and carceral system involvement may be, either in the first year of their lives or more generally across the life course, and it is invoked casually and frequently as part of the cost-savings argument for LARC. It echoes long histories of devaluing poor women's reproduction, children, and mothering, and histories just as long of treating them as a burden on the government resources to which they contribute taxes far out of proportion to their income (Flavin 2009; Gordon 2002; Gutiérrez 2008; Mink 2001; Roberts 1997, 2002; Rousseau 2011). The enumeration of precisely how much various policy initiatives—or their absence—might cost is built into the legislative process, as several

[28] Ian Haney López (López 2010) and Pauline Lipman (Lipman 2013) explore related processes and how intersectional structures of power and domination shape them. See particularly López's (2010) *anti-statist whiteness*, which probes how race is both used and ignored in neoliberal and capitalist regimes.

interviewees described in Chapter 3. And indeed, understanding how much various policies cost is considered to be an unequivocally important part of legislating. Yet in its very taken-for-grantedness, it is insidious: it becomes an unquestioned part of nearly all policymaking, even that related to human rights such as healthcare, education, and reproduction.

Building on this foundation, the second component of reproductive responsibilization is the implication that because low-income people's babies may draw on state resources to survive and thrive, preventing their birth represents an important source of state income. The state, in other words, stands to benefit financially from preventing the births of babies born to mothers who qualify for state-funded social and medical services. Drawing directly on the mathematics described above, this frame subtly shifts attention from the *cost* of birthed *babies* to the cost *savings* of "averted Medicaid *births*." Not only has the emphasis moved to the savings side of the equation without fanfare or explanation, but the expenditure to be prevented has changed from babies to "births," a word with considerably less connection to a human life. That this prevention of birth is considered a clearly positive policy initiative rests on the idea that unintended pregnancies are uniformly unwanted pregnancies, despite clear evidence that this is not always the case, particularly for low-income people. Yet even with the benefit of this convoluted logic, the state does not have the capacity to save this money by direct action, at least not through legal means.

The third component of reproductive responsibilization, therefore, is the idea that low-income cisgender women must take responsibility for saving this money by preventing *their own* "too-expensive" babies' births, by contracepting. There is an imperative, in other words, for them to be *reproductively responsibilized*, assigned what is properly the state's responsibility for achieving a balanced budget and pressed to carry it out through preventing

pregnancy. Here, however, even the manipulated logic we have followed so far hits a crucial stumbling block: controlling images of low-income women, and particularly of low-income women of color, construct them as deeply irresponsible, and specifically *reproductively* irresponsible. As a result, dominant narratives suggest they cannot be trusted to contracept effectively through daily action (e.g., oral contraception, which requires the user to take a pill at the same time every day for maximum effectiveness). This construction elides or even masks the fact that some low-income women may appear to contracept ineffectively precisely because they *do not wish to* prevent pregnancy.

If low-income women simultaneously are made responsible for balancing the state budget *and* are considered too irresponsible to do so independently, their "unmanaged" fertility becomes a problem for the state, to be solved by some other means. After the twentieth century's largely successful activist campaigns to make state-sponsored eugenics illegal in the United States, the government has considerably less power to impose fertility management on low-income women. Long-acting reversible contraception, which prevents fertility for up to twelve years absent a doctor's intervention, is one workaround. The state's (literal) interest in lowering the fertility rate among low-income people, then, has been foundational to increasing access to LARC in this population. Below, I explore the effects, or "harvest," of this rhetoric, according to lobbyists, advocates, and other stakeholders in Texas, where this conversation is still active.

Navigating the Cost-Savings Landscape

I focus specifically on Texas as a case study for how reproductive responsibilization happens and what advocates' concerns about it were, through an examination of the cost-savings argument. While this process is relevant to both California and Texas, I take the

latter as a case because these dynamics were very active there during data collection. In California, in contrast, the cost-savings argument and the related reproductive responsibilization were more present in past years. This process was interrupted there before it fully unfolded, at least relating to the cost-savings argument, by conversations and readjustments within and among reproductive health, reproductive rights, and reproductive justice movements. Because of this deliberate effort to redirect the conversation, and because it was several years ago, for advocates in California the dangers of reproductive responsibilization by means of the cost-savings argument were much less present, current, and detailed than they were for Texas-based advocates.

I build here on advocates' concerns about the cost-savings argument raised in the last chapter, beginning with an exploration of advocates' suspicions about legislators' interest in saving money in the first place. I next consider what advocates suspect is in fact driving legislators to invest in LARC for low-income Texans, before discussing the dangers they see in drawing on the cost-savings argument in light of this discrepancy—both for individual people in Texas and for reproductive justice, reproductive rights, and reproductive health movements themselves. Finally, I consider how advocates reported they navigate those concerns in their decisions about LARC advocacy.

Doubting Legislators: "Do They Actually Care about Fiscal Responsibility?"

The cost-savings argument for increasing access to LARC is premised on the idea that state legislators value fiscal conservativism. In my interviews in Texas, this point came up repeatedly, both as justification for using the cost-savings argument and as very much in question. Michelle, a white reproductive health advocate, described how the state

legislature's stated commitment to this value affects her advocacy work. Emphasizing the power dynamics at play, she explained:

> They [the state legislators] set the conversation parameters. […] They've stated that they care about fiscal responsibility, and therefore we have to meet them on that ground, of talking about fiscal responsibility, without examining, do they *actually* care about fiscal responsibility?

Noting that the state legislature has the power to determine the nature of the conversation, she identified in our conversation that the question of whether or not they were truly committed to fiscal conservativism was nearly moot.

A white reproductive rights advocate, Scott, elaborated on this point and provided a neat summary of concerns I heard in several interviews about legislators' stated interest in fiscal responsibility. When I mentioned the responsibility incumbent on those who spend state money in relation to the cost-savings argument for LARC, but noted there seems to still be a fair amount of irresponsibility in that spending in Texas, he replied emphatically:

> No, they're not [being responsible with state funding]. No. And if that's the criteria we want to use to make public decisions about public expenditures, there's—if you really want to analyze the Texas decision to excise Planned Parenthood [from state family planning programs], there's just no way to make the policy argument on those grounds, that it was a wise decision. It's just—it's just naked ideology. Which *of course it is, everybody knows that. Everybody on all sides actually knows that. Even when they don't acknowledge it. And they always knew*. But yeah, if [legislators are trying to say,] "Oh my god, there's a higher standard for spending public dollars, therefore we're going to take an efficient provider serving two-thirds of the state's population and with no preparation drop them out of the program"? That makes me call bullshit on the argument that this is really about the difficulty of, the higher scrutiny that follows public funding. That's just bullshit. (emphasis added)

Here, Scott focused specifically on what he considered one dead giveaway indicating that the state legislature is not, in fact, committed to spending state funding efficiently over other concerns: the exclusion of Planned Parenthood from the state reproductive healthcare

delivery programs in 2011. Several other interviewees similarly emphasized this point, which bears a bit of explaining.

Planned Parenthood, which until 2011 was a state-contracted reproductive healthcare provider in the state family planning program, is an exceptionally efficient provider of reproductive health services. They provide a very high level of services to a very high number of clients, for very little state money invested. Excising them from the program explicitly meant relying on far less efficient—and therefore more costly—medical providers to provide reproductive health services to the state's low-income population. By excluding Planned Parenthood from the program in violation of federal law, the state additionally lost the ninety percent cost-share the federal government had previously provided for the state reproductive health program. With the rule change in 2011, therefore, the state legislature made an exceptionally cost-inefficient decision in favor of an ideological boon: terminating the state's relationship with Planned Parenthood. Scott drew on this as a clear example of how little the state government values cost efficiency on its own merits, and, notably, repeats in four different ways (italicized above) that the emptiness of this supposed value was well known even before this incident.

"Things […] Go Astray": Suspected Legislator Motivations

The quotes excerpted above indicate that while advocates hear state legislators profess an interest in fiscal conservativism in the area of reproductive healthcare, they doubt the sincerity of this interest. That doubt suggests the presence of a "something else," something that goes unnamed but, in these statements, presumably lies below the stated value of taking great care with public dollars. When I asked why Republicans supported LARC

access in Texas, Heather, a Caucasian reproductive rights advocate, made this point more explicitly:

> I think that, out loud, lawmakers would point to cost savings, and they would say that the prevention of unintended pregnancy is good for the state. And then from there… things might go astray as they got a little bit more honest.

Heather here suggested that, were lawmakers "more honest," they would admit that cost savings are not the true reason they support LARC. With the word "astray" and a concerned tone of voice, she connoted a more concerning or possibly deviant reason—something "off the beaten path," so to speak, of accepted rhetoric. Several participants suggested that the area "off the path" was rife with intertwined racism, classism, and sexism, and a few quite directly explained that it is so.

For instance, when I asked David, a white reproductive rights advocate, if he had noticed any resistance to LARC advocacy at the Legislature or elsewhere, he explained that sometimes people in the reproductive rights and reproductive justice communities pushed back on this kind of advocacy out of concern about coercion. Identifying some new supporters of LARC, he explained:

> [A]ll a sudden there's people who are not.... who by action don't seem to really have women's health or public health forefront of mind. Who all of a sudden, they're pushing LARC and you're like, "Wait a minute." [… And] the history of coercive contraception and sterilization overlays that, right? And I mean, let's just say—the people making these decisions in Texas don't have a very robust race power analysis.

People who are not trustworthy women's or public health supporters who "push" LARC, he suggested, are to be doubted—particularly in light of LARC's connection to forced contraception or sterilization. With what sounded like well-earned cynicism, he suggested that "the people making these decisions in Texas"—which is to say state legislators and perhaps state agency leadership—act either incidentally or deliberately to shore up racism in

their work. Connecting this to his earlier point about LARC, by way of the history of coercive sterilization and contraception, David implied that state leadership may be supportive of LARC because of its capacity for reproductive control of marginalized populations.

Scott, a white reproductive rights advocate, also pondered this topic when it came up in our interview, taking it one step farther. Discussing the possible role of racism in Republican support for LARC in Texas, he considered:

> I wonder how much xenophobia and bigotry underlies the support on the right for family planning. It's probably true. […] Well, and explicitly in our Texas politics right now we talk a lot about the changing demographics of the state. It's seen as a reason for hope among the progressives, and it's definitely seen as a looming fear by state-entrenched Republican folks.

Moving from a general question about possible "xenophobia and bigotry" to the fact that white Texans are an increasingly smaller portion of the population, he identified Republicans who have worked in the state government for a long time as particularly concerned about this latter point. Contraception, he suggested, in their eyes could be one tool toward addressing that concern.

Michelle, the white reproductive health advocate quoted above, was answering a general question about the most common or effective arguments for increasing state investment in LARC when she identified racism as a key dog whistle. She similarly focused on the changing demographics in Texas to communicate this point:

> The argument a lot of people make for LARC to conservative people, which I did not participate in, is the same as birth control [more generally], which is, there's clearly a desire within Texas to… there's a [unintelligible] white supremacy that's underlying a lot of things, and a desire to not change the demographic makeup of the state. And so birth control, I think by some legislators—though not stated explicitly—was probably viewed as a way to, you know, keep a more white state.

This excerpt was contextualized in Michelle's broader opinion, communicated throughout the interview quite clearly, that she saw a great deal of racism at the Texas Legislature. Taking pains to report that this argument was common while separating herself from it, she explained that "some legislators" see contraception generally and LARC specifically as a means to population control for racial dominance. Other interviewees also moved quickly from my general questions to this specific concern.

Potentially Dangerous Outcomes: "I Don't Want This to Be Population Control"

In interviews where participants raised concerns about legislators' dubious reasons for supporting LARC, as in those excerpted above, I typically followed up by asking if they saw those reasons as dangerous, and if so, what specific danger they saw. Two categories of concerns came up in response to these questions: the danger to individual people in Texas, through reduced reproductive autonomy or increased coercion, and the danger to the movements for reproductive rights, reproductive health, and reproductive justice. The latter generally included ways that using a cost-savings argument, particularly knowing that legislators may not truly believe this rhetoric, can limit the movements' ability to meet their broader goals. These limitations included making it harder to advocate for other kinds of reproductive health services, reducing the movements' potential to attract new participants, and prioritizing short- over long-term needs and goals of the movements, thereby endangering those long-term goals.

The first danger advocates in Texas identified in using the cost-savings argument for LARC was the potential reduction of patient autonomy over their own reproduction. David, a white reproductive rights advocate, emphasized that this was a possible outcome of building

programs around cost savings—whether or not legislators were truly committed to fiscal responsibility.

> They don't let the clinicians or the people who are specialized family planning providers inform program design or policy. Because […]—maybe the program was only designed to save money. It's not actually designed to provide people reproductive autonomy. Right? Right. So then that's the value the program is designed towards, right? Not reproductive autonomy.

Focusing on the problems inherent in the cost-savings argument in general, even aside from legislators' other, more nefarious goals, David directed attention here to the intended and stated goals of reproductive health programs. As he explained and other participants echoed, cost savings may be a component of state-funded programs out of necessity, but regardless of legislative priorities, making it the central goal is a mistake. The goal should, instead, be reproductive autonomy.

Shannon, a white reproductive health advocate who had worked within the state health system, similarly pointed to the potential for the cost savings goal to take precedence over patient autonomy. Attending specifically to this concern in the realm of LARC policy, she explained:

> I think it is a fuzzy line between saving money [and more problematic terrain], not just because we're in a conservative state with a lot of fiscal conservatives, but also because, you know… I think it *is* important for public agencies to be really good stewards of public dollars. But it's also not our place either, as a healthcare payer or as the government, to be making those individual choices for women.

While pointing out—as many participants did—that there is an imperative for the state government to "be really good stewards of public dollars," she identified a "fuzzy line" across which the government has taken individual choice away from women. That metaphor captured the way many participants described the space dividing the two. Shannon was particularly eloquent and thoughtful about this point, and she spoke from an especially

knowledgeable location inside the state system. As a result, I was especially interested in her assessment of where that line was located.

A few minutes later in the same interview, I asked, "Where does it start to shade [from fiscal responsibility to making individual choices for women]? You know, like where does it shift over?" Shannon replied:

> Yeah, that's a really interesting question. I don't know that I really thought through that much, to be honest. I kind of—where those—where you kind of get to the… Yeah, it is a blurry line. It's not like you just, all of a sudden one day [say], like, "Well, let's just like, you know, stop them all from having babies."

Her hesitation in this answer was notable. After beginning three different sentences that seemed to be attempts to answer it ("I kind of—where those—where you kind of get to the, like"), she reverted to her original assessment: that of a "blurry line." Even with her expertise, Shannon could not identify a precise place where a reasonable attention to budgetary concerns became an infringement on patients' reproductive autonomy. Her inability to do so highlights just how conceptually blurry the line between the two is seen to be. That it is so, rather than defined in bright red ink, raises the question of how exactly an advocate or state agency staffer might know when they cross it.

Other interviewees also noted their uncertainty about precisely where that line was, or whether or not it had yet been crossed. David, the white reproductive rights advocate quoted above, also gestured toward this point. He elaborated on where, precisely, he saw the possible danger:

> What is really the concern [about the cost-savings argument] is that, in an attempt to make access to good contraception available, and LARC available, then you incentivize its use such that the clinicians' incentives are aligned to force LARC on their patients. […] That's the real fear, right? […] I suspect we're not there yet [in Texas' state-funded programs]. But that's how that happens, is that you […] start to align incentives and it—and you can see the roots of it, right? And talking about saving money, right? And it's like, "Oh, well, we'll reimburse you more for any

> family planning visit that ends up with LARC insertion." Right? And then you align […] the incentives so that if *we* [the state] save money here, then *you'll* [the provider] make more money and then look, we saved money. Then you make the money and then… with no concern for the woman on the other end of the health care.

In this excerpt, David spoke specifically about one way the state and other funders have drawn on the cost savings potential of LARC as a way to make it more available to residents: increasing reimbursement rates for LARC provision, such that medical providers receive a higher payment for providing a long-acting reversible contraceptive method than they do other types of contraception. This practice is common and, in many ways, practical. Long-acting reversible contraceptive devices cost dramatically more than other types of contraception, and their insertion is more time consuming than prescribing other methods. If they were not reimbursed at higher rates, smaller providers especially would be hard pressed to prescribe them. Yet as David explained, there is a clear danger in this process—it aligns the cost savings to the state with cost savings to the medical provider, explicitly *not* aligning either with the needs and wants of the client. This approach, he suggested, opens the possibility that a client might be prescribed LARC for reasons other than their own preference.

This concern is particularly important because, as described more fully in previous chapters, only a subset of Texans, disproportionately the most marginalized among them, access their reproductive healthcare through state-funded programs. Emily, a white reproductive health advocate, spoke directly to this point. When I asked her what the general attitude seemed to be toward LARC in Texas, she replied,

> Surprisingly so, Texas has been pretty progressive on this issue. I think that it started from a place of cost savings. […] My end goal is that every woman in Texas who wants a LARC can get a LARC. […] The focus has really been on Medicaid women [as opposed to commercially insured, higher-income women, though], and I have concerns around that, because I don't want this to be population control, I don't want

> this to be about less poor brown babies. And I think for many of us working on this that is *not* the aim, but I think that there can be… the optics can—not be great sometimes. And when you talk about some of this stuff in a cost savings term, we have to think about *how* we're saving those costs, and it's essentially through averted births, and if you're only doing this in Medicaid, it can be problematic.

Emily, in this part of the interview, explained that while her own focus is on LARC access for anybody who wants one, much of the focus in the state more broadly has been on access for low-income women specifically. Connecting this focus to the cost-savings roots of LARC access initiatives, and identifying it as a concern, she suggested that the cost-savings frame implicitly poses averting Medicaid births as a state goal. In this way, Emily here traced the logic of how the cost-savings argument can lead to eugenics thinking and in fact, to population control.

The second type of concern advocates raised about the cost-savings argument was about the consequences for the reproductive health, reproductive rights, and reproductive justice movements more broadly. One effect, they suggested, was that making cost savings a key tenet of state-funded healthcare programs could make it more difficult to preserve funding for, or expand those programs to include, other kinds of services. Angie, a reproductive health and reproductive rights advocate, noted: "If cost is your only driver, then you're going to be in programs where they're not funding STD testing, [where] they're not funding the cancer screenings." When I raised this question with Rob (Caucasian), a longtime reproductive health advocate, he agreed. I asked about the potential for adding fertility support services to publicly funded reproductive health programs, and he replied: "You're avoiding pregnancy [through these programs], you're not *encouraging* pregnancy. Yeah. I haven't even thought about that, but I don't see how the state funding [for] access to those sorts of services, would even get on the radar."

To some extent, these concerns overlap with the patient autonomy concerns described above—note specifically Rob's straightforward explanation that these programs are designed to "avoid" pregnancy—but they also gesture toward a separate issue. Although certainly the programs do include services that cost the state heavily, with cost savings as a key motivator for funding reproductive health programs, medical services that represent a cost to the state are much harder to justify than those that save money. This tension has particularly important ramifications for medical services that fit under the umbrella of reproductive justice, where some of the most expensive services relate to *becoming* pregnant. As noted in my conversation with Rob, services such as these would struggle to "even get on the radar," revealing that emphasizing the cost savings of preventing pregnancy in this way makes the right to become pregnant more elusive for the lowest-income Texans.

Two participants spoke particularly passionately, and at length, about the related consequences of the cost-savings argument for future movement building efforts. They worked for the same reproductive rights organization, an organization that was, at the time of research, particularly oriented to long-term movement building. The organization that employs them does not use the cost-savings argument at all, in any capacity. They both identified important risks of this argument for their movement-building efforts specifically, including its failure to attract or retain movement participants. David, a white reproductive rights advocate with long experience in this field, explained a second concern:

> A big talking point from family planning advocates for a long time has been [that roughly] every dollar you put into family planning saves 14 [dollars], seven [dollars], whatever the number is. […] It's been baked into how we talk about this program because of who, because of the population they serve. Right? And it's an unfortunate shorthand for the realization that perhaps the counterparts [in the state government] don't give a shit about women's health, don't really care about healthy spacing of pregnancies. Right? That they have other interests in mind. So, it's an attempt to address what their *perceived* interests are to garner their support for the programs. It's

> a short-sighted tactical message to try to get people on board, and not a long thinking [about] what's really our values around providing Texans access to quality family planning. (emphasis added)

Identifying the low-income residents served by family planning programs as a reason the cost-savings argument has been "baked into how we talk about" it, David specifically emphasized that recipients of this message truly care about neither women's health nor cost savings ("perceived interests"). He also identified it as a short-sighted strategy, a message echoed in my interview with Amanda, an advocate of color at the same organization.

I asked Amanda, who has experience at reproductive health, reproductive rights, and reproductive justice organizations, about why some other organizations use the cost-savings argument for LARC. She said: "I think it's an effective argument, they think, to getting policies passed immediately. I don't think it will be in the long run [though]." I probed this point a bit, interested because so many other participants identify the only benefit of the cost-savings argument to be its efficacy. When I asked if she considered the argument to be effective or necessary in the short term, albeit ineffective in the long term, she replied,

> I don't think it's necessary in the short term. We think it is because things get bad, but what we're starting to realize is things get even worse if we just put these quick fixes on things. […] So, I feel like no, the quick fix isn't worth it either.

Moving here from naming this argument as ineffective in both the long and the short term, Amanda identified that it also has the potential to make "things"—which, in context, connoted the state's legislative and administrative barriers to reproductive rights and justice—worse than they already are. She saw this as a key risk to the movements posed by using this argument, and as a further reason to refrain from using it in her advocacy. Amanda's perspective illuminates that she and other advocates who decline to use this

argument do so not only out of a commitment to their ideals, but out of a longer view of efficaciousness.

Cost/Benefit Analysis: "Do the Ends Justify the Means?"

Nearly every person I spoke with in the reproductive policy advocacy ecology of Texas had made an active or passive decision about whether or not, and how, to use the cost-savings argument for increasing access to LARC in their state-level advocacy. While for some, their employing organization had a stated position and an explicit or implicit requirement that they either use it or avoid it, others weighed the relative costs and benefits alone, either as the heads of their respective organizations or as the most senior advocacy employee on staff. In my interviews, three broad categories of answers to this calculus emerged. First, as discussed above, some people firmly rejected the cost-savings argument as a tool in their work. Second, some people used the argument but wrestled, often profoundly, with its implications and possible consequences. Third, some people categorically embraced the argument for its potential, despite the associated risks. Throughout this section, I draw only on interviews where the conversation reached this level of explicit discussion of the argument.

Leslie, an African American reproductive justice advocate, explained that she does not see a cost-savings argument as valuable because she does not believe it goes to the heart of what legislators are truly invested in: "[In our legislative advocacy,] we have to stop feeding what we see [on the surface] and start really engaging in conversations about what's really happening underneath." Amanda, a woman of color with experience in reproductive health, reproductive rights, and reproductive justice, also landed clearly on the side of rejecting the cost-savings argument:

> [My organization] does not use that tactic because we come from a values-based position. […] We don't use the cost effectiveness [argument] because it doesn't reflect our values and it also doesn't move people to be on our side, so it's not worth that sacrifice.

Both of these advocates, along with some others, had made a clear decision not to use this argument in their advocacy. Others, however, wrestled with it substantially more.

Lisa, a Hispanic reproductive rights advocate, exemplified the kind of out-loud thinking many participants shared with me as they considered whether the cost-savings argument was worth using despite the possible racist and classist motivations it tapped into on the part of legislators. As many did, she put it in terms of weighing the ends and the means: "Is it okay, that the ends justify the means? Is that okay? Because it's helping women? [very doubtfully] Maybe? It's better than nothing? Yeah, it's… That's a tough struggle." She spoke sadly and quietly, and although her organization does use a cost-savings frame, she did not arrive at a conclusion in the course of the interview about whether the ends do indeed justify the means for her. The way she framed the tension, and her repeated use of a questioning tone, were similar to many other participants. Another aspect this excerpt shared with others was Lisa's emphasis on the provision of some reproductive health services, no matter questionably funded, as better than none. This theme emerged again and again in my Texas data, and echoed through descriptions by reproductive health, reproductive rights, and reproductive justice advocates as "taking any scraps we can," or working "with our backs pressed against the wall."

Heather, a Caucasian reproductive rights advocate who throughout our interview was thoughtful and reflective about her role as a white person in this ecology, raised several concerns about the cost-savings argument. She particularly struggled with what she saw as

the racism in the Legislature. When I asked about the possible effects of what she considered to be the motivations of the legislators funding these programs, she wondered aloud:

> Can bad intentions produce good outcomes? I think sometimes. And it's good, women are getting access to reproductive healthcare that they want as a result of this, and that's good. At the same time, I wonder if it doesn't kind of poison the well and contribute to a culture of racism within the state and within America. […] Hopefully the women are interfacing with clinicians who have done a good job of starting to try and overcome their own racial biases, […] but we do know that sometimes women of color feel pressured into contraceptive methods. The clinician might assume that they need this long-term method, whether or not they want it. […] So, there is definitely a lot more to unpack, especially through a lens of anti-racism, and also nationalism.

Following Heather's thought process here is instructive because she moved through several stages of reasoning in this short excerpt, shifting from a positive assessment of women "getting access to reproductive healthcare they want" to concern about broader effects on racism in the United States. She also connected rhetoric to clinical practice, explaining that while she hopes women do not face contraceptive coercion from medical providers, she knows they sometimes do. Immediately following this statement, I asked how she handles that tension and those concerns in her job. She answered:

> I think about it a *lot*. And I occasionally feel some distrust around it. I try and talk to a lot of the folks who are doing really good anti-racism work, and having the conversations with them I find helpful—not for feeling better about it but just for keeping it more present in my mind.

While Heather reported using the cost-savings argument when necessary in her advocacy, she clearly struggled with the implications of this approach, making a point of trying to keep anti-racism active in her thinking about her work. Indeed, she was the source of the first quote that opens this chapter, about incorporating anti-racism into her work, and spoke repeatedly about its importance.

While Lisa and Heather exemplify those participants who wrestle with the risks and rewards of using this argument, a third category of participant resoundingly declared that

while they may not feel comfortable with the implications of a cost-savings argument, they were very confident in their decision to achieve policy goals by doing or saying what was necessary. In an interview with Rob, a Caucasian reproductive health advocate, I shared an example of a legislative staffer applauding state reproductive healthcare programs as a means to reduce the birthrate among undocumented immigrants. When I asked how an advocate should handle that kind of situation, he replied, "You don't say anything. You just smile and nod... Because nothing good will come of it. […] All you can do is, you know... Just let it be and move on." A few minutes later, he expanded:

> No one's pristine in this [advocacy work]. I mean, it's a matter of what your goal is and how do you achieve that goal. And sometimes you do things or you say things that maybe you wish you didn't have to, but if you want to achieve that goal—I mean, that's just the way that the process tends to work.

Adding to his point that pushing back on racism in a legislator's office is ineffectual, he explained that advocacy is inherently about tradeoffs—so much so that nobody remains "pristine." The two points together, that resisting that racism neither would accomplish anything nor is fundamentally in line with his expectations about the work, echoed frequently across my interviews in Texas.

Emily, a white reproductive health advocate in Texas, used very similar language to describe these tradeoffs, refuting the idea of any "cleanliness" in this profession. A reproductive rights advocate with tremendous passion for her work, she emphatically declared:

> It's hard, but you know, you have to pass bills, you have to—I mean, it's not clean. [laughs] It's really not. And you've got to figure out—for me, at the end of the day, every decision I make is about a woman in the [Rio Grande] Valley getting access to care. […] Everything else falls away for me when I think about that, when I know that there is a woman who will not be able to get care if those [clinic] doors close. So, [… w]hose hand do I have to shake, whose table do I have to sit at, what hard

> decision do I have to make today? Because, I mean, that's really—that's where we're at. I mean… It's a hard state to navigate women's health.

Lifting keeping medical provider doors open as her goal above all others, in this quote Emily proclaimed her willingness to go to any lengths to achieve that goal. Throughout the course of the interview, moreover, she repeatedly emphasized that legislative racism and classism, while despicable, could be filtered through ethical funding agencies and clinicians to protect Texans from its impact. This confidence helped shape her view of the cost-savings argument as well worth deploying to keep clinic doors open. Indeed, she has been exceptionally effective at this goal. She exemplifies the perspective of those who see legislative motivations as simply background—concerning and contemptable, but not as profoundly influential or dangerous.

Conclusion

In our conversations, advocates in Texas raised many concerns about the cost-savings argument as a "crop" planted in their advocacy field. Despite those concerns, and despite the argument's implication in reproductive responsibilization, nearly every advocate I spoke with in Texas had used it at some point in the work. Many continued to do so. The reasons for this varied, from seeing it as effective in the short-term to seeing it as the only option. Feeling some level of concern about it, however, held constant almost to a person. Alongside my own analysis of the potential dangers of tapping into eugenics rhetoric among legislators through the dog-whistle of a cost-savings argument for LARC, I argue these concerns signal deeper concerns about the broader process at work, reproductive responsibilization. Yet we need not look far to find a starting point for developing a different approach. In the same interviews in which they raised these concerns, almost every one of my participants shared some snippet,

or more, of an idea regarding “how we can do it better.” In the concluding chapter to this project, I draw on these diverse and thoughtful ideas, combining their expertise with my own analysis to propose a shift away from advocacy that draws on reproductive responsibilization and toward what I term sustainable advocacy.

Conclusion: Sustainable Advocacy

> *We're in this place, honestly, like so many movements in our time, of figuring out how we reconcile the old with the new. So, the old-school way of talking about [contraception] was very "Republican moderate-friendly," because that was the legislature we had. […] Now, the reproductive rights movement is […] in a place that is much more either centered around or in the lens of reproductive justice and understanding the terrible impact that a lot of reproductive rights efforts have had particularly on women of color and marginalized communities and on poor communities. And so, figuring out in a political sense, how do we advance to talk about this with members who are Republican-leaning or moderate-leaning or conservative Democrat? And they do respond more positively, favorably, to a financial message that really [is] at its core just that poor people should not be having babies. Versus the reproductive justice part, which is, everybody has a right to decide if and when and how they have children and raise those children in a safe, healthy environment. So, I don't have a good answer, there's no perfect way to do it. […] People are just… figuring it out.*
>
> ~Monica; Latino; Texas reproductive rights advocate

Heading for a public meeting of reproductive healthcare advocates in Texas one summer during data collection for this project, I parked my car in downtown Austin, walking through the blistering heat and into the hushed chill of an air-conditioned office building lobby.[29] Entering an enormous conference room and collecting a printed agenda from a table by the door, I glanced around. Lining the tables that were arranged in a square in the center of the room were representatives from some of the largest and some of the smallest reproductive healthcare clinics in the state, lobbyists from influential medical professional organizations, advocates with several non-profit organizations, a few researchers, and a range of other stakeholders from across the state, most dressed in a recognizable business casual

[29] To preserve the anonymity of those attending public meetings, this description represents an amalgamation of multiple meetings.

style. Most of those present were white women, with women of color scattered among them; only one or two attendees were men. Notably absent were representatives from the range of reproductive justice organizations in the state, along with those from any "abortion-forward" organizations. This semi-annual gathering, with the aim of updating interested parties about the current status of work toward expanding reproductive health access in Texas, was open to the public but typically attended only by those both "in the know" and drawn to a relatively moderate approach to reproductive policy advocacy. The energy in the room was friendly and attentive, as people chatted with friends and acquaintances and networked with those new to the group, picked up lunch from the spread along one wall, and skimmed the agenda for the day. As the clock inched toward the top of the hour the group quieted, settled into their seats, and turned their attention to the women at the front of the room, who opened the meeting with warm greetings and gratitude for the interest and commitment of those gathered.

After a round of introductions around the tables, the meeting facilitators shared a brief update on reproductive health advocacy efforts at the Capitol. This update included a few recent bumps in the road of expanding access to LARC, such as the relatively low rate of LARC uptake in the state's publicly funded reproductive health programs and the need for more funding for LARC in the state budget. Afterward, the facilitators opened the floor to the assembled crowed, and those gathered shared an assortment of reactions and concerns. As the air conditioning hummed somewhere far above us, one person explained that medical providers were so poorly reimbursed for long-acting reversible contraceptive devices and insertions that they struggled to provide them, her voice ringing through the room while the woman to her left emphatically nodded in agreement. Another attendee questioned the state

agency's official statistics estimating the number of residents enrolled in each state reproductive health program, arguing there was dramatic unmet demand for long-acting reversible contraceptive devices in rural areas along the Mexican border, while a third shared her concern that LARC was not being properly understood as a means to prevent maternal mortality. Finally, a fourth asked for updated numbers on the cost of unintended pregnancy to the state, double checking that these updates had been incorporated into organizations' LARC advocacy materials. As the conversation unfolded some of those listening took careful notes, while others nodded along, already familiar with each point. Passersby dressed in everything from power suits to street clothes moved past the enormous windows separating the sidewalk from the conference room. A few curiously peered into the cavernous room where others debated the very shape of the healthcare programs designed to serve them.

At one level, this story is unremarkable. In rooms just like this one all over the country, advocates and other stakeholders—primarily middle- or upper-income, white, formally educated cisgender women—chart a course to what they see as better healthcare policy for low-income residents. Each person present that day would likely have expressed their enthusiasm for reproductive health access and professed a passion for individual people's right to choose their own contraceptive method. Without the work of the people in that room, further, the state's reproductive healthcare options would doubtless be dramatically narrower and public programs would be substantially less well-funded. Yet the lenses of Black feminist theory, stratified reproduction, and responsibilization—and the rest of the data gathered for this project—cast into sharp relief important contours of this story that might otherwise go unmarked. Building on these bodies of research and theory and in

accord with reproductive justice advocates and scholars, I argue this scene is best understood as one small part of the *reproductive responsibilization* of marginalized people.

Theoretical Contribution

Black feminist theory, and specifically the frameworks of intersectionality and reproductive justice, illuminate the interrelation of systems of power and domination in the meeting described above. While the range of structures that connect in relation to these events is vast, four rise above as relevant in the context of this research. Gender, class, race, and immigration—and their mutual influence—all shape both the backdrop to and the implications of the exchanges at this meeting. Of these, gender is most commonly understood to be relevant to a discussion of contraceptive access, in that sex and gender structure individuals' reproductive self-determination and experiences of reproduction itself. Yet the other three structures intersect with and shape how gender operates in this setting. Without a clear understanding of these connections, the full picture of contraceptive policy—or even one meeting of advocates on a summer afternoon in Texas—cannot be understood.

First, income and class define the population under consideration when the topic is publicly funded reproductive healthcare programs. Eligibility for such programs is defined through income level, making the latter core to understanding the former. While each advocate I spoke with in this project clearly supported increased LARC access for all state residents, in practice their attention was typically quite narrowly focused on the poorest among them. This narrowing stems in part from the fact that public policy most directly shapes publicly funded programs—those that cover low-income residents—and in part from the fact that the poorest residents are typically least able to access any healthcare, including contraception. While these reasons are far from nefarious, if attention to how class intersects

with gender elides attention, the question of precisely whose unintended pregnancies are being prevented through increased contraceptive access goes unasked.

The nominally race-blind approach to the question of LARC access and maternal mortality likewise belies the fact that the maternal mortality crisis is profoundly raced. In the United States, Black cisgender women are two to three times more likely than white cisgender women to die during childbirth (Centers for Disease Control and Prevention 2020). Finally, immigration status—while implied by reference to women "along the border"—is not directly named in the conversation described here, but nonetheless dramatically shapes both who has access to and how people experience reproductive healthcare services, including long-acting reversible contraception. More broadly, of course, class, race, immigration, and gender are closely intertwined, including through the employment and wealth structures in the United States and the racialized feminization of poverty.

Each of these aspects shapes how the other aspects operate both in healthcare systems and in the rooms where advocates debate legislative priorities and hammer out advocacy strategies, including by directly influencing who is "in the room where it happens" (Miranda 2016). As just one example, the specter of the welfare mother, a controlling image of Black women used to justify the limitation of Black reproduction (Collins 2009), haunts these conversations in references to the cost of public services. So too does the long history of efforts to control the "leaky" border with Mexico, across which the likewise "leaky" bodies of immigrant women are understood to move (Chavez 2008). When these intersections are unmarked, however, their influence is not only invisible but heightened. Reproductive justice advocates have long made these arguments, posing that gender-based domination cannot be understood without attention to its intersections with other structures of power (Beal 1970;

Combahee River Collective 1977; Hull et al. 1982; Luna 2020; Moraga and Anzaldúa 1977; SisterSong Women of Color Reproductive Justice Collective 2020). Yet reproductive health and reproductive rights advocates have often engaged with each of these aspects individually or with only two at once—as in efforts to improve access to contraception "for low-income women." These dynamics play out under the surface of discussions about LARC policy, and affect advocates' perceptions of good or bad policy, of who policies should be designed for, and of which contraceptive methods are best or worst in any given situation.

Theories of stratified reproduction (Colen 1986), including more recent applications of this approach to a wide range of social settings (Flavin 2009; Gutiérrez 2008; Roberts 2002; Solinger 2001), emphasize that some people's reproduction is valued more highly than others. Scholars have connected this body of theory with Black feminist work to draw out the ways LARC is implicated in histories of eugenics and, more broadly, the positioning of some pregnancies as responsible and some as burdensome (see, e.g., Gomez et al. 2014, 2018; Mann and Grzanka 2018; Roberts 1997; Takeshita 2012). Through stratified reproduction, actors including state employees, medical providers, and public health officials present marginalized people's pregnancies as unduly expensive and logistically complicated to the state, implicitly (or at times directly) raising the question of whether that "undue burden" should be minimized. Against this backdrop, the status of long-acting reversible contraceptive methods as particularly "imposable" contraceptive technologies (Clarke 2000) is especially meaningful—not least because it has often been targeted at marginalized people in particular (Frost et al. 2016). Bringing this body of work to bear on LARC policy formation reveals the central role stratified reproduction plays in creating and continuing to influence public policy in reproductive healthcare.

Responsibilization theory provides one additional useful angle from which to understand the events of the meeting that opens this chapter. Responsibilization, originally theorized in the field of criminology, is the process by which the state shifts criminogenic responsibility from the state onto community organizations and, in turn, individual citizens (Garland 1997; Cruikshank 1999). More recently, however, it has been further developed to apply to other social settings, including the welfare system (Myers 2013). Broadly speaking, this theory proposes that as the state renders individual people and organizations accountable for work the state has historically done, state power expands even as it becomes more diffuse. Applying this lens to reproduction and situating it alongside Black feminist theory and theories of stratified reproduction, I argue, reveals a new arena in which responsibilization operates: reproductive healthcare policy. This lens brings into focus the fact that the state government has transferred responsibility for maintaining a healthy population and a healthy state budget onto individual citizens, a process unfolding quietly underneath, behind, and surrounding the otherwise unremarkable events that open this chapter.

Synthesizing and drawing from the collective knowledge in the fifty-five interviews I conducted and the websites I analyzed, and building on the literature described above, I identify the processes at work in the meeting that begins the chapter as part of *reproductive responsibilization*. In this process, as described in Chapter 4, the state responsibilizes marginalized women, charging them with helping the state meet its fiscal goals by contracepting. Many advocates in both Texas and California have drawn on a cost-saving argument for increasing access to LARC, which I argue (often unwittingly) contributes to this process of reproductive responsibilization. LARC advocacy seems likely, though, to be

only one of many sites of reproductive responsibilization. Future research could fruitfully explore other areas of reproductive health advocacy, services, and policy in which it may operate, such as abortion policy, prenatal care, and fertility support. In arenas such as these, just as in LARC policy, governments hold (marginalized) individuals accountable for work previously assigned to the state *and* find them too irresponsible to do so independently. These points of tension, where responsibilization collides with reproductive controlling images, may serve as particularly rich areas of inquiry for future work drawing on this framework.

I interviewed very few people in either Texas or California, however, who believed leaning so heavily on reproductive responsibilization was the best path forward. Rather, advocates often expressed serious reservations about the arguments that comprise it, and conveyed ideas about how to avoid it or to minimize its negative effect. These points were particularly prominent and eloquently expressed in interviews with representatives of reproductive justice organizations. Reproductive justice advocates have long argued that their counterparts in reproductive health and reproductive rights movements take too short a view of history and endanger broader reproductive justice goals through their advocacy and organizing decisions (see, e.g., Silliman et al. 2004). I also heard these concerns and ideas about how to handle them differently, though, from people working for organizations across the spectrum of reproductive health and reproductive rights organizing. Building on those experiences and testimonies, I propose a new orientation to reproductive policy advocacy, which I term sustainable advocacy.

Drawing on theories of sustainable agriculture, sustainable advocacy takes a much longer view of organizing for access to reproductive healthcare. Turning away from an

emphasis on shorter-term approaches—such as relying primarily on advocacy strategies that "leach nutrients from the soil"—it attends instead to investing in the long-term health of the metaphorical "fields." As I describe further below, however, this approach need not focus exclusively on what happens within the bounds of advocacy fields. Instead, sustainable advocacy is capacious enough to address much larger questions. These might include not only refraining from planting crops that leach nutrients from the soil, but also asking where such seeds come from and whom they benefit; not only irrigating crops that rebuild the soil but also looking upstream, to see who works the fields and rivers from which that water was diverted—and who owns the springs themselves. This approach to advocacy is not only longer in view but broader in scope than current approaches. I argue it carries the potential to produce a rich harvest for those in need today while also providing for generations to come.

Mapping the Way Forward

Across my interviews with advocates and other stakeholders in the reproductive health, reproductive rights, and reproductive justice movements in Texas and California, several specific aspects of what I came to understand as sustainable advocacy surfaced repeatedly. While some of them related specifically to avoiding or minimizing the harmful effects of the cost-savings argument for LARC, many were broader and more generally oriented to making these movements as successful as possible at meeting their goals and staying true to their ethics both in the long and short term. In this section, I briefly overview those that came up most frequently. At the broadest level, the ideas that emerged from the interviews can be grouped into these categories: building broad, communicative, honest coalitions; centering patients and patient communities; adjusting the use of the cost-savings argument and other potentially harmful arguments to minimize their damage; proactively

addressing the potential fallout of these arguments; and working on broader "culture changes" alongside working toward specific policy goals. I conclude the section with my own impression of how best to move forward.

In both states in which I conducted research, the importance of coalition work among organizations was a thread that ran through many interviews. Much as farmers benefit from collaborating across property lines to buy seed or rent equipment together, advocates reap great rewards for working in concert. In coalition, they are better able to coordinate messaging and strategy, and to resolve tensions before they boil over. In California, for instance, the existing coalition among reproductive justice, reproductive rights, and reproductive health organizations has been critical to achieving policy aims while collaborating across movements and across major differences in political orientation. Its long history and steadfast relationships make it particularly effective. In Texas, the division between coalitions—some focused strictly on reproductive health, others on abortion-forward advocacy, still others on reproductive justice—has hindered cross-movement collaboration.

The particular proposed details of such "cross-farm" collaboration varied across interviews. Typically, the particulars included an emphasis on ensuring that everybody is at the table and heard, including grassroots groups and reproductive justice organizations and people to the far left, *before* conflict or tensions arise. Several people in both Texas and California emphasized that building these relationships of trust before they are desperately needed is critical. One benefit to this approach is that with regular coalition-based communication, organizations and advocates can coordinate messaging. Not all organizations need to carry the same message; rather, many participants explained, a "different messages from different messengers" approach may be most successful. However, these messages

must be coordinated carefully, with mutual respect and space for critical feedback. Importantly, from some reproductive justice advocates in particular I heard an emphasis on reproductive health and reproductive rights organizations "staying in their own lanes," collaborating with reproductive justice organizations without trying to *become* reproductive justice organizations or seeking to lead the charge on issues reproductive justice organizations have worked on for years.

Second, I repeatedly heard the importance of centering patient experiences and voices. Like farmers attending more to market forces than to the people they feed, many people in both states noticed a pattern of "losing their way" when too much emphasis was placed on medical provider needs or legislative concerns, rather than patients and other community members. Participants often prioritized making space "at the table" for patients to share their own concerns, working especially closely with grassroots collaborations, working to change the evaluation metrics of state-funded programs to measure what patients value rather than what the state values, and intentionally engaging people about what they need to safely build the families they want. While these recommendations run the gamut from changes in coalition work to changes in lobbying work, they all revolve around the importance of keeping reproductive health, reproductive rights, and reproductive justice advocacy firmly rooted in the needs of the ultimate constituents of each interviewee organization: the individual state residents who are served by state-funded reproductive health services, and their communities.

The first two of these recommendations attend to movement dynamics, paralleling interactions among farmers or between farmers and others. The third and fourth, in contrast, concentrate on which metaphorical "crops" advocates should "plant" and how to plant them.

For instance, over and over again, participants considered how precisely the cost-savings argument could be used with as little damage done as possible. Many people concluded that it is too detrimental to the "soil" to use at all. Many others, however, thought it could be used if an effort was made to mitigate its potential to do harm. These ideas, which closely track sustainable agricultural approaches like mixed intercropping or sequential cultivation, involve "planting" the crop in relatively safe ways. One means to do so might be using it as just one small part of the pitch for reproductive health services. An advocate might pair it with other arguments, use it last in a string of arguments that primarily focus on reproductive autonomy, de-emphasize it, or contextualize it in the broader argument for reproductive justice. Like mixed intercropping, these approaches might mitigate the harm of the cost-savings argument. Roughly mirroring agricultural techniques like sequential cultivation or relay cropping, participants also often mentioned some form of "staged" advocacy. In this type of approach, an advocate might begin with the arguments that most appealed to a given legislator—"meeting them where they are," for instance, with a cost-savings argument. Then slowly, over time, the advocate could work in another "crop," seeking to slowly convince the legislator that reproductive justice is a more important reason to fund reproductive healthcare.

An additional idea advocates raised for the future was orienting to the possible danger represented by cost-savings arguments, to be as proactive as possible in addressing those possibilities. These ideas largely revolved around being more honest about the potential unintended consequences of a cost-savings approach, rather than hoping they could be prevented by not addressing them head on. For instance, several people mentioned the potential power of having explicit conversations within the movements about the

implications of this approach, to "call out" what is happening and why. Others mentioned the need to continuously ask whether advocates have identified the correct line between what is necessary and what is right, to be able to adapt quickly and nimbly if they determine they have not. Relatedly, many noted that preparation is key: preparing for unintended policy outcomes, preparing for tense conversations, and coming to both outcomes with ideas for solutions rather than simple critiques. On a more directly policy-relevant note, one person suggested tying funding for LARC to funding for contracting with reproductive justice organizations to present anti-bias trainings or other trainings, so the two would always be paired. Others described the importance of teaching legislators about reproductive injustices associated with particular reproductive health services alongside advocating for their funding as part of reproductive justice for all. Each of these approaches involves being realistic about the effect of planting "crops" that may damage the soil.

Finally, among reproductive justice and reproductive rights advocates in particular, I heard a clear emphasis on looking beyond direct legislative advocacy work—or the "field" in question—when seeking to build a roadmap forward for reproductive health, reproductive rights, and reproductive justice movements. Some people advocated for educating community members, those who become "the casualties" of poorly designed (or malicious) policy, on the possible effect of various policies on them and on their communities, so they can advocate more effectively for themselves. Others placed great priority on changing culture, not simply contraceptive policy. In other words, rather than merely trying to influence legislators to include more funding for reproductive healthcare, these advocates and the organizations that employ them were invested in changing hearts and minds across Texas and California, from members of the press to members of the public. They saw this approach

as having the potential to move some state legislators left, to replace those who would not move, and to place greater pressure on the legislature in general from the outside than any one, ten, or fifty organizations could level alone.

In addition to these ideas, which emerged from my interviews, I propose one more. In both Texas and California, but especially in the former, I see a clear need for a movements-wide strategic planning effort. Farming collaboratives periodically reorient and become more effective by undergoing strategic planning, during which they establish long-term priorities, assess their current efforts toward those goals, and adjust as necessary. In much the same way, the reproductive justice, reproductive rights, and reproductive health movements in each state I examined would benefit from such a process. Of course, such an undertaking would require a great deal of preliminary work to establish relationships among organizations and build trust, particularly in Texas but also in California. It would need to be undertaken slowly, working from small joint projects to slightly larger ones, before a larger conversation could launch about priorities, strategies, and metrics of success. Yet it became very clear over the course of fifty-five interviews that many people in these movements are, at the moment, speaking past one another. Rectifying this problem, in part by clearing channels of communication to be able to look to the future together, ought to be one of these movements' very first priorities. As Texas moves slowly but steadily leftward on the political spectrum and as progressive advocates continue to gain power in California, these strategies have great potential: to yield short- and long-term crops, but also to improve not only the field itself but the broader landscape.

Research Overview

In this project, I have explored how reproductive policy advocates make the case for increasing state investment in long-acting reversible contraception in Texas and California. Specifically, I have considered the role of the cost-savings argument for LARC in light of these methods' historical and contemporary implication in raced and classed domination. I find that the cost-savings argument operates as part of what I theorize as *reproductive responsibilization*, a process by which the burden of state-level fiscal responsibility is shifted from the state government onto marginalized women and specifically onto their reproductive decision-making. In this process, I theorize, low-income people, and particularly low-income women of color and immigrant women, are expected to "be responsible" by "choosing" to contracept using long-acting methods, in order to balance the state budget. Knitting together an examination of the structural conditions in which advocates operate (the "soil"), the advocates themselves (the "farmers"), the advocacy strategies and arguments they deploy (the "planting"), and the effect of those strategies and arguments (the "harvest"), I argue that the cost-savings argument is a dangerous crop to plant, with the capacity to leach nutrients from the ecology of reproductive policy and services. In its stead, my interviews suggest—and I conclude—advocates should move toward a more sustainable advocacy.

In the first substantive chapter, I considered the metaphorical fields the advocates work—the structural settings that surround them. These conditions both provide context for understanding the data I present in later chapters and help illuminate why particular advocates have chosen a given approach to their work. Through the comparison between the structures in place in Texas and California, moreover, I showed that while there are important differences between the two states, their similarities are many and influential. The states both have a mix of rural, conservative areas and urban, progressive areas; they each border

Mexico and, as a result, economically rely on the flow of laborers and commercial products in each direction. They also share the struggle to deliver reproductive health services to enormous populations with dramatic differences of income, access to education, and distance to a medical provider, stretching both states' health delivery systems to the very limit. Critically, advocates in each state also report that fiscal conservativism is a central value at the state legislature, as a consistent concern in Texas and a recurring, cyclical issue in California, depending on the state's economic wellbeing in a given year. Set against the backdrop of these similarities, the political affiliations of the states' powerholders are even clearer. The particular combination of shared and distinct structural conditions means that advocates in Texas experience different professional paths and choices than do those in California, but with more overlap than is immediately apparent.

In Chapter 2, I turned to the question of who, precisely, is advocating on the topic of long-acting reversible contraception in the two states. These "farmers" in the reproductive policy advocacy ecology inherit the structural conditions described above (the land on which they farm), and within those constraints, make a series of decisions about how to cultivate the land and which crops they believe should take priority over others. In both states, the advocates I interviewed were predominantly women who report a great passion for progressive issues. Those in Texas, however, professed a more specific drive to work on issues of reproductive policy than did their counterparts in California. They also experienced a higher rate of turnover from job to job, including a relatively high number of current advocates who previously worked inside the state government. This factor may be both a drawback—in that turnover means inefficiency—and a benefit—as it also means a constant influx of fresh energy and prior expertise. In California, in contrast, advocates reported

staying in one job for long stretches, enabling the building of long-term relationships of trust within and across organizations. In combination with the structural conditions described above, these characteristics of the team of "farmers" in each state help explain the "planting" decisions they make.

In the third chapter, I explored these decisions, asking how reproductive policy advocates in Texas and California make the case for investing in low-income residents' access to LARC to state legislators. I find that in Texas, the arguments fall into three broad categories: the efficacy with which long-acting reversible contraceptive methods prevent pregnancy; the cost savings those prevented pregnancies represent for the state; and the improved health outcomes, for mothers and babies, associated with the pregnancies that do go forward. In California, I find two collections of arguments: the cost-savings argument, as in Texas, and what is often called "the social justice argument," which draws on the non-medical benefits of LARC use or access for the individual contraceptor. The variation in arguments within each state was wide, and the overlap between the two states was substantial. I focus particularly in this chapter on the overlapping cost-savings argument, arguing that it, along with many of the other arguments, rests on the incorrect assumption that preventing pregnancies among low-income state residents is an uncomplicated policy and human rights "win." As I conclude in this chapter, further, advocates themselves have many questions and concerns about this approach.

In Chapter 4, I take up the advocates' concerns about the possible effects of the cost-savings argument. Attending specifically to the raced and classed implications advocates noted, I argue that the cost-savings argument is part of what I theorize as *reproductive responsibilization*. I trace how its logic unfolds, from placing a high price tag on the

reproduction of low-income women to framing them as capable of achieving fiscal health for the state as a whole through their contraception, and finally to placing that responsibility on their shoulders or, perhaps more accurately, on their wombs. In the second half of the chapter, I explore how reproductive responsibilization happens in Texas, taking the state as a case study because these dynamics were particularly active there during the time of data collection. I analyze advocates' perceptions of state legislators' values and motivations for funding LARC access. I conclude by discussing the possible dangers they see and the work they do to navigate those dangers, or to forestall them from coming to pass.

As I have traced throughout this project and as I argue here, advocates' individual choices matter. They have the potential to change how legislators perceive marginalized people's reproduction, to influence policy, and to shape the very state programs that deliver reproductive healthcare to low-income state residents. For these reasons, I suggest that movements and individual advocates should choose the strategies and arguments they use carefully and in coordination with one another as much as possible. Yet the processes that I describe in this project unfold not in a vacuum but in a broader structural context that both enables and constrains their choices. As the individual actors I interviewed choose courses of action by weighing their agency against the bureaucracies they face, they are surrounded by structures of domination. In this context as in any other, there is no "pure" choice to be made, no path that will guarantee an outcome entirely consistent with one's deeply held beliefs.

This project is not intended, then, as an indictment of any individual who is seeking to balance competing priorities and tensions in often profoundly difficult circumstances. I conclude, rather, with a call to action amplifying the same imperatives I heard from participant after participant—to establish and maintain clear lines of communication within

and across movements, to coordinate to the extent possible toward the goals every participant in these movements shares, and to commit to staying agile and humble enough to make small adjustments along the way, before bigger ones become necessary.

The people I interviewed for this study have shouldered an immense burden. They carry the weight of protecting and expanding access to reproductive healthcare, a tall order in either California or Texas. Advocates frequently must choose among bad options, often with very little time to consider the choices. The decisions are weighty: reproductive health services in Texas and California change the lives of thousands of residents each year, and particularly in Texas, such services are deeply precarious. Reproductive policy advocates' work is correspondingly both difficult and imperative. Pressed for time and bandwidth, advocates often find it difficult to step back and take stock of their own concerns about the decisions they make or to map a new way forward, much less to do so collectively. Yet in nearly every interview conducted for this study, I heard advocates share a deep desire to begin these conversations. With the immense privilege of the time and space necessary to place these voices alongside one another in this research, I argue that these conversations are the crucial first step toward a more sustainable advocacy.

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Appendices

Appendix A: Methodology

This appendix includes methodological details not addressed in the main body of this document. In designing this study, I elected to interview policy advocates rather than other populations such as medical providers, legislators, or the clients who utilize public health programs. While these other populations also have important perspectives on the question of reproductive healthcare, I was especially interested in how reproductive health policy is created. In this, I followed the finger pointed by public health program clients and medical providers, who have shared concerns about how these programs are shaped in their legislative testimony and elsewhere. While other scholars have delved into different aspects of what we might understand as the broader "culture of LARC coercion," I focus here on an often difficult-to-reach population to which I had particular access: advocates.

Policy advocacy is field rich with theoretically generative tensions. Collecting this type of data, however, often presents a methodological puzzle, in part because of subject nonresponse (see, e.g., de Figueiredo and Richter 2014). As a previous director of policy and advocacy for the Texas Women's Healthcare Coalition, I benefited from extensive prior knowledge about the field of LARC advocacy at the state level, including training in the complex systems of service delivery, a professional network among reproductive health, reproductive rights, and reproductive justice advocates in Texas who in turn connected me to contacts in California, and a line on my resume that attested to my commitment to access to reproductive healthcare. This experience, along with my position as a doctoral candidate in the University of California system, no doubt influenced my ability to access the interview data in both states in this study.

As a first step toward scheduling interviews, I typically requested just 15 minutes of potential participants' time for a phone call, for the purposes of sharing some information about my project and determining if they would be interested in scheduling an interview. These conversations built rapport with interlocutors and enabled me to share information about my project. This approach additionally had the benefit of being a very minimal imposition on their time. At the end of these phone calls, I typically asked if they would be interested in scheduling a full interview; the vast majority said yes. While this two-step approach was not always possible due to scheduling constraints or potential participants' willingness, I attempted to follow it whenever possible. I noticed that in interviews that built on an earlier conversation, the data were richer, and my voice took up less time in the transcript—not least because it reduced pressure on me to help them understand who I am.

The COVID-19 pandemic and resulting change from in-person to video or phone interviews had some effects on data collection. First, many interviewees commented that as a result of coronavirus they had busier schedules than usual. This outcome may reflect the fact that many people I sought to interview are employed in the public health sector and therefore experienced some changes to their portfolios when the pandemic began. Notably, though, several interviewees emphasized in our conversations that by April 2020 (four to six weeks after many stay-at-home orders began), they were grateful for the opportunity to discuss public health matters that were unrelated to coronavirus. They appeared particularly enthusiastic about discussing long-acting reversible contraception. Additionally, some public health professionals experienced a decrease in their workloads at the beginning of COVID-19, because their organizations pivoted to address the pandemic rather than issues related specifically to the interviewees' portfolios. Finally, I note that phone and video interviews

are less personal than face-to-face conversations. It was more difficult to build rapport in these interviews, and some people may have disclosed less to me than they would have chosen to do in an in-person interview.

I offered all interviewees the option of anonymity. Many asked to remain anonymous, while others did not state a strong preference. The fields of reproductive policy advocacy in Texas and California are relatively small and insular, meaning that identifying some interviewees necessarily limits the anonymity of the others, by process of elimination. Therefore, I have generally anonymized my respondents by identifying them and the organizations for which they work only in general terms as necessary to contextualize their statements. However, I have not altered information about their race or other key demographics, the primary goals of the organizations for which they work, or the geographic regions where they are located due to the importance of this information to understanding the study's findings.

The quoted interview excerpts in this study have been lightly edited for length and clarity. This process included omitting speakers' hesitation noises (e.g., "um"), filler words (e.g., "you know," "like"), repeated words, and my own quiet noises of comprehension (e.g., "mhm"), except when doing so would have changed the analytic import of the quotes.

The documents published online by interview organizations and analyzed for this study inform my broader analysis. For each organization, I used Google to locate the organization's main website. I opened all individual web pages related to policy, advocacy, organizational work, history, mission, or values, or related topics. I then downloaded all documents describing the organization itself, along with any policy documents that referenced contraception, and coded them in the qualitative coding software Dedoose. For

most organizations, I analyzed between two and ten documents, with particular attention to how the organizations presented their work and its relationship to contraception advocacy or LARC advocacy. By means of this deep reading of relatively few documents for each organization, I explored the ideological patterns at work in and below the words themselves. I drew on this analysis as background to and context for the interview data presented in this study.

Appendix B: Long-Acting Reversible Contraception Statement of Principles

In 2016, SisterSong: National Women of Color Reproductive Justice Collective and the National Women's Health Network collaborated to draft a document titled "Long-Acting Reversible Contraception Statement of Principles." The document, which has been signed by many influential organizations and individuals in the arena of reproductive health, reproductive rights, and reproductive justice, is an important part of the landscape of LARC advocacy. It is available at this link.

Appendix C: Publicly Funded Reproductive Health Care Programs in Texas

In 2021, researchers with the Texas Policy Evaluation Project released a research brief detailing the recent history of publicly funded reproductive healthcare programming for low-income Texans. The brief, titled "Publicly Funded Reproductive Health Care Programs for People with Low Incomes in Texas, 2011-2021," provides useful background information to the data included in this study. It is available at this link.