

PUBLICLY FUNDED FAMILY PLANNING IN NEW YORK STATE:
SOCIAL LINEAGE, QUALITATIVE INTERVIEWS, AND HUMAN RIGHTS

A Thesis

Presented to the Faculty of the Graduate School
of Cornell University

In Partial Fulfillment of the Requirements for the Degree of
Master of Science

by

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August 2009

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ABSTRACT

The current state of publicly funded family planning (FP) in New York State has been shaped by a history of diverse women's needs, the efforts of charismatic individuals and successful social movements, the development of agencies, and most recently, negotiated legislation, funding and policy changes on federal and state levels. In this study, FP advocates and providers are interviewed about their work in order to discern their meaning frames. Goffman's frame analysis is referred to, as it has been elaborated by Benford, Snow and others in social movement scholarship. This research introduces an analytical device called a social lineage. The Margaret Sanger lineage triangulates with interview narratives involving inclusion of diverse women in FP access and decision making and the recognition of reproductive and sexual health as human rights. Interview questions focused on the changes and subsequent impacts in the last 10-15 years of FP related policy. Two dominant themes in the interviewees' answers are identified: a commitment to provide services to diverse and marginalized groups of women and families, and concern over ideological barriers to service and information provision.

BIOGRAPHICAL SKETCH

Emme Edmunds received a B.S. from the State University of New York at Albany where she studied Anthropology, Fine Art and Biology. She moved to Ithaca and received a M.A. in Anthropology from Cornell University. While working and raising her son, Avery, she received an RN degree from Tompkins Cortland Community College. She later earned a M.S. in midwifery from the State University of New York at Stony Brook, and has since assisted at home births. Emme has worked as a midwife and women's health nurse practitioner in family planning for 10 years. In addition, she and Avery founded and ran a summer Shakespeare troupe in Ithaca for 10 years.

This thesis is dedicated to my mother,
Nancy Irving Edmunds,
who loved blue herons and was my true friend.

ACKNOWLEDGMENTS

It has been a continued blessing to have several inspiring mentors in my life. In particular, I would like to thank Art Willis, Bernd Lambert, Linda Schutt, Lauren Faessler and Tony Cotraccia for embodying clarity and kindness over many years. I aspire to be such a friend and mentor to others in turn.

I am very grateful to the colleagues I have worked alongside as a health care provider, as well as the colleagues I have found at Cornell University.

They make the work lighter and the breaks more enjoyable.

In this academic endeavor and career change, I am grateful to have the opportunity to work with my advisors, Lindy Williams, and Alaka Basu. I admire their pedagogy and scholarship, and I trust and appreciate their guidance.

I give special thanks to my son, Avery, who teaches me about love and family.

I give gratitude to the source of life and to the lineages of gentle people.

May my efforts benefit all beings and families.

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LIST OF ABBREVIATIONS

AFDC	Aid to Families with Dependent children, Federal program known as welfare
BC	Birth Control
CEDAW	UN Convention on the Elimination of All Forms of Discrimination against Women
CRC	UN Convention for the Rights of the Child
FP	family planning
FPBP	Family Planning Benefit Program, a NYS Medicaid expansion program
FPEP	Family Planning Extension Program, a NYS Medicaid extension program
GWHRM	Global Women's Health and Rights Movement
HLP	Healthy Living Partnership program
ICPD	International Convention on Population and Development, Cairo, 1994
IRB	Internal Review Board
MCH	Maternal Child Health – a federal block grant
MLP	Mid-Level (health care) Provider
PRWORA	Public Responsibility and Work Restoration Act, the legislation that ended welfare
SCHIP	State Child Health Program, funded by federal block grants
SSBC	Social Services, a federal block grant
TANF	Temporary Assistance to Needy Families, a federal block grant
UDHR	Universal Declaration of Human Rights
UN	United Nations

CHAPTER 1 INTRODUCTION AND THEORETICAL APPROACH

In Albany, the capital of New York, the legislature has come back into session to work on the late budget. It is August 2008, and budget cuts are everywhere. In the marble hallway, a huddle of women stands with clipboards and large handbags around the chairman of the Health Services Committee as they look at the latest budget line by line. They point at his printouts, speak in hushed voices and take hurried notes. One hundred fifty miles away, two 20-something girls bend over the clipboards in their laps, murmuring to each other and filling out applications for free family planning services in the busy waiting room of a clinic in an economically depressed city in upstate New York. One holds a baby who reaches for a pink and yellow pacifier, which has fallen and rests on the edge of a chair. They giggle at each other when a teenage boy brushes by them, bee-lining toward the exit with a small bag of condoms. How and why did all these people come to be huddled over clipboards, trying to make their way in a system in order to give and receive help to best make important private decisions which will affect their lives and those of the subsequent generations?

Scholars and historians who work in areas regarding reproductive health frequently assert that women and men have used contraceptive methods with the intention of trying to control their fertility since before recorded history (Himes 1936; Riddle 1997). In the current era, the myriad methods, the successful industries producing and providing contraceptive medications and technologies, and the high utilization of family planning health services all indicate a robust present day demand for the means which allow women and families to control the timing and spacing of childbearing.

In the United States, as elsewhere, policy affecting publicly funded family planning agencies is constantly changing. Due to the involvement of individuals and social movements and to the enactment of legislation and policy, its history is one of sudden, large changes and years of refinements and reversals nested within a pattern of incremental growth. This may be an indication of the controversial nature of the subject as it is socially framed by competing groups.

In this study, the following research questions are addressed: What are the frameworks which providers and advocates use to ascribe meaning to their roles and work with policies affecting publicly funded family planning (FP) in New York State? How do they feel current policies help or hinder the provision of family planning services? How do they as actors use these meanings in the shaping and administering of policy? Further, is there evidence of a persistence of a frame(s) when comparing the narratives supplied by current actors to biographies and narratives about central historical actors from the turn of the century?

Frame Analysis

Framing refers to the social construction of social phenomena by individuals, social movements and organizations. In his 1974 work *Frame Analysis: An Essay on the Organization of Experience*, Erving Goffman broke ground on a conceptual model that has gained increasing explanatory significance within constructivism and social movement theory. He describes frames, or primary frameworks as

varying in degree of organization from neatly presentable as a system of entities, postulates and rules; others...appear to have no articulated shape, providing a lore of understanding, an approach or a perspective. Whatever the degree of organization however, each primary framework allows its user to locate, perceive, identify and label a seemingly infinite number of concrete occurrences defined in its terms (Goffman 1974: 21).

Frame analysis is closely related to constructivism as both work with subjective ideas as described above. Eager (2004) defines constructivism as a discursive process which

...focuses on understanding how intersubjective agreement is reached by both state and non-state actors regarding appropriate forms of behavior. Constructivists in general often study ideas, interests, norms and identity puzzles (Eager 2004).

The concept of framing was later greatly expanded by theorists and researchers interested in social movements, such as David Snow, Robert Benford, Myrna Marx Ferre and Rhys Williams. Their works have mined and developed framing theory for useful concepts in order to better understand the growth and trajectories of social movements and social change, along with theories of political opportunity processes and resource mobilization. In their 1986 paper, Snow, Rochford, Worden and Benford develop the concept of frames as composed of several interactional and ongoing constructive processes. They also identify several factors, which account for the variability of success of a social movement's frame, including "the degree of resonance with the current life situation and experience of the potential constituents"(477).

In later work, Benford and Snow (2000) provide an overview of how framing processes have been used in social movements, where they develop into collective action frames. One of the variable features they attribute to collective action frames they call

"Flexibility and Ridgidity, Inclusivity and Exclusivity: Collective action frames may vary in the degree to which they are relatively rigid, inelastic and restricted or relatively inclusive, open, elastic and elaborated in terms of the number of themes or ideas they incorporate and articulate. Hypothetically, the more inclusive and flexible collective action frames are, the more likely they are to evolve into "master frames"(Benford & Snow 2000:618).

They define master frames as a subset collective action frames that are larger in scope and which can function as “a kind of master algorithm that colors and constrains the orientations and activities of other movements” (618).

Benford and Snow (2000) further develop the variable feature, *Resonance*, which they had originally identified to in the 1986 paper. The degree of resonance and thereby the success of a frame relies on its credibility, salience and narrative fidelity. As they put it, credibility means “the apparent fit between the framings and events in the world” (620). Salience means both that a frame is central to people’s lives and “congruent with [their] personal, everyday experiences” (621). In addition they assert that resonance is also dependent on narrative fidelity, which means that framings correspond to cultural stories, myths and ideologies. They assert that frames with greater resonance are more likely to mobilize people and to contribute to successful social movements and change.

There are precedents for the use of meaning frames regarding reproductive health issues. Dawn McCaffery and Jennifer Keys explore how feminist organizations and their conservative opposition use frame alignment processes around issues regarding abortion in social movements and counter-movements. In their 2000 article, “Competitive Framing Processes in the Abortion Debate: Polarization-vilification, Frame saving and Frame debunking”, they look at newsletters published by the National Organization for Women (NOW) to identify strategies in which framing processes are used to mobilize action by interested citizens and lawmakers.

In addition, and more central to the theme of this paper, framing theory is employed as one part of a processual model of normative change by Paige Eager in her 2004 book, *Global Population Policy: From Population Control to Reproductive Rights*. In this work, she refers to human rights as a “meta norm complex” in which reproductive rights are embedded (23). I believe this clearly corresponds to Benford’s

and Snow's "master frame" mentioned above. Human rights as a complex becomes a master frame which is larger in scope and which strongly influences other movements and frames.

In this paper, I will use framing theory in several ways: first, to construct an analytical device/explanatory concept based on narratives from the biographies of two persistently influential historical figures, Margaret Sanger and Anthony Comstock. I will employ this device against a backdrop of constructed human rights, and peer-reviewed research on the scope, functions and roles of publicly funded family planning policy and practice. Secondly, I will examine the frames that emerge out of semi-structured interviews I held with twelve FP advocates and providers working in New York State conducted in the fall and winter of 2008. I will then compare the emerging frames with each other to look for trends and information.

The plan for this paper proceeds as follows: In chapter two, I will examine and introduce themes and frames from the biographies of Sanger and Comstock as an example of a type of ethno-historical analytical device called a social lineage. In chapter three, I will review a brief history of the construction of, and contention around, human rights and reproductive rights. I will summarize recent policy regarding publicly funded family planning in the United States and New York in chapter four. In chapter five, I will discuss interview methods and researcher positionality. Then in chapter six, I will search for trends in the frames and meanings found in interviews of providers and advocates who currently shape, provide and implement family planning and sex education in New York State. In chapter seven, I will propose that the competing social lineages of Sanger and Comstock may serve to triangulate with the semi-structured interviews as well as with current policy trends, as well as pointing out an important difficulty of this social dialog. I will close in chapter

eight with the intention of providing insight about the frames in relation to human rights, which may be useful in future dialogues and planning.

CHAPTER 2

AN EMERGING DEVICETHE INTRODUCTION TO SOCIAL LINEAGES

The shape of current policies in family planning is the result of a complex interplay of individuals motivated by frameworks of meaning, who then confront and interact with structures which have been enacted and manifested earlier. In this process, individuals form collaborations, communities and social movements with shared and competing frameworks of meaning and goals.

In this thesis, I will argue that many of the current structures affecting family planning policy in the United States can be traced to the actions of and the communities surrounding two prominent actors with very different strategies and agendas: Anthony Comstock and Margaret Sanger. Anthony Comstock (1844-1915) doggedly opposed all forms of contraception and abortion as well as information pertaining to either by pressing for legislation that meted out imprisonment and fines to transgressors. Legislation that he designed and had passed managed to hold up open discussion and distribution of FP devices and literature through the early 1960's (Tone 1997, Tone 2001, D'Emilio & Freedman 1988).

Margaret Sanger (1879-1966) fought to provide information and access to (primarily) contraception, which she dubbed "birth control", eventually helping to establish FP clinics in the United States and world wide(Tone 2001, Chesler 1992). While examining the lasting effects of their works and legacies, I have identified patterns and continuities much like biological lineages, only these were social frameworks of meaning. Looking through the lens of what I call these "social lineages" as a sort of analytical device, Comstock and Sanger can be seen as providing foundational biographies to these socially opposing frames, which have each had profound effects upon US FP policy. Their descendants retain much of the founding

frameworks of meaning, but with changes resulting from exposure to new influences. The lineages of Comstock and Sanger have outlasted their own founders' lives by many decades, and have gone on to shape and inspire others to carry on and adapt key ideas in the contentious debate over family planning.

Anthony Comstock

Born March 7th, 1844, Anthony Comstock grew up on a farm in Connecticut as the devout son of wealthy and very religious Christian parents. After serving in the Civil War, he moved to New York City and was alarmed to find a booming, and very public, sex-trade with thriving auxiliary businesses in pornography and sex-based entertainment. The presence of a flourishing prostitution industry, and the large and the significant public health problem of (then untreatable) sexually transmitted diseases combined in his mind to form a powerful threat to institutions of marriage and family which he saw as the foundation of society (Tone 2001, D'Emilio & Freedman 1988). Comstock took it upon himself to intervene, intimidate and prosecute the purveyors of these dangers, and he was remarkably successful in doing so (Bremmer 1967, Tone 2001, D'Emilio & Freedman 1988).

Comstock included sex education, contraception and abortion among the moral evils threatening the safety and sanctity of the American family, thus aligning himself with many patrons and communities within Christian churches and the Young Men's Christian Association (YMCA). The YMCA had instituted an anti-obscenity crusade just after the Civil War. Comstock joined forces with them in 1872 and formed the New York Society of the Suppression of Vice (NYSSD) (D'Emilio & Freedman 1988). He was able to successfully influence Congress to pass the Comstock laws making the sale of contraceptives a punishable obscenity in 1873 (Tone 2001, D'Emilio & Freedman 1988). These laws equated the dissemination of literature regarding family limitation, sex education, or any devices used for these purposes with pornography

and obscenity. While obscenity laws had been in existence for many years, Comstock's triumph was that the 1873 act included all information and devices and medications having to do with contraception and abortion, making it the first federal legislation to deal with these subjects (Tone 1997, Bremmer 1967).

The 1873 act alone shaped and affected the development of the family planning movement and industry in the United States for almost a century. Lumping matters of contraception and sex education in with prostitution and pornography created a quagmire for those who framed these issues in a different light. People working for public health, small time manufacturers of contraceptive devices, and some private physicians, as well as many calling for social and family reform, all found themselves on the wrong side of the law (Tone 2001, D'Emilio & Freedman 1988). Comstock was able to create for himself a position as U. S. Postal inspector for the purposes of investigating and enforcing these obscenity laws. In the process, many people, otherwise not involved in "obscene activities", were arrested, convicted and sentenced to hard labor. People were jailed and lost their livelihoods, and several suicides were later attributed to the very public, vehement and intimidating persecutions of Mr. Comstock (Tone 2001, D'Emilio & Freedman 1988).

Comstock was a devout Christian, who assumed "that humans had an in-born tendency toward wrong doing which was restrained mainly by fear of the final judgement. Hence any literature that removed that fear...or awakened 'impure thoughts' struck him as a 'devil trap'" (Bremmer 1967:xxii) He felt his efforts benefited and protected vulnerable people by protecting them from the effects of their own impulsivity upon exposure to certain ideas, and it is likely that in some cases this may have been true. In his book of 1883, *Traps for the Young*, he describes lust as the companion of all other crimes, and delineates in florid religious language the people and the devices which lure children into decline, insanity and death. In a chapter

about the traps of "free love", a movement whose proponents advocated for the abolition of marriage, he wrote:

...as advocated by a few indecent creatures, calling themselves reformers- men and women of foul speech, shameless in their lives, and corrupting in their influence, we must go to a sewer that has been closed, where accumulations of filth have for years collected, to find a striking resemblance...I know of nothing more offensive to decency, or more revolting to good morals, than the class of publications issuing from this source. Science is dragged down by these advocates, and made a pretended foundation for their argument, while their foul utterances are sought to be palmed off in the public as scientific efforts to elevate mankind. With them, marriage is bondage; love is lust; celibacy is suicide; while fidelity to marriage vows is a relic of barbarism. All restraints which keep boys and girls, young men and maidens pure and chaste, which prevent our homes from being turned into voluntary brothels, are not to be tolerated by them(158).

As out-dated as the religious and incendiary language may seem today, the arbitrary authority and power which Comstock evoked and used quite successfully for many years took its toll. Bremmer writes in the 1967 editor's introduction to the reprinted 1883 *Traps for the Young*, that Comstock and agents acting on his behalf were able to arrest over 3600 men, women and children, many of whom were imprisoned (Comstock in Bremmer 1967:xi). Bremmer further writes:

...this definition of obscenity was subjective and his exercise of power arbitrary. Impiety and indecency were synonymous to him and he used epithets like 'infidel', 'free-luster' and 'abortionist's pimp' interchangeably. Whatever Comstock deemed objectionable on religious grounds became illegal, at least for the persons fined and sentenced to prison terms on the basis of his uncorroborated testimony (xvii).

In her book, *Imperiled Innocents: Anthony Comstock and Family Reproduction in Victorian America*, Nicola Beisel asserts that the moral crusades of Comstock and his supporters were deeply intertwined with efforts of powerful elites of the upper class to ensure their class and status reproduction within the larger, rapidly changing society. She argues that Comstock's fight against abortion and contraception "concerned not only relations within families, both between men and women and

between parents and their children, but also invoked the threat posed to the family by the city and its immigrants." (Beisel 1997:26) Although her claim has important implications regarding class reproduction which warrant follow-up, I was unable to find other supporting narratives within Comstock's writings or his lineage.

One sign of the power and persistence of Comstock's legacy is the definition of "Comstockery" from Merriam Webster's Collegiate Dictionary eleventh edition, 2003: "(1905) n. 1: Strict censorship of materials considered obscene 2: censorious opposition to alleged immorality (as in literature)." The original use of this term is credited to George Bernard Shaw (Bremmer 1967).

Margaret Sanger

Margaret Sanger was born as Margaret Higgins in 1879, when Anthony Comstock was 35, and grew up in Corning, New York, as the sixth child in an impoverished family of 11 children. With persistence and family support, she was able to receive part of a college education, but was not able to study medicine as she had wished, due to economic constraints (Chesler 1992). Sanger eventually became a nurse and worked in Manhattan, often providing maternity care to impoverished immigrant women in their apartments (Chesler 1992). It was during the course of her work as a nurse that she reported receiving countless requests from women and men who sought to prevent yet more pregnancies. She was "appalled by the misery of working class women who had virtually no control over their fertility and bore child after child despite grinding poverty" (D'Emilio & Freedman 1988, 232). Sanger observed that the women themselves, in seeking to better their position and rise from poverty, often asked her for help and stated that they needed to prevent further pregnancies. This experience of working with families who were profoundly affected by unwanted pregnancy, and sometimes touched by the tragedy of maternal and child death, became the major inspiration of her work to promote sex education and to

transform the conditions of women and families (Sanger 1938). She was to ask then and for the rest of her life, "How were mothers to be saved?" (Sanger 1938, 93)

It was also in the 1910's, while Sanger was working in the city, that she encountered a vibrant, international intellectual culture, partly through her socialist husband, William, which exposed her to many new social and political ideas. She formed close contacts with people who were working to see that society addressed disparities in health, income and wellbeing. Sanger and her husband attended and hosted gatherings where she interacted with other socialists and reformers, such as anarchists Emma Goldman and Alexander Berkman (Chesler 1992). Some of their discussions were influenced by ideas from earlier movements that concentrated on alternative family structures, such as advocates of free love and organizers of utopian communities, who believed that monogamous marriage was unnecessarily restrictive, and not the only form in which sexuality or family must be experienced (D'Emilio & Freedman 1988).

In her magazine *The Woman Rebel*, Sanger "had made female autonomy , including control over one's body and the right to sexual expression, the centerpiece of the magazine"(D'Emilio & Freedman 1988, 232). D'Emilio and Freedman then write:

One can hardly overestimate the importance of this emerging birth control movement. It signaled a profound shift in the sexual norms that reigned supreme in the middle classes...To advocate fertility control for women through access to contraceptive devices rather than through abstinence implied an unequivocal acceptance of female sexual expression. It weakened the link between sexual activity and procreation, altered the marriage bond, and opened the way for more extensive premarital sexual behavior among women. As birth control became more widely available and used, it also broadened the roles women might choose, as biology proved less and less to be destiny" (233)

Between 1912 and 1915, in this milieu of intellectuals and reformers, as well as in the teeming neighborhoods where women urgently sought contraceptive help and information, Sanger violated the Comstock laws by writing, publishing and

distributing pamphlets, books and newspapers with information regarding family planning and birth control. She began writing articles for *The Call*, a socialist newspaper, and a pamphlet entitled “What every girl should know” and moved on to write her own publications. These pamphlets and books would repeatedly be confiscated as violating the Comstock laws, but it wasn’t until she published a pamphlet called “Family Limitation” that she was charged under these laws, with the possibility of facing many years of imprisonment (D’Emilio & Freedman 1988).

This series of threats resulted in her taking several trips to Europe, during which she communicated with like-minded intellectuals and reformers. When in 1915, her husband, who had remained behind, was detained and imprisoned for producing a copy of “Family Limitation” for a Comstock agent, Margaret prepared to return to the US. She was prepared to face charges herself, but before she arrived, Anthony Comstock became ill and died. With his absence, the tide of social sentiment became more favorable, and the charges against the Sangers were dropped. In the next year, 1916, Sanger opened a birth control clinic (D’Emilio & Freedman 1988, Tone 1997). She then went on to an even more public career which included trips to Europe, India and Japan as she promoted her ideas about birth control and the freedom of women internationally. In between trips, she returned to the United States to work with American colleagues and politicians to refine and develop campaigns to change minds and laws and to establish clinics to serve women (Chesler 1992).

While they stand out in the history of family planning policy in the United States, neither Comstock nor Sanger acted alone. Rather they belonged to, emerged from, sought out and attracted other actors, patrons and communities who collectively contributed to the direction of family planning policy and practice. Similarly impassioned, but with very different means and different biographies, narratives and communities, Sanger and Comstock each sought to protect and save men, women, and

families. Their work and the communities to which they belonged have given shape to many of the structures which still define the conditions in which family planning is constituted and provided in the United States. Though they have changed and evolved, threads of framing and meaning persist into current issues regarding policy and funding affecting family planning. One of the most persistent and significant differences between the Comstock and Sanger approach to family planning information and materials can be articulated as a competition between two frameworks of meaning. The two competing frameworks are closely intertwined with those which today would be referred to as patriarchal fundamentalisms and secular human rights (Goldberg 2009).

Both Comstock and Sanger were attempting to save people from (sometimes tragic) consequences associated with desiring and engaging in sex. Comstock was attempting to save primarily men from the consequences of indulging their own desire, especially outside of marriage, by preventing their access to materials that would arouse their sexual desires or enable them to express their sexual appetites. These materials were then classified as obscene and illegal and their trade and possession deemed criminal and punishable. Comstock did not trust the common person to make decisions in their own (or their future family's) best interest. His approach was to protect people from their impulses and urges by criminalizing and blocking access to ideas, materials and technologies (D'Emilio & Freedman 1988). Sanger, on the other hand, was attempting to save [primarily] women from the consequences of men's sexual desire and expression, especially within marriage. She argued that what was needed was not the prevention of sexual expression, but its emancipation from mandatory reproduction (D'Emilio & Freedman 1988). This would be accomplished by providing information and technology that would prevent pregnancy and also decrease the spread of diseases.

The clash of frameworks occurred because some of the “obscene” ideas and items that Comstock banned in order to protect people were the very same that would be necessary to provide protection for people in Sanger’s approach. Where one advocate of family health fought to ban, control, censor and prosecute, the other worked to educate, empower and legitimize. Comstock’s decision to lump information and materials necessary for contraceptive practices with sexually explicit and often violent literature and visual media may seem confusing. Both of our historical figures and their surrounding supportive communities were, by their own accounts, working for the health of the family.

The question then arises, what else might Comstock and Sanger have been trying to do that made their methods so divergent and contradictory? Here it is necessary to envision the type of power balance in the family and society which Comstock was so desperate to preserve and that Sanger was eager to change. By decoupling reproduction and sex, information and access to contraception represents and enables one of the most profound shifts in gender politics in human history. The now expanded repertoire of sexual and reproductive options has affected employment, standards of living and education levels. Arguably, women have become more autonomous, better able to pursue careers, and to provide for (often) fewer children, and experience the leisure necessary for other life pursuits. The intellectuals of Sanger’s time sensed these possibilities and wrote about them. Historians and social scientists since have chronicled them (Tone 2001, D’Emilio & Freedman 1988). However, from the vantage of his own framework, Comstock was right to be alarmed. It appears that he greatly loathed and feared that which he thought heralded the complete breakdown of family hierarchies (Beisel 1997). He expended significant energy to prosecuting and intimidating these agents of change, one by one, until he died.

Most of the fears which haunted Comstock have not been realized. As we approach the 100- year anniversaries of Comstock's death and the first beleaguered birth control clinics, the vast majority of families of every constitution succor their children with care and attention, young adults make vows of marriage, and relatives come together to care for sick and elderly members. Despite the sea change the mass production and provision of contraception has wrought in the lives of people, families that care for and nurture one another persist. The legalization of contraception and its broad availability were important changes among a host of other changes over the last century. Alongside the heterosexual, one-woman-one-man, male-led families, other families aspire to live safely and openly, to provide what they can to the sustenance of their members and to contribute to their communities.

It is not new that charismatic and influential people in history often come to be associated with a series of ideas. In some cases, the strength and persistence with which such figures serve to embody social meaning frames deserves special notice. The legacies of Sanger and Comstock appear to have attracted colleagues and movements which have since generated new, *related* ideas actions, and behaviors. Because these movements, organizations and individuals retain important meaning frames while simultaneously adapting to newer social challenges and structures, I refer to them as "social lineages". Figures such as Comstock and Sanger may be denoted as "founders", even though they may not have begun the entire framing project that they have come to characterize or represent. These social lineages provide social constructions, which enable us to recognize how the lives and contributions of individuals in history can provide useful devices or structures for thinking about agency and life narratives in the social construction of frames and norms. Founders complement or enrich a meaning frame with narratives from and about their lived biographies.

Once I had identified the influence of the group opposing FP, or the Comstock lineage, on the meaning frames of my interviewees, the Sanger lineage, I realized that one possible social science approach could be to interview members of the Comstock lineage as well. However, my current project is to remain focused on the Sanger lineage, and to interview providers and advocates of FP as the present day inheritors of the lineage. My purpose was to listen closely to members of the Sanger lineage to discern if there is something useful in their own meaning frames that could be helpful to policy makers or the public. In other words, I wanted to know if there were important themes that emerged, which could be drawn out and highlighted, and which could contribute to a deeper understanding of the work of FP providers and advocates. The existence of the two frames in an historical, oppositional relationship emerged as I conducted research in order to do qualitative interviews, and added a dimension and possible analytical device with which to triangulate the interviews and journal articles. In this context, the most significant things about the Comstock lineage and FP opponents is their effect in helping define the frames of FP providers and advocates and in influencing current policy. Therefore, I felt compelled to acknowledge and examine the history and presence of the opposing group and its influence on FP and on the meaning frames of the interviewees. Though it is not exactly parallel to my research, for a thorough, fair-minded ethnographic treatment of anti-abortion as well as pro-choice activists, which uses narratives, interviews and observation, see *Contested Lives: The Abortion Debate in an American Community* by Faye Ginsburg (1989).

In the sense that I am construing them, social lineages are framing processes that focus on narratives of founders' lives, and they must contain several elements. They are relational, oppositional, enduring, broad-ranging, involve power, and are influenced by, but not dependent upon, inheritors' knowledge of the founders. First,

social lineages develop over many decades in relation to, in conversation with, and in opposition to each other. Benford and Snow (2000) write that frame construction in social movements is a process which is discursive, strategic (goal directed) and contested. Contention is fueled by struggles regarding the power, autonomy and responsibility of individuals and social institutions. This device may be especially useful when looking at contentious oppositional processes with significant social change at stake over a period of some duration, several decades or more beyond the founders' lifetimes. Subsequent actors, movements or institutions may or may not be aware of the lives and works of their founders, but their actions will carry on and elaborate, develop and sometimes modify the frames of the lineage.

Persistence of the Comstock and Sanger Lineages over Time

Much of the public is unaware of the fact that a coalition of people of several religious denominations extends their opposition to FP beyond the Catholic position opposing birth control and abortion, and now includes opposition to most forms of birth control (Shorto 2006, Di Mauro & Joffe 2007). In his 2006 article in the *New York Times Magazine* called "The War on Contraception", Russell Shorto writes about how this coalition of FP opponents has been gaining ground over the last few decades. He quotes Cynthia Dailard, a researcher at the Guttmacher Institute:

Increasingly, they have moved to attack and denigrate contraception. For those of us who work in the public health field and respect longstanding public health principles- that condoms reduce STD's, that contraception is the best way to help people avoid unintended pregnancy- it's extremely disheartening to think we may be set back decades (51).

An important thread, which I have already alluded to, and which remains visible throughout the history of the Sanger social lineage, is the awareness of disparities and inequalities among different socio-economic groups and racial and

ethnic groups. The Sanger lineage began with a concern for immigrant women, often in impoverished conditions. Much later, public funding for family planning commenced as the result of both a concern for improving the life chances of economically disadvantaged people, and as a way to augment the efforts to decrease welfare rolls (Dailard & Gold 2000).

The Comstock lineage did not take into account the different realities of families from different social, economic, racial or ethnic backgrounds. In his *Traps for the Young*, he consistently writes about the risks to the purity of American purity and youth (Bremmer 1967). Through the Comstock lineage lens, it was invisible or irrelevant when women had to work to support their families, and that unplanned childbearing could often be a difficult or dangerous burden, especially for the poor. For the Comstock lineage, the family was more idealized and universal, and Comstock was more likely to attribute problems to the temptations and vice which would disrupt its structure or contaminate it. For Comstock, sexuality out of the context of marriage and reproduction was unacceptable and dangerous (Comstock 1883, Beisel 1997). To him, the family appeared to be a pure, inviolable construct for all groups of people, and to fall short of this ideal was to be contaminated. As in the resurgence of religious fundamentalist thought, roles of women and men in families are likely to be essentialized around reproductive biology, and seen as more given and fixed. In *Contested Lives*, Ginsberg (1989) writes of some members of the pro-life movement:

Abortion is thus a condensed symbol for the devaluation of motherhood and the central attribute assigned to it in this culture- the self sacrificing nurturance of dependents. Abortion represents in addition a threat to social guarantees that a woman with children will be supported by the child's father. It is seen as undermining an important cultural code that links sex with reproduction and male support of families. In this conflict, then, one sees a struggle taking place over the meaning attached to reproduction and its place in American culture(7).

On the other hand, Sanger witnessed various constitutions of family during her work with immigrants and low-income families. Flexibility of roles enabled women and men of different communities and backgrounds to marshal their resources and increase their life chances. Women and babies in the tenements where Sanger worked sometimes died from the complications of childbirth in the context of poverty and poor nutrition. Sanger spoke and wrote of many women who begged her for FP information and services which they could not find (Sanger 1938, Chesler 1992). For these families it was a matter of survival to be able to determine the timing or occurrence of their pregnancies, even when pregnancy occurred within the context of socially sanctified unions. Through her work, Sanger became aware of and concerned for the lives and well-being of people from a diversity of family types, classes and races. Eventually, she was to travel the world and expand her awareness and ideas even further into international arenas. Sanger then returned back home with a broader perspective, which further helped to bring the needs, lives and voices of diverse families out of invisibility and into a social conversation which involved and served them (Sanger 1938, Chesler 1992). This process is articulated in Benford and Snow (2000) as the variable features of flexibility, inclusivity and resonance which may account for some of the success and perseverance of the Sanger lineage. The frames which she and her lineage inheritors acted from were informed by experiences and requests of a range of real women and families.

Another significant thread in the contest of these two lineages, which reflect their continued vigor to the present day, is the battle whether to allow people access to information and education about sex, contraception and abortion. Two prominent examples are the enactment of abstinence-only sex education legislation and funding from the 1990's to the present, and the Mexico City Policy (known as the global gag rule) enforced intermittently since 1984. Abstinence-only sex education began to be

funded by special federal grants during welfare reform in 1996 under a program called Title V (more on this in chapter four). In order to qualify for funding, state programs had to avoid discussing contraception except to stress its possible failures, and to sanction sexual activity only in marital relationships (Di Mauro & Joffe 2007). A subsequent congressional investigation found that many of the programs deliberately understated the preventive and contraceptive effectiveness of condoms and included other inaccuracies, omissions and misleading assertions in their curricula (Di Mauro & Joffe 2007). The Mexico City policy refers to a federal ban on provision of international (and sometimes domestic) FP funding to agencies which include referral for, or even the mention of, abortion to women seeking family planning care (see memos about the Mexico Policy in Appendix Two).

As D'Emilio and Freedman write in *Intimate Matters, a History of Sexuality in America*, there was a battle between those who wished to have open discussion of sexual matters and "moral crusaders" who wanted to criminalize the dissemination of all information about sexuality and contraception. They characterize the struggle as follows:

Was sex best regulated by expanding or restricting its public discussion? In the late 19th century, the restrictive policy advocated by Comstock triumphed in most of the battles. By the early 20th century, however, the expansive mode, supported by free lovers, suffragists, and sex educators would win the war. (157)

This was written in 1988, before passage of legislation granting millions of dollars in federal funding for abstinence only sex education, after the gag rule was initiated, but before it was revoked, reinstated, and revoked again. Perhaps in 2009, it is still too early to decide the outcome of the "war".

*It is important to note here that while the construction of the Comstock and Sanger lineages represent a useful device with which to examine the persistence of

competing social frames, they do not represent absolute or monolithic characterizations of individuals or groups. One example would be people who oppose abortion and support contraception and diverse family roles for men and women.

CHAPTER 3

CONSTRUCTING HUMAN RIGHTS

Perhaps nowhere in human history, not even when a group of theologians decided what to include and what to leave out of the Christian Bible, has there been a collective editorial process with greater stakes for human suffering and its potential alleviation/amelioration, than the ongoing process regarding the definition and ratification of human rights (Petchesky 2003, Eager 2004). After years of negotiation and debate following upon centuries of philosophy and codes of conduct, Eleanor Roosevelt and a UN commission finished drafting the *Universal Declaration of Human Rights* (UDHR), which was adopted in 1948 by the General Assembly of the United Nations. Contested by intellectuals and religious figures alike, for vastly different reasons and with vastly different intentions, it nevertheless has become the most translated and most widely disseminated document in history (Chavkin & Chesler 2005). Consensus about what constitutes human rights, and their universal attainment, remain elusive.

Though the definition and scope of human rights is contested by some groups, rights are considered universal to all people and are non-negotiable. These sections from the *Declaration's* preamble describe the responsibility of individuals and states in promoting and observing them:

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in co-operation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Now, Therefore THE GENERAL ASSEMBLY proclaims THIS UNIVERSAL DECLARATION OF HUMAN RIGHTS as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

(<http://www.un.org/en/documents/udhr/>)

The process of drafting, recognition, ratification and enforcement of human rights is a social construction project on the grandest scale, with far-reaching stakes and potential effects upon most aspects of human life. In spite of or because of this, the authority claims of the Declaration and its subsequent elaborations in the forms of conventions and covenants are often dismissed, challenged and attacked, particularly by entities who stand to lose power. Rosalind Petchesky wrote in 2003 that the struggle over the construction of human rights makes them "troublesome and irrepressible" but that they are "ultimately indispensable to movements for social change" (Petchesky 2005, 22). She writes further:

...we should think of human rights as a discursive field of power relations that operate within a domain of racialized, gendered global capital in its present form- relations that are constantly in the process of realignment and change (Petchesky 2005, 22).

Women, Rights and Power

In all of this contested terrain, in no other aspect has the contest over the authority claims of human rights been as persistent, nor the opposition as organized, as in the struggle to define women's roles regarding family and reproductive functions. Since the UDHR was drafted, there have been numerous conventions and covenants expanding the reach of human rights, most have been ratified by the United States. Yet

two in particular remain excluded. The U.S. joins only Somalia in its dissent, though every other country in the world has ratified the "Convention on the Rights of the Child" (CRC), which was adopted by the UN in 1989. Additionally, though millions of women and men throughout the country have called on the U.S. Senate to ratify the "Convention to Eliminate Discrimination against Women" (CEDAW), it remains unratified and unenforceable (<http://www.udhr.org/history>). The special distinction of these two conventions are the claims that women and adolescents have the right to reproductive health care and information (<http://www.udhr.org/history>, Miller & Schleifer, 2008). CEDAW, which was adopted by the UN in 1979, affirms women's rights to family planning information, counseling and services, and to have equality with men in the decision making power to determine the number and spacing of children (Eager 2004). These affirmations have earned the sometimes successful opposition of delegations from patriarchal religious fundamentalists from around the world (Petchesky 2003).

The drafting of the conventions extending human rights affected, were informed by, and took place simultaneously to several decades of international population conferences. Called by the UN, they began as a meeting of scientists and demographers in Rome in 1954, and subsequently met each decade, moving to Belgrade in 1965, Bucharest in 1974, and Mexico City in 1984. Over the years, the focus of the meetings became the site of increasingly contentious social dialogs about demography, population control, development and human rights issues (Eager 2004). By the Mexico City meeting, the UN was near the end of its decade for women, during which multiple meetings had assisted the growth of the global women's health and rights movement (GWHRM) (Eager 2004). However, a political move entirely oppositional to human rights as they were then being constructed by the GWHRM, won and still carries the name of the "Mexico City Policy". It was instituted when a

representative from the Reagan administration at the conference announced a withdrawal of all US aid to foreign family planning services that counseled about or provided abortions, even with their own funds (Di Mauro & Joffe 2007). (see appendix on Mexico City Policy)

By the time of the next global population conference in Cairo in 1994, both the GWHRM and the fundamentalist right had regrouped and reappeared, having worked hard to shore up their positions in the interim. This conference was called the International Conference on Population and Development (ICPD) and its success is due in part to hours and hours of work done at pre-conferences by hundreds of participants. In Cairo, demographic targets were largely discarded in pursuit of a more holistic reproductive health approach based on broadly defined human rights. Gender equality was linked with development strategies. Over 180 nations participated, and it was here that the famous Programme of Action (POA) regarding population health and development was adopted for the next 20 years. This new Programme placed emphasis

on the indissoluble relationship between population and development and focuses on meeting the needs of individuals within the framework of universally recognized human rights standards instead of merely meeting demographic goals. The adoption of this Programme marks a new phase of commitment and determination to effectively integrate population issues into socio-economic development proposals and to achieve a better quality of life for all individuals, including those of future generations. (<http://www.unfpa.org/icpd/icpd.cfm>)

This historic conference marked a convergence of feminist scholarship and work over many decades and is still viewed by many as a significant paradigm shift. Beyond the holistic approach described above, the language of the POA which came out of Cairo speaks for itself. From the section on "Reproductive Rights, [Sexual and Reproductive health] and Family Planning", it is clear that the language of rights has been embraced by the drafters of the document:

7.2. [Sexual and reproductive rights embrace certain human rights that are already recognized in various international human rights documents and in other documents reflecting international consensus.] The cornerstone of [sexual and reproductive health] rests on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, [and the right to the enjoyment of the highest attainable standard of sexual and reproductive health]. It also includes respect for [security of the person and] physical integrity of the human body as expressed in human rights documents, [and the right of couples and individuals to make decisions concerning reproduction free of discrimination, coercion and violence]. (<http://www.un.org/popin/icpd/conference/offeng/eng694.html>) (brackets theirs)

Eager (2004) writes that it was in Cairo that reproductive rights were codified into international human rights, when almost 180 governmental delegations accepted the Programme of Action.

As heralded as this conference was by the GWHRM and the international rights circuit, it did not even register in US policy. Two years later, with a change in the balance of Congress and cries for welfare reform, millions of federal dollars were diverted into abstinence-only sex education, essentially dismissing the right to FP information adolescents and high school students (Di Mauro & Joffe 2007). This would have been considered a human rights violation if the CRC or CEDAW had been ratified in the US. Even today, the United States still has not ratified either convention (<http://www.un.org/womenwatch/daw/cedaw/>).

The lack of the recognition of rights for women is not limited to their reproductive and sexual health. In a paper prepared for the Cairo conference, Rosalind Petchesky and Sonia Correa detailed “four principles of a feminist ethical perspective on reproductive and sexual rights”. They are: bodily integrity, personhood, equality and diversity. (Petchesky 2003, 8) *Bodily integrity* includes the freedom from all forms of abuses and assaults. In 1990, Charlotte Bunch wrote an article for *Human Rights Quarterly* which would supply the slogan "Women's Rights are Human Rights", saying,

Significant numbers of the world's population are routinely subject to torture, starvation, terrorism, humiliation and even murder simply because they are female...yet despite a clear record of deaths and demonstrable abuse, women's rights are not commonly classified as human rights (quoted in Chavkin & Chesler 2005, 16).

These repeated abuses of power indicate that there is more at stake than the surface view of FP and reproductive issues would indicate in the denial of human rights to women. The entire possible range of positions occupied by women in society are undermined by this violence. As Petchesky writes in *Global Prescriptions* (2003):

Foremost in the field of players contesting reproductive and sexual rights is the cluster of ideological positions and their advocates, I will call, for want of a better term, 'fundamentalist'. I take contemporary fundamentalisms to be political movements that cut across all major religions and geographical regions, though they typically use religious language and symbols as rhetorical tools...their objectives are conservative, in the sense of wanting to restore a real or imagined past against the encroachment of a real or perceived enemy. Central to this project is the restoration of a patriarchal form of family and authority, including the subordination of women to men and their confinement to traditional social roles, dress codes and norms of sexual behavior (36).

The third and fourth principles Petchesky and Correa write about are equality and diversity. They describe these as follows:

...*equality* in access to health services and all social resources, not only of women with men (gender equality) but of women with one another across lines of class race, ethnicity, age, marital status, sexual orientation, physical ability and other common social dividers; and *diversity*, or the right to be respected in one's group affinities and cultural differences in so far as these are freely chosen and women are empowered to speak on their own behalf, not subordinated to group claims of tradition(8).

Thus situated, family planning, and more broadly reproductive and sexual health are at the intersection of (at least) two main currents in recent human history. One current seeks to include all people under a (still under construction/contestation) universal umbrella of human rights, another to (re- or newly) invoke and enforce patriarchal constructions of power, gender and family. In its present form, this is a battle to define the types of legitimate family, the accepted role(s) of women, the range of accepted sexuality, and who has legitimate power and authority over whose

bodies (Petchesky 2003, Foucault 1978, Solinger 2005). Nestled within this struggle, my study has a more narrow focus, yet it must still acknowledge the greater context and high stakes for people's lives. The narratives of FP history and the voices of providers and advocates supply information about values, about the groups that deserve access to FP information and services, and about who should have autonomy over their own life decisions.

CHAPTER 4

HISTORY OF PUBLICLY FUNDED FAMILY PLANNING IN US AND NY

An exploration of recent policy reveals long-term trends as well as shorter term fluctuations in FP policy, funding and practice. Current US federal policies and programs are a significant, but not the final or only determinant of which services are offered to citizens. State, and sometimes local, governments must share the cost and responsibility for providing funding, guidelines and mandates for family planning care for their citizens. With the changing administrations in Washington, new state legislators, and pressures exerted by advocates and constituents, these changes must be viewed over periods of decades in order for observers to discern that the overall direction has been toward inclusive, comprehensive contraceptive coverage and sex education. But this is not new. In 1936, the sociologist and demographer Norman Himes wrote,

Opposition to contraception and the democratization of such knowledge never has been successful whether repression came through religion or law...There has thus been a general drift, whatever the occasional recessions, throughout history toward the acceptance of conception control (Himes 1936, reprinted 1963: 422)

In June of 1965, the US Supreme Court, in *Griswold vs Connecticut* struck down the State of Connecticut's 1879 anti-contraceptive statute, and guaranteed the right to privacy in the bedroom for married couples. This decision specifically allowed a clinic in New Haven to resume providing birth control to married women and set a national precedent (Tone 1997). In 1972, the Supreme Court extended this to include single people by "articulating freedom from government intervention in matters pertaining to sexuality and reproduction as a quintessentially individual right." (Tone 1997). The Supreme Court's famous decision on *Roe vs Wade* regarding legal access to abortion and the right to privacy came next in 1973, nearly 100 years after the Comstock Act was enacted into law.

As the tide of public opinion and legislation rolled over the Comstock laws, new research showed that low-income women wanted, and yet could not access the means of controlling their own fertility (Dailard & Gold 2000). Public subsidy of family planning agencies began in the same era. In the 1960's early programs to fight poverty and improve public health included family planning components (Gold 2001; Dailard & Gold 2000). Medicaid, which was established in 1965 by President Johnson, would eventually evolve into the largest family planning funding source, but it wasn't solely dedicated to family planning. Rather it was the enactment of Title X of the Public Health Service Act in 1970 within the federal Department of Health and Human Services which stands out as the significant milestone. It remains the first and sole federal-level program devoted to family planning. After research showed that many low- income women could not realize their family planning goals, Title X was enacted to ensure access to family planning for all Americans regardless of income, and it has since helped build and support a national network of family planning agencies. (Dailard & Gold 2000; Gold 2001; Sonfield, Alrich & Gold 2008a) Title X provides partial support in all 50 states and can be used flexibly by agencies.

The Title X program also set unprecedented standards for provision of care, which apply to all women, and has also helped reduce disparities in access with sliding fee and free access to services and supplies. Title X mandates that contraceptive and family planning services are voluntary and never coercive, are connected with other related health and screening services, including non-directive counseling, have no eligibility criteria, and can cover uninsured people. In addition to these points, the founding and implementing of the program helped establish a gold standard of confidentiality which influenced the rest of the health care complex (Gold 2001, Sonfield 2008). One of the main limitations of the program is that Title X subsidies cannot be used to pay for abortion. Providers must charge women directly and/or

develop other sources of subsidy or payment for abortion services (Gold 2001). On the other hand, there are a number of ways that Title X funding can be used that are not allowed under Medicaid, such as covering the gap between the cost of care and Medicaid reimbursements, providing new methods, diagnostic testing and educational outreach activities (Frost, Frohwirth & Purcell 2004).

Though it was introduced in 1970 by President Nixon with bipartisan support, Title X's status was subsequently compromised by severe budget cuts during the Reagan administration in the early 1980's and intermittently ever since. These cuts often reflected political charges that its subsidy of family planning access encourages teenage sexuality and compromises traditional family values (Dailard & Gold 2000). Frost, Frohwirth and Purcell (2004), write that, "since its inception Title X has faced a variety of financial and political pressures, with funding appropriations rising and falling depending on the political will of the moment." (p. 206) Even though the funding was sometimes partially restored, the coverage amount, adjusted for inflation, and the percentage share of family planning costs that Title X covers has steadily decreased. As its contribution to family planning funding decreased, other federal and state sources have been positioned to help provide funding for FP clinics and services. They have included Medicaid as the primary source, Maternal and Child Health (MCH) and Social Services (SS) federal block grants, AFDC (Aid to Families with Dependent Children) and more recently, the State Children's Health Insurance Program (SCHIP) services and TANF (Temporary Assistance to Needy Families) programs. In addition, these have been supplemented with funding from state, local and private sources (Boonstra 2002; Dailard 2000; Sonfield 2008a). These sources and some of their changes are described below.

Medicaid, (Title XIX of the Social Security Act) is an open-ended entitlement program, is mandated to fund family planning and is jointly funded on federal and

state levels. It has undergone many challenges and changes in funding since it was enacted in 1965, and it has become the largest source of family planning funding. "Open ended" entitlement means that all individuals who fall within pre-set eligibility requirements (such as an income within a certain percentage of the federal poverty level) are entitled to receive services. These eligibility requirements are fulfilled by submitting demographic, citizenship, asset and income information (Gold & Sonfield 1999). During the effort to revise and reduce "welfare" in the mid 1990's, Medicaid was altered so that it was "delinked" from AFDC, which was then changed to TANF. Assistance through TANF was not administered through an open-ended entitlement basis, and time limits for family eligibility were introduced (Boonstra & Gold 2002).

The MCH and the Social Services Block Grants (Title V and Title XX of the Social Security Act, respectively) are federal block grants that go to state agencies. These state agencies then have total discretion regarding expenditures on family planning, including whether to invest in any family planning at all, which populations will be served, and which agencies will receive funding to do so (Gold & Sonfield 1999). In their 1999 article, Gold and Sonfield found that in 1997, nearly all the states used part of their MCH block grant for family planning, but only 15 states used the Social Security Block Grant (SSBG) for such programming.

Welfare reform

In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), and instituted TANF to replace AFDC, which was the program that most people usually think of as "welfare". In the past, families determined to be eligible for AFDC also received Medicaid, which included family planning. It was then that Medicaid assistance was delinked from financial assistance for low-income families. Welfare reform was driven largely by a political and public

outcry against what some perceived to be a top-heavy welfare system that undermined traditional family values and discouraged work productivity. PRWORA also included

"broad social objectives aimed at reforming individuals' sexual behavior and restoring 'traditional family norms'. Because AFDC benefits historically had been reserved almost exclusively for single mothers, many proponents of welfare reform argued that the welfare system itself had become a powerful disincentive to marriage. However inadvertently, they argued AFDC had undermined the 'traditional' family by encouraging nonmarital childbearing among poor disproportionately minority women."(Boonstra & Gold 2002:42)

Like MCH and SS, TANF prescribes block grants that are federally funded and state administered. In addition, states are allowed to transfer some TANF monies to the SSBG (Sonfield et al. 2008a).

The SCHIP is another federally funded, state controlled program (again: State Children's Health Insurance Program). It was created in 1996, during the time of welfare reform (Dailard & Gold 2000). Some, but not all states were allowed to design their own state programs (S-SCHIP) and others continued to participate in Medicaid expansion programs (M-SCHIP) (Sonfield et al. 2008a). States were given fixed amounts of funds to use.

Medicaid-managed care programs have grown rapidly from the mid nineties through the present, enrolling more than half of all women on Medicaid. This made things more difficult for publicly funded clinics in two ways. Clients did not always know which plans would and wouldn't cover FP at clinics, and then when clients went out of network to receive care, clinics would supply it, but were then unable to get reimbursed from managed care insurers(Lindberg, Frost, Sten & Dailard 2006; Gold & Sonfield 1999).

Another significant development of the late 1990's and early 2000's during and after welfare reform was the resurrection of abstinence only sex education programming. Abstinence-only sex education condemns sexual activity before or

outside of heterosexual marriage, and refrains from teaching about contraception and safe-sex disease prevention measures other than to disparage (or sometimes misrepresent) their rates of success (Di Mauro & Joffe 2007). This is in contrast to comprehensive sex education, which includes and often encourages sexual abstinence while still providing information on contraception and disease prevention. Abstinence-only programming had previously been introduced as part of the Adolescent Family Life Act under President Reagan in the early 1980's (Miller & Schleifer 2008). In 1996, as part of PRWORA, it was born again with a funding stream and guidelines.

After George W. Bush became president in 2000, the federal government began a massive push for faith-based initiatives and created a community based abstinence-only education program which by-passed states which were found to be administering the program too flexibly (Raymond et al. 2008). Despite growing evidence and reports critiquing the effectiveness of abstinence-only education (Miller & Schleifer 2008), in 2004 the federal government increased funding for the program and moved it into the same department which was charged with promoting marriage. Requirements then became even more stringent for states to qualify for millions of the allocated federal education dollars, prompting several states to refuse the federal funding, even though for fiscal year 2008 Congress allocated more than 175 million dollars for domestic abstinence-only programs (Miller & Schleifer 2008). In 2007, New York State refused the funding (Raymond et al. 2008).

Publicly funded FP in NY

Consistent with the example above, many of the more deleterious federal funding cuts and confusing or prohibitive policies were offset in New York by the actions of legislators who worked together with FP advocates to create programs and channel funding to maintain and strengthen the publicly funded FP clinic system in the

state. Most notable is the Family Planning Benefit Program (FPBP), which is state-run and was created as an expansion of Medicaid in 2002. FPBP serves to lower the income eligibility criteria, thereby allowing more women access to free or low cost FP services.

In the face of declining Title X funds, this program has been credited by some as saving the FP clinic system in NY. However, FPBP does not provide the flexible pool of funding that Title X provided each agency for use in covering multiple costs; it is closely monitored, individually administered per client, and can only be used for certain services. The paperwork now requires each woman to register for the program, prove residency in NYS as well as US citizenship with original documents, and to declare her income (Kuhmerker 2002; Sonfield et al. 2008b). In addition, women are informed that if they choose not to enroll in the program they will still get services free of cost, so many choose not to participate in the enrollment process, and the agencies provide services without access to reimbursement. Often the only reasons women take the time to go through the enrollment process at all are either their perception that FPBP is the only way to get free services, or because they realize it will help keep the clinic open (personal experience working in field).

FPBP in New York, and similar programs in many other states, have helped finance clinics in the wake of decreases of federal funding, but they also add to a new level of bureaucratic burden. In order to get operating grants or insurance reimbursement clinics have faced a growing amount of work (Dailard & Gold 2000). Trends of increasing complexity, multiple funding sources, and increased client and clinic burdens have increased many fold since 1994, when Henshaw and Torres wrote the following:

Clinics continue to rely on a variety of public sources for financial support. This diversity reduces agencies' reliance on any one source but it adds to their administrative and grant writing burdens. Agencies say

that on average, only about 18% of their revenue comes from client fees...it means that agencies still piece together most of their support from multiple federal, state and local sources. (58)

The complexity in administrative work regarding funding sources, which are being accessed to provide for increasing uninsured and underinsured populations, has grown massively. This increase in complexity is occurring simultaneously with changes that increase or confuse requirements for identification of eligibility and changes that shift funding from largely flexible sources to less flexible sources. These trends leave clinics with fewer reimbursement options, lower funding levels and more work to obtain funding (Dailard et al. 2000; Sonfield et al. 2008a).

Publicly Funded Family Planning- Services Provided and Clients Served

The specific role of publicly funded clinics (as opposed to private, for-profit providers) has been well researched and documented. In the United States, one in four women go to publicly funded clinics for contraceptive services, and specifically, in the year 2001, "a total of 6.7 million women, including 1.9 million teenagers, received contraceptive services from publicly funded clinics." (Frost, Frohwirth & Purcell 2004:209). Public funding for family planning reached a level of approximately \$1.85 billion in fiscal year 2006 (Sonfield et al. 2008a). This level of expenditure has been estimated to help people "avoid over one million unplanned pregnancies a year and the myriad consequences that would otherwise result to themselves, their families and society at large" (Forrest JD & Samara R 1996:192). Dailard and Gold (2001:24) write that "over the last two decades women attending these [Title X funded] clinics have avoided almost 20 million pregnancies, nine million of which would have ended in abortion." They also estimate that of these pregnancies, approximately 5.5 million were to teens and that about 2 million abortions to adolescents were prevented (Dailard and Gold, 2001).

Within these numbers are other more nuanced stories, perhaps one of the most important of which involves the groups of women who are most often served by these clinics. Large scale studies and evaluations show that as well as serving middle-class women in their 20's and 30's, the clinics provide care to teens, minority women, immigrants, rural, suburban and urban low-income women, refugees, and older low-income women(Sonfield et al 2008). Dailard et al. (2000) write:

Women served by the clinic system are generally young and they overwhelmingly have very low incomes. Those who are employed often work at entry level jobs that offer no health benefits. Many are still in school or are young parents trying to make ends meet. For substantial numbers of women, a family planning clinic is their only source of health care (6).

Later they report,

Immigrants and refugees frequently have limited resources and therefore rely on publicly funded services for family planning care... As a result many clinics are making it a priority to develop the expertise necessary to reach out and provide services competently and effectively to individuals in these subgroups (36).

Thus, publicly funded FP has as a primary mission, and has been demonstrated in research to reduce disparities in access to these necessary health services.

CHAPTER 5

METHODS

Qualitative and Feminist methods

The employment of qualitative methods is appropriate in order to examine meaning frames because these frames are formed and influenced in a fluid, complex socially mediated conversation which is affected by dominant discourses. Furthermore, because these particular frames involve power, intimate family matters and gender roles, the social conversations that constitute them are very often contentious. Because the values that people hold and meanings they assign to social phenomena are the result of constructive processes, their ideological sources and outcomes are sometimes incommensurable, and their ultimate "truths" cannot be proven or disproven. They constitute forms of knowledge, which do not exist outside of people or their products, yet which have profound effects on social actions and can be engaged and apprehended in conversation.

In addition, because of the role of power and the consequences of who is wielding it for or over whom, I have used feminist methodology to inform this study and guide my choice of methods and the manner of investigation and analyzing data. This calls for methods such as conversations, interviews, and listening closely to find, apprehend and (re)construct meaning. The investigator must be willing to establish and maintain rapport and deal with contentious processes, as well as to notice and address power, autonomy, inequalities and gender roles. While feminist researchers may develop or employ abstract concepts in order to seek better understanding of the processes of socially constructed norms and policy, we are motivated by concern with the very concrete experiences of our own and others' embodied human selves. Embodiment as an experience and its meanings are only apprehended through multiple, partial, specific accounts and perspectives (Haraway 1988). The results of the

discursive process of forming concepts, norms and, eventually, policy and practice regarding family planning and fertility directly impact the lives and bodies of women, and by simple extension, those of children and men. Seeking to better understand these social processes enables us to reflect and provide useful information to the actors who participate in the ongoing conversation upon which the life chances of so many depend. As Sherryl Kleinman writes in *Feminist Fieldwork Analysis: Qualitative Research Methods Series vol. 51*(2007), "By telling us how people reproduce inequalities, feminist analyses give us ideas about how to undo or interrupt that reproduction" (111).

In feminist and constructivist ethnographic research, I am able and obligated to declare my specific positionality, and to have my subjectivity become an active and legitimate part of the research process. This addresses some of the bias concerns regarding reliability and validity of the research. In this case, disclosure is additionally useful because it provides background and context to my questions and a partial explanation of how I was able to gain entrance and rapport in order to do my research.

I have worked as a midwife and nurse practitioner in family planning for ten years and have done home birth assisting intermittently during that time. I have also worked in public health programs with low-income families, substituted as a school nurse in a public school system, and taught comprehensive sex education courses and workshops to teens and young adults for several years. I chose to return to academia in order to do research on FP policy and related social construction of meaning because I am concerned about the ongoing barriers to services and information, and felt I couldn't explore them as a health care provider in clinics or as a sex educator. This research is undertaken in the context of a career change in order that I may become as useful as possible in the service of the same goals as FP providers and advocates. My main goal is the support of all peoples' reproductive rights and justice.

I formulated the questions in this study so that I could develop a better understanding of the meaning frames of people I consider(ed) to be my peers and colleagues in family planning work. The object is for me to develop greater understanding of the reasons why they(we) engage in the work they(we) do. I undertook to listen to them in order to expand and transcend my own subjectivity, for three reasons: one, for a "reality check" on my own perspective, so my future projects would be more representative of a collective frame and have greater authority claims; two, so I can amplify, validate and communicate their voices to an interested public and to policy makers, and three; so I can provide useful feedback to the interviewees and/or the community of FP providers and advocates.

Though this study is situated in an area of controversy for some, for many it is continuing an important current of established social knowledge and practice. As a researcher, I accept the premise that universal access to broad-based family planning services and comprehensive sex education promotes beneficial social and health outcomes for citizenry. Myriad women's narratives, the testimonies of professionals and health care providers, and academic studies have sufficiently demonstrated that when women are able to access family planning information and services, they and their families are better able to avoid or overcome poverty, provide for children, achieve higher levels of education, experience greater health and enjoy higher standards of living (Gold 2001, Dailard & Gold 2000). By accepting this strong relationship between FP and well-being, I build upon these narratives, authorities and studies, as well as on my own career experience as a family planning provider.

My position and commitment no doubt greatly facilitated access to the advocates and providers I interviewed. I interviewed providers and advocates who are currently working in or with publicly funded family planning (FP) in New York State (NYS) in the last 15 years. While their work involves influencing, changing or

administering policy, they work in several capacities and are not all experts in policy matters. In these interviews, I ask how they became involved in their work and what they notice regarding policy and policy changes in order to develop understanding about how they frame the meaning of their work. I also ask about their perceptions of the meaning and sources of policy changes, who they think the current policies most affect, and what important changes they would like to see.

The snowball sample was located through networking and cold calling. I got recommendations for interviewees from my professional networks, and they in turn suggested other interviewees in other agencies and positions. The *providers* I interviewed included people who worked at point of service in publicly funded agencies: sexuality educators, and senior administrators (n= 4), and mid-level providers (MLPs) (again, n= 4) such as nurse practitioners, midwives and physician assistants. MLPs provide physical exams, health screenings, diagnoses and prescriptions for treatments or contraception as well as counseling for each service provided. The *advocates* (n=4) I interviewed worked in agencies at the interface between point of service providers, consumers of care, and legislators and the public. There are several agencies in New York and Washington DC which provide advocacy, leadership and lobbying regarding family planning. People in these positions most often had backgrounds in communications, law, medicine and higher education.

I chose semi-structured interviews as my primary method of data collection for several reasons. Interviews are widely seen as one of the best ways to discern the process of meaning making and by extension, meaning frames (Yow 2005, Kvale & Brinkmann 2009). This passage from Kvale and Brinkmann (2009), regarding features of interview knowledge, powerfully sums up my motivation for the research as well as my choice of method:

Knowledge as pragmatic. When human reality is understood as conversation and action, knowledge becomes the ability to perform effective actions. Today the legitimacy question of whether a study...leads to *true* knowledge, tends to be replaced by the pragmatic question of whether it provides *useful* knowledge...There is an insistence in pragmatism that ideas and meaning derive their legitimacy from enabling us to cope with the world in which we find ourselves (55-56). (italics mine)

Yow asserts, in *Recording Oral History*, that in-depth interviews can elucidate the way social processes change over time, and can reveal the images and symbols that people use to represent their feelings and the meanings they give to their experiences. She also states that interviews reveal "informal unwritten rules of relating to others that characterize any group" (12). This was particularly important regarding the meanings that providers and advocates hold about their work with groups of people that they serve, as well as groups who support or oppose their work.

Scope and Language

For the purpose of this study I focus my inquiry on family planning services, inclusive of sex education; on counseling regarding, and provision of, contraception; and on the diagnosis, prevention and treatment of sexually transmitted infections. While I do not focus on abortion, I affirm that it is part of the continuum of family planning in these interviews. I purposefully leave it as a part of the continuum with a pragmatic goal in mind. Access to safe, legal abortion on women's health outcomes is well supported throughout the medical, public health and social science literature, and it is seen as a necessary part of reproductive health care and reproductive rights. When brought to the foreground, the controversy surrounding abortion often confuses and obscures the urgent dialogue regarding contraceptive access and sex education. This paper focuses primarily on policy regarding the provision of sound sex education and effective, safe contraception because they are vital to increased well-being of women, children and families. In dialog with the interviewees, the provision of safe abortion came up repeatedly as part of the continuum of services. It is significant to note here

that in the Sanger lineage, providing contraception and offering sex education are widely held to be the most effective ways to decrease the incidence of abortion. This is not necessarily a view held by descendants of the Comstock lineage, some of whom oppose contraception and comprehensive sex education along with abortion (Di Mauro & Joffe 2007, Shorto 2006).

Language plays an important and complex role in family planning, as it does in any controversial social arena (Petchesky in Ginsburg & Rapp, 1995). I use and used the term “family planning” although it has a contested history. One interviewee in management and PR compassionately corrected me and said she did not use the term “family planning”, that it was old-fashioned and connected with colonial and racist notions of population control. She informed me that during the international population conference in Cairo in the 1990's (ICPD), the term had been discarded in favor of “reproductive health care”, “reproductive rights” and even more recently “sexual health care”. I assured her that I was aware of and inspired by that conference and the histories around it, and was becoming as familiar as I could with its debates and discussions. I added, however, that I was still using the term for two reasons, primarily my own history as a consumer and provider of FP services, and secondarily, my concern that FP services not be seamlessly melded with all other health care services, as important as they may be.

Validity and Reliability

My position as a researcher with a substantial work history in family planning has already been discussed. My bias includes a collegial respect and affection for, and identification with the interviewees. This is hopefully matched by my desire and ability to produce useful information regarding frameworks which may help to inform advocacy and policy, based on the data they have provided for me. The measure of usefulness can only be determined after I return to them with observations that I

developed through a combination of interviews, historical review, and literature review regarding policies and human rights. The main goal of this effort would be to promote a dialog between their everyday work and human rights. Then, if providers and advocates feel more informed about the enduring history and effect of movements they participate in, as well as the ongoing growth of the human rights dialog in which reproductive and sexual health is/can be nestled, I will have given them insight and information they can use to strengthen their practice.

I approached the process of constructing my interview guide with the thought that in order to hear providers' and advocates' meanings regarding their work, I would have to avoid explaining in too much detail what I meant. I asked the questions in an open-ended manner, so they could take the answer in whatever direction they wanted to go. Relatedly, I also felt that if I directly asked "why" interviewees worked in the field, I would likely hear the same types of things we tell ourselves every year at our staff retreats and that are published in our pamphlets, editorials and annual reports. This could be a validity problem. I wanted to avoid putting myself and my informants through this performance, and to give them the opportunity to make their own disclosures of meaning in the context of answers to specific open-ended questions which could be answered with concrete narratives. I decided to elicit answers about their employment histories, the ways they have responded to policy changes, the clients they serve and the changes they would like to see. In their replies, they were able to give me insight into their meaning frames. It is my impression that this indirect approach gave me more valid and authentic data. In keeping with pragmatism, this approach seemed to work well. As the interviews progressed, the respondents were able to express their meanings and values in the incidents, people, actions and things that they remembered and focused on.

My sample size is small (n=12). In *Interviewing for Social Scientists*, Arksey & Knight (1999) write that small samples are appropriate for preliminary work and cannot validly be used to make generalizations. In order to make valid generalizations, I would need a larger sample in which saturation is reached and repeating themes identified. However, even though preliminary, validity in the pragmatic paradigm involves values and actions which shift "emphasis in social research from primarily mapping the social world with respect to *what is* to changing the focus to *what could be*... as a means of transforming culture" (Kvale & Brinkmann 2009, 259).

The interviewees were asked to focus on policy changes within the last 15 years. This time period was chosen for several reasons. On the global level, the Cairo ICPD (International Conference On Population and Development) occurred in 1994, 15 years ago as of this writing. Additionally, it was relatively easy to find experienced interviewees who had been working in these and related policy and health areas for the last 15 years and who were still currently working. They were also asked about their career path, the clients they served and changes they would like to see.

An IRB (Internal Review Board) proposal was submitted and approved, and a consent form was reviewed, discussed and signed before each interview. I decided for the sake consistency and confidentiality that neither individuals nor agencies would be named, even though several gave explicit permission to be "on the record."

Some of the interviews were with people I had worked with for years, which were especially gratifying in some ways, but also presented unique challenges. One gratifying part was the sense, sometimes verbalized by the interviewee, that this process of asking and listening was an affirming moment in an often hectic and demanding work schedule and might possibly reach a larger or influential audience (this last part is admittedly wishful). One challenging part was that in some of those

interviews I sometimes became aware of a sense of shifting roles even in the midst of collegiality. Contrasting with a sense of ease and familiarity, an uncomfortable new sense of distance and difference emerged while in the midst of the interview. I interpreted this to be a feeling or an awareness that I was moving slightly away from our shared work in the clinic and "on the front line" in order to do another kind of work. I don't know if this was shared: it wasn't part of my project, and I didn't see the use of asking about it. I came to view it as a personal artifact and something to accept. One of the places this shift and distance seemed to emerge most prevalently, though, was when there was a question which the respondent wanted me to explain. In explaining briefly why I was being careful not to supply leading questions (for reliability and validity issues), it became clear that this was not the free exchange that we would have in most other situations. Intellectually, we all understood what was going on; it was an interview for gathering data, it wasn't a mutual dialog, but it did feel strange. While this was not a problem with the interviewees who didn't know me beforehand, it was awkward with people I had worked closely with as colleagues.

Interview Strategy

Before the interview, I let the interviewees know that I didn't want or expect them to prepare anything or have any specific information at hand or memorized. This served several purposes: it acknowledged that they were already giving me valuable time, and removed some of the stress from them in having to do yet another thing in the midst of everything else they do. I think it also piqued their curiosity. What useful data could this exercise produce? I told them I was more interested in their impressions and experiences of their work.

Before I began the interview proper, but after all the business of consent and IRB forms was done, I briefly told the interviewees a little about my background in FP, especially if they didn't already know me. I told them I was doing so because I

knew I would like to say things during the interview as in a regular conversation, but that during that time I really wanted to listen to *them*. So in the spirit of reciprocity, I told them a short, bland account of where I had worked and when and said I'd be glad to talk more if they wished when the interview was over.

I started off the interviews with two questions which allowed the interviewees to talk about themselves in the context of their jobs. I thought it would be a good idea to start with a subject that most people can feel relaxed and comfortable talking about: themselves, more specifically, their public selves. The first question was about the interviewees' roles in their agencies and the second was about how they entered into this particular line of work. This was usually a pleasant part of the interview during which we both got to know a little more about each other. For my part, I was able to learn more about them in their work context and what brought them to this point and sometimes quite a lot about their values. This gave me the opportunity to let the interviewees know my interviewing style- that this was a fairly flexible open forum with a just enough structure to keep it on topic, to be able to get through several questions, and to end on time.

The next four questions were more complex and had to do with policy. I asked first about changes in FP policy the interviewees had noticed during their work. I often had to reassure them that I wasn't concerned with exact dates or names of policies, or with a comprehensive list (which I could get from the publications about policy I had reviewed), but was more interested in the context and effects of policies. This then led into the next questions which focused on what or who they attributed the policy changes to, how the policy changes affected their work, and who (mostly what groups of people) they thought were most affected by the policy changes. I felt that these questions would provide some good data about the meaning frames held by the interviewees, because in the process of talking about concrete things they would be

able to express their values by what they chose to articulate about what they remembered, and how they spoke about it.

Then I asked interviewees what changes they would like to see and what their top priorities were. The questions differ subtly in point of view, level of subjectivity and emotional content. I asked the question "What changes would you like to see?" to invite a more personal, emotional response, and I asked the question about top priorities to elicit a more professional assessment. I wanted to give interviewees a chance to think or imagine as big (or small) as they wanted to. I realized that the previous questions about specific policy changes were asking the interviewees to tell me about the "*what is*" of their social world that they had to see and interact with. I also wanted to hear what they thought was most important, what they wanted, their vision of "*what ought to be*", and to just listen to where they went with it.

The next two questions ended up being problematic during the interviews, but very instructive for me. My plan was to see how (and if) interviewees linked FP to human rights and then to development goals. The human rights question yielded some interesting results (see the discussion and conclusion), but the development question fell flat. As I reviewed their responses to the development question in particular, I had initially thought that in asking about global development, I was leading the interviewees to make a leap in thinking that I wanted them to make. While this may be true, I think now that mainly the question was beyond their range of expertise and they found it strange that I would ask. Every single one of the respondents either balked, had nothing to say and passed, or asked me to explain the question. This to me, constituted a "failed question" (Arksey & Knight 1999). Though I was able to learn from it, I was sorry to have put my interviewees through that part of my process. I was attempting to do too much, and had even been advised ahead of time to reconsider whether it would indeed be useful to pursue that line of questioning.

For the last question I asked if there was anything else the person wanted to add, and often someone did add something or elaborate on a previous point. When we had enough time at the end of the interview, this question gave me the opportunity to make sure the interviewee felt heard and nothing was left waiting to be said.

I ended the interview on the note of mentioning one or two specific things that I learned or appreciated hearing about. I then thanked the interviewee for her/his perspective, time and work in the world.

CHAPTER 6

DISCUSSION AND ANALYSIS OF INTERVIEWS

Two dominant themes emerged from the interviews as I analyzed them. One was a concern with making sure quality FP services were available to all women, especially women who are in marginalized or at-risk groups, and the second was a common concern with the effect of politics and ideology on FP funding. Other, sometimes overlapping themes emerged as well.

The main themes:

1. All interviewees expressed concern regarding **clientele who are most affected** by FP policy changes. Most used terms such as "poor" or "low-income" and "uninsured" women, but many also referred to young people, members of minority groups, immigrants, less educated people, uninsured, and rural people. Several also mentioned older, low-income women.
2. Almost all interviewees mentioned concerns about the effects of **lawmakers' ideology and religion** on FP policies, whether through budgetary measures or practice and education restrictions. This includes misinformation, valuing religion over science-based evidence, and fear based information.

Other themes:

3. All interviewees mentioned **budgetary constraints** as having substantial impacts on FP services. Almost all interviewees mentioned having to try to provide more care to more people (need is growing) with fewer resources

Several facets of budgetary concerns:

- A. Budgetary constraints come from many directions including economic structural problems, the recession and ideological funding decisions.
- B. Increased complexity and regulations on the provider end: paperwork, administrative work, billing multiple insurers, complex competitive funding streams,

mandates -many unfunded. Some for protection of clients, some as requirements for increasingly scarce funding, others appear to be merely due to growth of bureaucracy.

C. Increased complexity and documentation on client end: multiple programs, citizenship proof, some represent attempts to decrease enrollment and save costs to public funding agencies.

4. Almost all want to see **comprehensive sex education** and almost all mentioned **universal health care**.

5. Most believe FP and health care are **human rights**, though only a few express it in context of UN conventions or Cairo and subsequent language.

6. Many mentioned the **need to trust women**, young people, low income people with information and services regarding sexuality, health and family decisions.

7. Most mentioned that **New York State is relatively supportive** of FP compared to other states and interviewees found this to be positive. However, most also acknowledged that federal leadership, especially by the executive branch, makes a very big difference in the types of policies and the overall tone of a time period in terms of support for FP.

8. Many lamented having to be **defensive and "losing ground" to opposition** on a federal level and in many states in recent years.

Selected excerpts from the interviews on the major themes:

1. A concern for different **groups of women who are most affected** by policy changes was foremost. When I asked the providers and advocates who these policies affect most and what groups of women they serve, they had a lot to say and their responses were animated. It was evident that the concern with including all sectors of women in FP care was a pressing concern for the interviewees, primarily when inclusion wasn't happening or was precarious and threatened. The interviewees

seemed to be aware of the groups of women they were trying to reach and provide services to, who was using the services, and to some extent, what groups did not have access. When they spoke of women who came to them and could not get the services they needed, or women who were no longer able to access the services, their manner often changed. They sometimes seemed agitated and sad or angry, raising their voices or changing their vocal tones in ways that reflected rising or conflicting emotion. Conversely, when they spoke of successful efforts to include formerly excluded groups, they often conveyed a sense of satisfaction. Thus, it was not only what they said, but how they said it that made these expressions stand out in the interviews. Talking about how the changes in FP policies were affecting some women more than others, and who could then access services, seemed to carry a lot of meaning for the interviewees. It seemed to me that most of them had given a fair amount of thought to this topic. There did not appear to be differences in responses between providers and advocates regarding this question. I have grouped them as advocates and providers, and section breaks indicate each different person.

Initially FPBP didn't cover access to benefits for immigrants. 20% of NYS is foreign born.

Our agency partnered with the Center for Women in Government and ran a UN style, plenary session with 3 policy priorities. This was where the Black, Puerto Rican and Asian legislative caucus got involved as co-sponsors. We also invited 50 Immigrant women's organizations to come give their input and voices to the substance and process. We came up with one page distilled initiatives- "Ensuring Language Access in Reproductive Healthcare"

-An Advocate

Minors are most affected, and immigrant women. Also lesser educated people, young adults and teens. Miseducating teens about ineffectiveness of condoms for example.

-An Advocate

Women suffer the most under these changes, and women of color suffer disproportionately because they are underinsured.

-An Advocate

Who gets left out? Women in states who haven't expanded Medicaid and women in states which are not as effective as NYS.

-An Advocate

People requiring assistance for service are the most vulnerable. If we didn't have the FPBP, it would impact them more.

-A Provider

Patients who live rurally don't always have the means to get to the main centers. Are they going to have access? We may never know how it impacts them. They don't make a lot of noise... These people may not speak up and we may never know.

The people most affected are the people whose particular programs are decreased. In general as FP clinics look at how to remain viable, the services that serve smaller numbers are at risk of being cut.

Lower income people without transportation, often rural, may not have gas money or a car. They are the most affected because don't have resources to utilize another source.

There are quite a few uninsured people and even more now because of layoffs and our economy, it's even more of a strain

People trying to live day to day and just trying to maintain their existence don't have the time or know where to turn sometimes. I see people like that in the clinic sometimes, they are worrying about where they are going to live or get food and clothe their kids. They can't focus on other things. They would not have the energy to rally and make noise or get the attention of legislators.

-A Provider

Anyone who is not a socially conservative, Caucasian, heterosexual male.

Young people, poor, women overwhelmingly, older women too.

I think it [cutbacks, restrictive policies] even hurts the people who think it's in their best interest – because I think they have bought into fear/shame and a restrictive one- dimensional view of life and relationships. [they are] forced to think small instead of thinking big.

-A Provider

People who don't have health insurance and don't have any other options. We welcome people with insurance but a lot of people don't have it.

It's who is always affected by this stuff: Young, poor, immigrants, people of color.

-A Provider

Ages 18-25 form the bulk of our population, and women who cannot afford to go to a private doctor.

-A Provider

But for women over 40 or who don't need birth control, the HLP program is so important and it was cut. If they can't get their mammograms and they find a breast lump, where will they go? I saw a woman who is 50 and she has a breast lump. Where is she going to go? It's just bad all over.

-A Provider

People who don't have insurance are the main source of patients for us. As it gets more expensive to get insurance, we start to see more and more people. Especially over the last couple of years. Women in their 30s and 40s. Especially those who have lost their insurance. Mostly for women who don't have insurance, and need a mammogram or referral to a breast care center. Mainly the working poor. They work, but don't get or can't afford insurance. [the people who are most affected are] Mostly the people who come to see us. Not just young girls, but also older women. Care is provided based on what they can afford, not what they need.

-A Provider

People with the least resources were the most affected. Our demographics – 80% are 29 and younger... Primarily the young poor, who are hurt the most. People with the most life ahead of them. It causes stress on education and the social system. After the poor, it is society at large that is the victim. Even people in rich suburbs will be touched by the problem.

-A Provider

As I read over the responses, it seemed to me that a frame of including diverse identities and communities emerged. I would define inclusivity here as a desire to provide services and information in such a way that they are accessible to and meet the family planning needs of all women and men, particularly those who are marginalized in some way. This inclusivity of diversity brings to mind variable features in Benford and Snow (2000) which will be discussed again in the conclusion.

2. Ideology and religion of lawmakers was noted by many interviewees as having a strong impact on FP funding and policy.

*Most of the anti-choice people are really anti-contraception" America's discomfort with sex and sex education has created a silence which has done so much damage
Catholic Bishops started partial birth abortion ban, and many lies about birth control...*

What the bishops do, who they will, and won't give communion to... But they are very careful about law, public pressure, how to lobby. People are under public pressure – they sometimes pass out postcards in church. One of the constant things we do is to work against the [misinformation] of the Catholic Church.

The Sex Ed Bill... We've been trying to get it through for many years, there is huge public support, but the Senate has been resisting it because they are very conservative and don't want to talk about sex
-An Advocate

The partial birth abortion issue was very damaging to the movement. We were so disorganized in our messaging around it. It took 2-3 years to come up with effective messaging. We lost a lot of ground. Opposition is getting better at spinning this. An area that really worries me
-A Provider

the strict father moralist vs the nurturing parent paradigm...Anti-woman, power and control over women
...Profound impact of the puritan ethic on the American political system
...Ultra-conservatives – growing strength of many conservative movements
But also this culture's discomfort about sex, therefore we don't have rational policies about it
- A Provider

I think it's primarily political. Money from the right...the right lobbies hard to get their views taught, and determine the level of FP funding. People who don't want us to succeed influence our outcomes with their money. Very hard to make education become part of policy. Religious groups have strong views towards abstinence only.
-A Provider

[There's a] Huge disconnect from reality driven by ideological issues that have a religious base to it
It started with Reagan's "contract on America" – the domination of conservative ideology is largely responsible for decreases in FP funding
-A Provider

As I listened to these responses, I heard the identification of a community with opposing goals and an opposing frame. But I also noticed that responders did not dwell on this oppositional community. After identifying the opposition, they often seemed eager to move on to other topics about their work. There was also often a vocal tone or facial expression which may have registered frustration or resignation. I

recognized discomfort and tacitly cooperated by dropping the subject. I realize now that I could have gained more understanding with follow-up questions, but I instead continued with other parts of the interview. Contention and discomfort are understandable considering the long-standing social argument between the Sanger and Comstock lineages. They have almost become a structural feature, a part of the landscape to be accepted or worked around. This will be explored further in the appendix on “the dangerous dialog”.

3. Budgetary constraints: "Mind of a tax attorney and heart of a social worker..."

By far the most prevalent topic of conversation was concern about funding. Some mentioned this even while defining their role in their agency:

I try to maximize funding... to make sure family planning is funded, mostly to fund provider services.

-A Provider

Not surprisingly, every single interviewee mentioned concern over budgeting when referring to policy changes and their effects. Some went into very specific detail about the effects of different policy changes on eligibility and program requirements.

For example, one advocate spoke at length about the Deficit Reduction Act -DRA

(2006):

Efforts to lower Medicaid spending have increased time and paperwork, and have an impact primarily on low-income people, who are the most vulnerable, and clinics. It requires proof of ID/citizenship- Birth certificate originals and this affects minors and many others, including students, military partners, and others who don't have documents. Also, student pricing for birth control is rising. Even what Medicaid does cover, it is at a low rate, and often clinics can't recoup some costs because Medicaid law forbids co-payment. The good thing is, the FP waivers reached up into underinsured women and cover them, but the provider clinics get contracts which are very complex and cumbersome.

What every provider knows is that we need universal healthcare.

-A Provider

Several interviewees put budget cuts in a different context, showing **how they perceive funding and ideology to be linked:**

I would like to talk about Welfare Reform – it should have been for an increase in planning and comprehensive education. The misnamed “Welfare Reform” was really an attempt to punish – to give penalties for out of wedlock birth. It was really wrongheaded. Maybe this was due to class differences. WR was very blaming. Didn’t give people tools but punished and blamed them. It did nothing to alleviate poverty. Also they didn’t really change Medicaid, they just pushed people off.

-A Provider

The 1980s was a period of deep, long lasting and horrible cuts on FP side as well as consolidation of attacks on public funding for FP and stupid policy provisions like the gag rule. In the 1990s, slowly funding crept back up.

-A Provider

One of the biggest changes of the last 8 years is the movement away from evidence/science-based approaches to ideological-based approaches. Attempts to divert funding away [from sex education] to fund abstinence-only...

-A Provider

Several interviewees remarked on how unfunded programs or mandates (requirements) impact FP services:

Different mandates take time, but don’t always provide money... Sometimes you get money for a new mandate for a service, but then when the money runs out, you have to keep providing that service.

-A Provider

Healthy Teens Act in NYS passed the Assembly several years ago, but not the Senate yet. But no money is attached to it. It’s toothless, it feels good, but doesn’t do anything... Without funding, what kind of victory is that? Just a feel good victory.

-A Provider

Still others remarked on the impact of funding cuts...

At a training to teach trainers and providers how to figure out eligibility requirements to find funding for low-income women’s repro health care, a

trainer said something like, "You need the mind of a tax attorney and the heart of a social worker- and usually the two are not found in the same person."

-An Advocate

One thing I notice is funding cuts, the more years advance the more funding is cut. On the other hand, I think my agency is moving more toward embracing issues affecting minority women and women of color. But this is affected by decreased funding due to lack of commitment by leadership.

- A Provider

There were funding cuts, and the first people to get cut were the educators – they didn't bring in any money, but I think it's important that they are out there in the schools educating the kids. Some practitioners got laid off. We still have to provide all the services, but not enough time and money for it.

-A Provider

Bad financial times (Wall St). A real strain on budgets

-A Provider

With decreasing funding and funding cuts, maintaining quality with less funding is very difficult. When we had funding cuts before, I wasn't always aware of it as a provider.

-A Provider

Comprehensive sex education and universal health care were on the wish list. Aside from increased coverage and funding, These two items were by far the most prevalent items mentioned when I asked "What changes would you like to see?"

Govts recognizing reproductive health as something integrated into the rest of health... We can't pretend we don't have a uterus when we walk into a Catholic hospital.

-An Advocate

Universal health care

-An Advocate

A well thought out developmentally graded comprehensive sex education program for country and state.

-A Provider

Healthcare established as a basic right in this country

Women's reproductive healthcare as a part of basic health care

-A Provider

All inclusive sex education- not just abstinence only. Of course we do comprehensive sex ed., but I mean in the schools. More education is needed, not just in the schools, too- some people don't understand how BC works.
-A Provider

I want to see universal healthcare. So much money is put into diagnostic procedures, etc like MRIs, CAT scans, but so little put into preventative care, e.g., exams, and education

Rescuing our healthcare system with the huge and growing number of uninsured, is a real strategy for economic growth. The various national entities (NIH, etc) are only able to fund 1 in 3 projects that are rated highly promising. Resources aren't there. Just by funding these projects, would have a big economic impact.

-A Provider

Some kind of universal health care system.

Increasing education for young people

-A Provider

Regarding **family planning and human rights**, some interviewees spoke hesitantly or asked for clarification, while on the other hand, several of the interviewees spoke in terms which indicated familiarity with UN Convention and ICPD language. These latter often acknowledged that those frameworks aren't prevalent in the US. People who worked in advocacy or had lived or worked abroad were much more likely to speak of human rights in those terms.

In regard to health issues the US doesn't so much work with a human rights framework, whereas, they often use human rights as a standard in other countries

-An Advocate, also worked in South America

Women's rights to control their bodies is a human right. I think that most people believe this. We don't have human rights in the US. By using a human rights framework to discuss health, it reflects a new way of thinking to try to get it into policy

-An Advocate

The most unique thing is in the US, we are so uncomfortable with the Human Rights framework. They don't get it. They are uncomfortable. People here

don't talk about it. We don't support HR for women or children. We don't get it. We don't have national health care

-A Provider, also did some advocacy work in Africa

Reproductive rights are basic human rights. [our agency] upholds tolerance, protection of the young, the vulnerable and civil rights. This is why I choose this job. I wanted to be a civil rights lawyer. This is why I do what I do.

-A Provider

I went to a conference 4 years ago in Northhampton about Reproductive Justice. It was called by some Planned Parenthood affiliates, Sister Song, Hispanic Women for Reproductive Justice. It pushed me in new directions. Also, "Family Planning" is a term of the 50s. It doesn't resonate outside of FP providers. Better ways of saying it are "Reproductive Justice and Healthcare". They are all human rights.

-A Provider, also worked in another country in Africa

For those who seek healthy forms of birth control, abortion. It is the essential crux of women's equality – their ability to participate equally in the workforce, education., etc. They cannot do that without having access to reproductive healthcare and reproductive choice. I think Cairo was a great moment, but we haven't been able to move forward towards its goals since then, especially with the Bush administration.

It's considered a basic right, no Human Rights for women without reproductive rights.

-A Provider, also formerly worked in Africa with Peace Corps

People aren't secure if they don't have the means to sustain good health. These are basic, basic fundamental human rights – the right to safety and health. From a reproductive justice point of view, the right to choose if you want to be pregnant, how many, how to space them, is a basic right that belongs to every woman.

-A Provider

Others, while strongly expressing a link between family planning and human rights, did not use language which indicated familiarity with United Nations Human Rights conventions or conferences. It was hard to tell for sure without further discussion, and I realize now that I could have clarified this with good follow-up questions. Often these responses sounded more like an assertion of personal opinion or commitment rather than an acknowledgement of a building body of consensus on human rights. The answers here seemed more qualified, like guesses.

I guess it's about access to healthcare. People who work and have insurance can go anywhere for healthcare and the poor people who don't have insurance are often in limbo. Also there's gotta be more sensitivity to different groups (cultures, races) in the clinics because they all have different backgrounds and knowledge of birth control, reproduction and sexuality.

-A Provider

Everybody should have access to affordable health care. There's a lot of people in this country who have to rely on free clinics and a lot of them don't even know about the clinics.

-A Provider

If something as essential as Roe v Wade was overturned, we would take a big step back in human development. When you provide abortion or options counseling, you see the scope of people who choose abortions, its not the stereotypical profile. It can be anybody. There was a woman who picketed against abortion outside [agency in small city], she came in, got an abortion, and went out and picketed again.

I think basic healthcare is a human right.

-A Provider

Women and young people need to be able to control their own bodies and make decisions.

I think health care is a basic human right: Autonomy, decision making security in your own person.

If you can't control your body, your rights of controlling your fertility, I don't think you're free.

...shouldn't be legislating what people do with their own bodies. They have a right to do what they feel is right with their bodies... it's a human right...it's worked it's way into a basic right.

-A Provider

Because of the mixed responses and the occasional request to clarify the question, I had originally begun to consider this question to be a failed question, that is, one that did not provide useful data (Arksey & Knight 1999). However, while reviewing the responses as well as reviewing the literature about human rights and the United States, it became clear to me that the responses warranted a second look. As mentioned earlier, I could have gained useful clarity with the right follow-up questions. It began to appear that the frames of the interviewees converged with those

of the Sanger lineage around certain aspects of reproductive and human rights, even in the continuing absence of US ratification of the conventions and even in the midst of providers' lack of information. This will be further discussed in chapter seven.

The themes regarding **trusting women, New York state being more supportive** and a feeling of **losing ground in the struggle for FP** were prevalent as well, but occurred less so than the above mentioned themes.

In summary, the primary themes emerging from the interviews centered on the desire to provide education and services to a diverse, inclusive group of women, concern over ideologically motivated opposition, and related decreases or scarcity in funding for resources, including information.

Two Points of Triangulation

The Sanger social lineage and the interviews end up triangulating with each other on the two main themes that I heard during the interviews. One, FP proponents (advocates and providers) hold a frame of ensuring access to *diverse* women and families, so that *all* women are included, especially underserved or vulnerable populations. Publicly funded family planning receives public funding in order to be accessible to low-income people and others who may not have been previously served in the private sector. Excluded groups may be rural people, teens, lesbians, women of color, low-income and others. Another area of triangulation is a belief that women (and people in general) have a right to FP *information* as well as FP *services*. These two frames contrast with the opposing framework that essentializes women, and suppresses access to FP information and services.

Diversity vs. Essentialism

The Comstock lineage views people in essential biologically determined gender roles and family forms under a universally assumed dome of Christendom. What has become more clear to me as I have examined the concept of inclusivity as a

frame, was that it could be differently and better expressed as acceptance of the *diversity* of people's actual preferences and experiences. This could then be contrasted with the essentializing of women's and men's roles.

Acknowledging the diversity of women's experience challenges the assumption of gender essentialism, or one essential role for women based on biological reproductive function. Acknowledging that women and men experience a range of social and family roles, not always related to biological parenting, is a feature of the Sanger lineage. This goes beyond gender roles to acknowledge and include differences in age, race, ethnicity, income level, immigration status and urban or rural residence. They may live in extended families, various members may work in or outside the home, one parent may be absent, and same sex- couples may parent together.

As we have seen in the interviews and in the literature about publicly funded family planning, today's inheritors of the Sanger lineage work to include diverse women and families by working to make reproductive and sexual health services and information more available to diverse groups, such as immigrants, low income, rural poor, and people of color. Several examples of this are evident in policies which seek to expand Medicaid coverage to a wider range of low-income people and immigrants, to include language and cultural training for staff, and in the efforts of clinic providers to make services available to rural, poor families. Specifically, in New York State, the FPBP program Medicaid expansion program provides free FP coverage for a large population of women, many of whom lost FP coverage when welfare reform took affect and title X monies were reduced. In addition, many clinics in New York State provide staffing and services out of small, part-time clinics in order to reach rural poor women.

The acknowledgement and acceptance of diversity also arises in the four principles drafted for the Cairo conference by Correa and Petchesky mentioned in chapter 3. The act of acknowledging diverse roles and family structures opposes and partially disarms the enforcement of essential roles. When different women's and men's experiences are accepted as legitimate, providing access to information and services gives them mobility and decision making power. Conversely, when women/men are reduced or confined to essentialized roles based on reproductive function, their choices and range are limited. In the Comstock lineage, by withholding access to FP services and information, this imposed order can be (and is sometimes forcibly) reproduced.

The irony is that language using terms such as 'natural' is sometimes used to describe these limited, essentialized roles for women and men. Yet, if observing the 'natural' meant empirical observation- to observe what actually occurs in the worlds of women and families, it would be seen that women inhabit a diversity of roles and family structures within a broad range of intersecting identities, some of them marginalized (having less access to resources and power than others). This willingness to notice and respond to the life situations, needs, (and rights) of others, rather than imposing or enforcing a specific set of gender roles, is where the Sanger lineage most stands apart from the Comstock lineage. When gender and family roles are essentialized, variation from the accepted or "normal" roles are marginalized or made invisible. It follows that when people are rendered invisible, it is difficult to plan or provide health care which meets their needs, and disparities for such marginalized people are likely increase or be reproduced. People who are inheritors of the Sanger lineage make it a point to notice these people, as well as the existing disparities, and to address them. Consider these excerpts from the interviews regarding who is most affected by policy changes:

Minors are most affected, and immigrant women. Also lesser educated people, young adults and teens.
-An Advocate

Women suffer the most under these changes, and women of color suffer disproportionately because they are underinsured.
-An Advocate

Lower income people without transportation, often rural, may not have gas money or a car. They are the most affected because don't have resources to utilize another source.
-A Provider

Anyone who is not a socially conservative, Caucasian, heterosexual male. Young people, poor, women overwhelmingly, older women too.
-A Provider

It's who is always affected by this stuff: Young, poor, immigrants, people of color.
-A Provider

In these passages reflecting a concern for diversity, the interviewees share the frame of the Sanger lineage. Sanger's work with immigrants in New York tenements, and her subsequent international outreach, set the tone for a view of women and families which had to include diversity. The Sanger Lineage is compelled to acknowledge diverse women and families, in part, because Sanger herself emerged from economic marginality, came into contact with and served families of different races, classes and ethnicities, and ultimately sought out and engaged with people of many cultures and nations.

As noted in chapter two, those opposing FP, as well as the pro-life activists in Ginsburg's *Contested Lives* can be called upon to reflect an opposing frame which denies or excludes diversity, and is more closely allied with an essentialist view of women's and men's roles. In this, it resembles or arises from the Comstock lineage.

The Right to Information

In Sanger's lifetime, women and families sometimes begged her for information about the means to limit their own fertility. She made it her project to try to fill this need, and was arrested and jailed for printing and distributing such information in violation of the Comstock act. Today, the inheritors of the Sanger lineage work to pass legislation and enact policies which require the teaching of comprehensive sex education in all public schools. In New York, this took the form of the Healthy Teens Act. It also manifested in the NYS refusal of federal monies which would have restricted schools to teaching abstinence-only sex education. Again, from the interviews of FP providers and advocates:

The Sex Ed Bill...[Healthy Teens Act] We've been trying to get it through for many years, there is huge public support, but the [NYS] Senate has been resisting it because they are very conservative and don't want to talk about sex

-An Advocate

The 1980s was a period of deep, long lasting and horrible cuts on FP side as well as consolidation of attacks on public funding for FP and stupid policy provisions like the gag rule. In the 1990s, slowly funding crept back up.

-A Provider

One of the biggest changes of the last 8 years is the movement away from evidence/science-based approaches to ideological-based approaches. Also, attempts to divert funding away from sex education to fund abstinence-only.

-A Provider

Though I have not collected interviews with present day heirs of the Comstock lineage, the results of the struggle between the two frames are evident in some of the policies I have mentioned which block and obfuscate access to FP information and services.

In terms of collective action frames, I assert that these two themes persist through the Sanger lineage frames into the work of the present day providers and

advocates of publicly funded family planning: 1. Women and men inhabit a *diversity* of identities and roles and identities in families and society, and FP services must reflect and address such diversity. 2. In addition to services, people need and have the right to *information* about sex and reproductive health. These frames have been developed in contentious dialogue with opposing frames in the Comstock lineage. The Benford and Snow (2000) article develops several concepts, “variable features”, which can help identify the continuity, and also account for some of the success, of these frames in the Sanger lineage. In addition, the construction of international human rights provides what Benford and Snow (2000) would call a “master frame”, within which sexual and reproductive rights are nestled. As I have mentioned in the introduction, the variable features are Flexibility, Inclusivity and Resonance. The features of flexibility and inclusivity enable the Sanger lineage frame to be compatible with the “master frame” of human rights. The feature of resonance refers to the fit of the frame to the empirical evidence, and the everyday experiences of people. As Benford and Snow put it, “...the more culturally believable the claimed evidence, and the greater the slices of such evidence, the more credible the framing and the broader its appeal” (620). This connects to the experiences of providers and advocates because they see a broad diversity of women and families as clients of publicly funded FP, as opposed to a few essentialized roles, and these clients come seeking information and services.

CHAPTER 7

CONCLUSION: "GETTING" HUMAN RIGHTS AT HOME

Recall the young women from the introduction, sitting in the waiting room and filling out forms. One is holding a baby. They and their peers aren't fictional, and they aren't all the same, nor are their situations and aspirations. They are as real, diverse and numerous as their lives and hopes. Whatever mode of transportation they have taken, however much time they have given up to wait in that waiting room, the young women have come seeking information and services. What rights do they have? Who is charged with upholding them? When and how will those promises be delivered? The answer to these questions is still under construction.

In this study, I have asked a different series of questions. What informs the people who meet the young women in the offices beyond the reception desks, as well as the people who work to make the very clinics possible? What frames of meaning move the providers and advocates of family planning? Listening closely to family planning proponents, looking into history and current policy, and drawing on my own experience in the field, I believe that advocates and providers are holding meaning frames which reflect the Sanger lineage and are identical and compatible with some of the primary aspects of the master frame of human rights as it is being constructed on an international level. These include recognition of the diversity of women's roles and their rights to information and access to services.

In this context, human rights constitute what Benford and Snow (2000) would call a collective action frame or a *master frame*, one already inclusive of the themes of diversity and the right to information. In their accounting,

...frames help to render events or occurrences meaningful and thereby function to organize experience and guide action. Collective action frames also perform this interpretive function by simplifying and condensing aspects of the "world out there",

but in ways that are intended to mobilize potential adherents and constituents, to garner bystander support, and to demobilize antagonists (614).

Larger, collective action frames can then be seen as action tools in a socially constructed, discursive process. Far from being finished or solid products, they are processes, more like verbs than nouns. They *act*, or rather, they influence *people* to act.

“We don’t have human rights in the US”

This leads me to look back at the interview question in which I asked, "Family planning and human rights, how would you relate the two?" I noticed that while some people were very comfortable with their answers, placing them in a larger and sometimes international context, others seemed to be guessing at a relationship. Their answers were vague, as if only in that moment had a relationship occurred to them, or that human rights were abstract, undefined, unattainable, or not an issue. In accordance with this, several of the interviewees pointed out that professionals- including some FP providers and advocates *themselves*- in the United States often don't think about human rights frameworks. These responses are from the providers who seemed more familiar with the current international human rights dialog:

In regard to health issues the US doesn't so much work with a human rights framework, whereas, they often use human rights as a standard in other countries

-An Advocate

Women's rights to control their bodies is a human right. I think that most people believe this. We don't have human rights in the US. By using a human rights framework to discuss health, it reflects a new way of thinking to try to get it into policy

-An Advocate

The most unique thing is in the US, we are so uncomfortable with the human rights framework. ... We don't get it

-A Provider

Reproductive rights are basic human rights. [our agency] upholds tolerance, protection of the young, the vulnerable and civil rights. This is why I choose this job. I wanted to be a civil rights lawyer. This is why I do what I do.

-A Provider

I went to a conference 4 years ago in Northhampton about Reproductive Justice. It was called by some Planned Parenthood affiliates, Sister Song, Hispanic Women for Reproductive Justice. It pushed me in new directions. I think Cairo [ICPD] was a great moment, but we haven't been able to move forward towards its goals since then, especially with the Bush administration. ...no human rights for women without reproductive rights.

-A Provider

Regarding the other responses, the hesitancy and lack of clarity about openly joining with and claiming the human rights framework may be attributed partly to the work of opponents to FP who have succeeded (thus far) in keeping the United States from fully engaging in human rights dialog about FP or ratifying the CEDAW and CRC conventions. Additionally, as Julie Mertus writes in *Bait and Switch: Human Rights and US Foreign Policy* (2004):

...to claim that Americans live in a human rights culture is a gross overstatement. The level of human rights awareness is extremely low. According to one study by Amnesty International, 94 percent of American adults and 96 percent of American youth have no awareness of the Universal Declaration of Human Rights (212).

She advocates teaching about human rights to the public and infusing them into existing social movements.

In her chapter "Human Rights from the Ground Up: the potential for sub-national, Human Rights-based reproductive health advocacy in the United States" from the book *Where Human Rights Begin* by Chavkin and Chesler (2005), Martha Davis makes a case for how international human rights language and law can support local advocacy within the United States for, in particular, the rights of low income women to FP and reproductive healthcare She writes:

...particularly after the devolution of welfare reform to the states in 1996, the choices that the states and localities make have a profound effect on low-income women's health and well-being; the lens of international human rights provides an important perspective on these policies. At the same time, a human rights framework has the potential to influence domestic conceptions of the scope of reproductive rights and health- to encompass issues such as the rights to bear children and the right to health education (238).

The recommendation I draw from Davis's work is that strides made in international human and reproductive rights frameworks can contribute to FP advocacy by being referenced and integrated into the thinking, practice, discussion, advocacy and policy of providers and advocates in the United States.

This exploratory interview work and its triangulation with the literature suggest some compelling further directions. In keeping with my own commitments and the themes emerging thus far, I would structure further research toward in-depth investigation into providers' understandings of linkages between FP services and information and recent developments in international human rights. This future research could possibly take place within a more interactive participatory action research (PAR) model, which would allow me to work more collaboratively with advocates and providers. One possibility would be for qualitative interviews and possibly focus groups to concentrate entirely on the intersection of human rights and family planning. For example, I could ask, what are their understandings and how do they perceive their roles in relation to human rights. I could then use follow-up questions in order to get to a deeper understanding without having to lead. Another direction I would like to pursue is to return to some of the agencies and share the results with the providers and advocates. We could then hold a discussion session or focus group about how they see their work in the context of human rights.

This paper and these investigations have the purpose of enabling me to enter a conversation about what current understandings advocates and providers already hold, why it persists, and what may be missing, in order to locate places for more

conversation and action. This process is part of a long-standing social conversation about family planning, and will continue despite the contention, power and violence which sometimes overshadow it. Benford and Snow (2000) refer to collective action frames as tools for action and mobilization. Finding my/our positions in relation to the powerful collective frame of human rights are acts of embodiment and declaration. In "getting it", and bringing human rights home to women in the United States (and elsewhere), this conversation becomes one incremental part of the larger process and movement, and one more contribution to what Petchesky calls the irrepressibility of human rights.

APPENDIX ONE
INTERVIEW GUIDE

What is your role in the agency? title, duties, roles, do you have a role in influencing policy or implementing it of both?

How/ why did you enter into this field of work- education, career path, calling, impulse...

A few Policy changes you noticed over last 15 years or so- Milestones, turning points- Federal/ NYS? Don't need to remember exact details or time frames at all, anything that stands out. They can be positive or negative policy changes in your view.

Attribution- who or what do you think caused or was impetus behind these policy changes?

Policy effects- did any of these changes cause you to change your practices?

Who is affected? (patient-wise, are some people affected more than others)?

What changes would you like to see? Top Priorities?

FP and human rights? How would you relate the two?

FP and development goals? How would you relate these services to global development issues?

Other: Anything else you'd like to add?

APPENDIX TWO

THE MEXICO CITY POLICY AND FOUR PRESIDENTS

1. The institution of the policy in 1984:

PRESIDENT REAGAN

In 1984, the Reagan Administration introduced the "Mexico City policy" at an international conference in Mexico City. It denied U.S. funds to foreign nongovernmental organizations (NGOs) that perform or promote abortion as a method of family planning, regardless of whether the money came from the U.S. government. This prohibition also included discussion the availability of abortion *as an option* elsewhere, or even when providing clinics use their own funds to provide abortions, and even in countries where abortion is legal.

<http://openrcs.com/document/IB96026>

2. The revocation of the policy in 1993:

PRESIDENT CLINTON

Memorandum on the Mexico City Policy

January 22, 1993

Memorandum for the Acting Administrator of the Agency for International Development

Subject: AID Family Planning Grants/Mexico City Policy

The Foreign Assistance Act of 1961 prohibits nongovernmental organizations ("NGO's") that receive Federal funds from using those funds "to pay for the performance of abortions as a method of family planning, or to motivate or coerce any person to practice abortions." (22 U.S.C. 2151b(f)(1)). The August 1984 announcement by President Reagan of what has become know as the "Mexico City Policy" directed the Agency for International Development ("AID") to expand this limitation and withhold AID funds from NGO's that engage in a wide range of activities, including providing advice, counseling, or information regarding abortion, or lobbying a foreign government to legalize or make abortion available. These conditions have been imposed even where an NGO uses non-AID funds for abortion-related activities.

These excessively broad anti-abortion conditions are unwarranted. I am informed that the conditions are not mandated by the Foreign Assistance Act or any other law. Moreover, they have undermined efforts to promote safe and efficacious family planning programs in foreign nations. Accordingly, I hereby direct that AID remove the conditions not explicitly mandated by the Foreign Assistance Act or any other law from all current AID grants to NGO's and exclude them from future grants.

WILLIAM J. CLINTON

<http://www.presidency.ucsb.edu/ws/index.php?pid=46311>

3. The reinstatement of the policy in 2001:

PRESIDENT G.W. BUSH

MEMORANDUM FOR THE ADMINISTRATOR OF THE UNITED STATES
AGENCY FOR INTERNATIONAL DEVELOPMENT

SUBJECT: Restoration of the Mexico City Policy

The Mexico City Policy announced by President Reagan in 1984 required nongovernmental organizations to agree as a condition of their receipt of Federal funds that such organizations would neither perform nor actively promote abortion as a method of family planning in other nations. This policy was in effect until it was rescinded on January 22, 1993.

It is my conviction that taxpayer funds should not be used to pay for abortions or advocate or actively promote abortion, either here or abroad. It is therefore my belief that the Mexico City Policy should be restored. Accordingly, I hereby rescind the "Memorandum for the Acting Administrator for the Agency for International Development, Subject: AID Family Planning Grants/Mexico City Policy," dated January 22, 1993, and I direct the Administrator of the United States Agency for International Development to reinstate in full all of the requirements of the Mexico City Policy in effect on January 19, 1993.

George Bush

(No date was given, accessed July 22, 2009) <http://www.usaid.gov/whmemo.html> /

4. The second revocation of the policy in 2009:

PRESIDENT OBAMA

MEMORANDUM FOR THE SECRETARY OF STATE
THE ADMINISTRATOR OF THE UNITED STATES AGENCY FOR
INTERNATIONAL DEVELOPMENT

SUBJECT: Mexico City Policy and Assistance for Voluntary Population Planning

The Foreign Assistance Act of 1961 (22 U.S.C. 2151b(f)(1)), prohibits nongovernmental organizations (NGOs) that receive Federal funds from using those funds "to pay for the performance of abortions as a method of family planning, or to motivate or coerce any person to practice abortions." The August 1984 announcement by President Reagan of what has become known as the "Mexico City Policy" directed the United States Agency for International Development (USAID) to expand this limitation and withhold USAID funds from NGOs that use non-USAID funds to engage in a wide range of activities, including providing advice, counseling, or information regarding abortion, or lobbying a foreign government to legalize or make abortion available. The Mexico City Policy was in effect from 1985 until 1993, when it was rescinded by President Clinton. President George W. Bush reinstated the policy in 2001, implementing it through conditions in USAID grant awards, and subsequently extended the policy to "voluntary population planning" assistance provided by the Department of State.

These excessively broad conditions on grants and assistance awards are unwarranted. Moreover, they have undermined efforts to promote safe and effective voluntary family planning programs in foreign nations. Accordingly, I hereby revoke

the Presidential memorandum of January 22, 2001, for the Administrator of USAID (Restoration of the Mexico City Policy), the Presidential memorandum of March 28, 2001, for the Administrator of USAID (Restoration of the Mexico City Policy), and the Presidential memorandum of August 29, 2003, for the Secretary of State (Assistance for Voluntary Population Planning). In addition, I direct the Secretary of State and the Administrator of USAID to take the following actions with respect to conditions in voluntary population planning assistance and USAID grants that were imposed pursuant to either the 2001 or 2003 memoranda and that are not required by the Foreign Assistance Act or any other law: (1) immediately waive such conditions in any current grants, and (2) notify current grantees, as soon as possible, that these conditions have been waived. I further direct that the Department of State and USAID immediately cease imposing these conditions in any future grants.

This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

The Secretary of State is authorized and directed to publish this memorandum in the *Federal Register*.

BARACK OBAMA

THE WHITE HOUSE, January 23, 2009.

http://www.whitehouse.gov/the_press_office/MexicoCityPolicy-VoluntaryPopulationPlanning

APPENDIX THREE

THE DANGEROUS DIALOG

Careful observation and listening are sometimes insufficient in a contentious social conversation. Sometimes dialog is dangerous. Two months ago, a conversation with an academic colleague stunned me out of a blind spot, prompting me to re-evaluate themes of power and violence in the history and current situation around FP. It was right after the 2009 assassination of an(other) abortion provider. It was also two months after an incident where I had been compared to Hitler, a perpetrator of genocide, and a Klan member while speaking about the pro-choice position on a panel (by the other panel member!). The particular discussion with my colleague happened during a break from working on our respective research. I had been telling her that one of the contrasts between the Sanger and Comstock lineages was that the Sanger lineage was willing to *trust* women with information and decisions about their bodies and fertility, whereas those in the Comstock lineage were not. I had not even finished my thought when she interrupted me. The best I can remember, what she said went something like this. "No, I think it's way more than that. It's not about trusting women or not. It's more like -whether you have the information or not, if you *do* anything with it, they're going to shoot you."

I wanted to shrug. I felt a familiar tight feeling that is hard to talk about. Many times during my work as a FP provider, and again during the interviews, I have seen people shrug off hate inciting speech and the threat of violence in the course of daily work. Yet, when I'm off the job, when I'm not doing this research, when I'm not trying to see patterns and solve problems, I understand what she means. When I see the violence and coercion, I say the same kinds of things. The struggle is about controlling women, and that if we can't control our own bodies we are not full citizens.

In Pregnancy and Power: a Short History of Reproductive Politics in America

(2005), Rickie Solinger recognizes this struggle, as well as the contribution of

Comstock as a central historical figure. She writes,

...These struggles have usually focused on conserving traditional power relations, often against women's claims to manage their own bodies...over time authorities have exerted power and women have resisted because women have always been determined to decide for themselves as best they can when and whether or not to become mothers (254).

I have been fortunate in having the opportunity to choose much of my own path. In so doing, I came to value a life in which I had the autonomy to make my own decisions, bear my own responsibilities, and share my resources and affection with those I care for. In order to gratefully give back, I have sought out ways to extend the possibility of similar autonomy to others. This requires paying attention to conditions and then taking effective actions. Long ago, I decided that being able to live this way and working for these rights was worth risks. So I have sought like-minded colleagues and taken measures to become part of this ongoing project.

Earlier, I alluded to a battle, and indeed some of the sources I encountered while researching these issues have referred to this social quarrel as a "war" (D'Emilio & Freedman 1988, Goldberg 2009, Shorto 2006, Solinger 2005, Tone 1997, Tone 2001). Unfortunately, the metaphor becomes more literal when, over the years, the FP health care providers who have been persecuted, wounded or killed, are accounted for. I know something about this "war" first hand. During the 10 years I have worked as a midwife and women's health nurse practitioner in the field of FP, I have sometimes had to work in dangerous situations and have known colleagues who have been stalked and threatened. In one clinic, armed federal marshals accompanied us on our lunch breaks after an assassination of a doctor in his house in a nearby city and several clinic bombings around the country. In another, an envelope of white powder with a letter labeling it as anthrax was delivered, forcing a HAZMAT unit to evacuate our

patients even while we remained at work. ("HAZMAT" is short for hazardous materials, and signifies a team of people who wear space suits and clean toxic or lethal materials while they gather evidence.) I can think of no other line of health care provision nor any professional service other than police or military duty, which entails more personal risk of violence.

So, if the construction of social norms and policy is the result of a social conversation, how do I/we dialog with violence? Do we? Somehow, I think we must.

Thus far, in my scholarship, I have found a helpful, critical community. I have begun to learn what I feel is the language of a larger, more inclusive, evidence-based argument. But I have not yet found the type of language that will help to transform the debate and end the violence. Is there a possibility of building such a language? I expect my pragmatic orientation will lead me further into non-violent conflict resolution, but this also worries me. I am willing to listen, but I won't compromise what seems already to be a very inclusive and reasonable middle ground, one which I feel reflects and honors the experiences and needs of a majority of couples and individuals. As referenced in the passage about fundamentalists by Rosalind Petchesky in the chapter on human rights, there is much more than just reproductive health policy at stake. The outcomes of these questions of power determine the range of types of lives that women can lead, and who they/we can be.

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