



Spring 2018

Attitudes Toward Contraception Among Fourth Wave College-Aged Women

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Attitudes Toward Contraception Among Fourth Wave College-Aged Women

Abstract

This research examines how college-aged women today view contraception in comparison to the ways it has been viewed by previous generations of women, as well as what they view the future of contraception in the United States to look like. This has been done through a lens of political action and advocacy, which has defined the fight for access to contraception and reproductive justice throughout history. In light of the recent threats on contraception and the corresponding responsive social movements, such as the Women's March, women in the United States are shifting their views on the matter, but what actions are they taking?

Reproductive health is highly politicized, yet college-aged/millennial women are not accustomed to an administration that attacks contraception and their access to it. In response to the current American political climate, we've seen an embracing of feminism in the mainstream media and feminist organization, such as the Women's March, but have yet to see any policy change. The question this has led me to explore is whether or not attacks on access to contraception will politically mobilize and unite women. This research is based in interviews with women on the Gettysburg College campus and the analysis of data on racial, geographic, and class disparities in health care/access in order to understand the politicization of contraception in women's lives.

Keywords

Contraception, Reproductive Justice, Attitudes Toward Contraception, Birth Control, Politicization of Contraception

Disciplines

Feminist, Gender, and Sexuality Studies | Health Law and Policy | Women's Health

Comments

Written as a senior thesis in Women, Gender, and Sexuality Studies.

Attitudes Toward Contraception Among Fourth Wave Millennial, College-Aged

Women:

A Study of Gettysburg College

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WGS 400
Professor Lebon
Spring 2018

Introduction:

When “Enovid”, the first contraceptive pill, was first made available to doctors in 1960, they were given a ‘free gift with purchase’ of a plastic paperweight, according to Bernard Asbell’s *The Pill*. It was painted gold with a three-dimensional representation of Andromeda, a princess of ancient Greek mythology, who had been captured, stripped and chained to a rock for her mother’s arrogance, breaking free from her heavy chains. It was a representation of the new freedom this “magic pill” would afford the women of the world. Now, in 2017, contraception, in its multitude of mediums, performs many duties: it allows for sexual freedom and exploration, economic independence and development, family planning, access to education, and a highly contentious political conversation. Despite the fact that, for many women across the United States, taking a birth control pill everyday has become a mindless part of their morning routine, contraception has been a highly controversial political debate since its inception.

The struggle for access to contraception for all women was not won overnight, in fact it is still waging today. The political climate of the United States, both leading up to and since the 2016 Presidential election, has inspired new debates regarding access to contraception, both in public and personal spheres. My research follows college-aged women, as the most recent political threats to contraceptive access are likely among the first they have personally encountered. Beyond this, my research hinges on the idea that The United States feminist movement may be entering a Fourth Wave, characterized by political action and

reaction. I hope to understand how these women view contraception on both a personal and a political level.

While recent threats to women's access to contraception have helped to mobilize discussion and popular women's social movements, I have found that it is not enough to band together all women under one unifying banner. More so than race, sexual identity, or geographic location, class has proven to be the main barrier to accessing medical contraceptives: Those who are of lower a lower economic status are more likely to have met discrimination and roadblocks in accessing contraceptives, and are therefore more aware of institutional biases and discrepancies in the health care system. These women are often more community minded than women who have not personally struggled to access contraceptives, who are able to turn a blind eye to said institutional issues. It is my belief that, in order for all women to put the issue of healthcare insurance coverage of preventative medical contraception at the forefront of their political agenda, something drastic and sweeping, such as repealing *Roe v. Wade*, must occur at the hands of the government.

My research revolves around attitudes towards contraception among millennial women¹ existing in what could be speculated as the Fourth Wave. I conducted research on the history of contraception and reflected on how attitudes have shifted over time in order to understand how we have gotten to the point we

¹ Although the term "woman" is not restricted to all those born with a vagina, this study looks at the role of contraception in the lives of cis-gendered women.

have reached today. I conducted interviews with women on campus to get a better, more direct, sense of attitudes about this topic among college-aged women.

If women initially viewed contraception as the thing that could free them from their shackles and allow them to participate in all spheres, how did we, as a society of women, get to a place where taking medical contraception, the pill, in particular, feels like a burden? Building upon this, how do we comprehend racial, geographic, and class disparities in health care/access in order to understand the politicization of contraception in women's lives? In response to the Trump Administration, we've seen an embracing of feminism in the mainstream media and feminist organization, such as the Women's March, but have yet to see any policy change. The question this has ultimately led me to explore is whether or not attacks on access to contraception will politically mobilize and unite women, as *women* first, before race, class, or party lines.

While the trajectory of feminist theory would suggest that we are on the cusp of a new wave of feminist theory and thought, the numbers suggest otherwise. Public conversation and embracing of feminism through popular social movements such as the Women's March, Time's Up, and #metoo have been overwhelmingly successful, but there have yet to be any tangible political gains. Many of those who have the privilege to not worry about accessing contraception do just that; they don't worry about how women outside of their class level access contraception. This is particularly significant because those with the most agency and ability to be an advocate often simply do not see an issue.

Contraceptive Use in the United States:

Contraception and access to it has always been hotly debated in the United States, especially today, despite the fact that it is widely used, safe, and effective. However, before any of the modern debates revolving around healthcare and access to contraception, Margaret Sanger, founder of the International Planned Parenthood Federation, led the crusade for women's sexual liberation and autonomy over their reproductive cycles. Sanger conceptualized an "inexpensive, easy-to-use, and completely foolproof method of contraception," something she had imagined women could take in the same way they brushed their teeth in the morning, but "with or without the consent of the man with whom she was sleeping." (Eig, 2014). This initial focus on sexual self-governance stemmed from her personal experience, which she then worked to turn into a public crusade.

Sanger's original motivations stemmed from the dire economic and health needs of women to control how many pregnancies they endured, which she experienced as a nurse in a maternity ward, (Asbell, 1995). The medical ramifications of many compulsory pregnancies within one woman's life span were and still is life threatening. According to Dr. Thomas F. Baskett, professor of obstetrics and gynecology at Dalhousie University, 70 women died per 10,000 births in 1915, compared to about 1 in 10,000 in the United States today. When the average family size was 9 or 10 children according to the CDC, which does not

include miscarriages or “unsuccessful pregnancies”, the ability to control one’s reproduction was of mortal importance.

Beyond physical safety, access to contraception in this time also promised the opportunity for women to participate in all spheres of life: the work force, social life, economic prosperity, and to act on their sexuality without the fear of pregnancy. Contraceptives were previously only barrier methods (condoms and diaphragms) or the withdrawal and rhythm methods, that were not fully effective and entirely under the man’s control (*Reproductive Rights and Technology*, Kranz, 2002). Even these methods were not legal in all states, but the Supreme Court Case, *Griswold v. Connecticut* provided the first major legal victory in 1965, allowing any married couple in the United States to get a prescription (O’Brien, 1981). From this point on there were small victories that chipped away the barrier between women and the Pill. A few years later, President Lyndon Johnson approved the first national budget for family planning services, the Comstock Law banning “obscene” information was struck down, and more money and energy was put into studying contraception and reproductive health to produce alternative contraceptive devices, such as the IUD in 1968. Another U.S. Supreme Court Case, *Baird v. Eisenstadt*, legalized birth control for all citizens, regardless of marital status (Kranz, Asbell and Cobble).

From this point, birth control use skyrocketed. As more women were able to liberate themselves of compulsory childbearing and have to sex more on their own terms, the number of women taking and talking about birth control also climbed. By

1965, less than five years after it was approved by the U.S. Food and Drug Administration (FDA), approximately one in four married American women under the age of 45 had or were currently using an oral contraceptive (Woliver, 2002). Around this same time, a “sexual revolution” of sorts began, which was highly publicized in the media and among college students. Evidence suggests that the introduction of the pill did not suddenly ignite these sexual desires, but allowed young women to act on the desires humans have always had and, furthermore, to talk about them with other women and in more public ways. By 1980, the pill was more popular among unmarried young women ranging from ages fifteen to 25 (Asbell, 1995).

Today, medical contraceptives are regarded socially and medically as a part of common discourse and practice. According to the Guttmacher Institute, 99% of sexually active women in their childbearing years (roughly 15-44 years) have used contraception, which could include barrier contraceptives such as male or female condoms, diaphragms, cervical caps, or spermicidal foam. Around 62 percent of these women are reported to be using medical contraceptives such as the pill, an IUD, the patch, the implant, or a vaginal ring (*see attached diagram*). Most poignantly for this research, 4 out of 5 women who had reported having sexual experiences in the United States have used the pill at some point during their childbearing years (Guttmacher, 2016). There are several variables impacting why some take oral contraceptives and others do not.

Research shows that black women are less likely to use oral contraception, than both Hispanic and white women in the United States. Beyond race, this data is impacted by the negative correlations between not having a college education and poor sexual education with contraceptive use (Frost, Darroch, 2008). Health care coverage then adds yet another dimension to these discrepancies. These statistics mainly represent the white women of this time, although some research has delved specifically into racial disparities in sexual behavior and contraceptive use. While more young black women were having premarital sex (53.5%) than young white women (23.4%) were more likely to have four or more partners: 16% as opposed to 11%. What is striking from this data set is that only 10% of the white women in the study had a child while not married (I have chosen not to use the term “wedlock” in light of it’s historically derogatory nature) as opposed to 41% of black women (Asbell, 1995), suggesting a disparity in minority groups’ access to contraception, as well as attitudes toward motherhood and marriage, which I will discuss in my findings.

My research cruxes on the idea that we are entering a Fourth Wave of Feminism, which is a conclusion I have come to in doing this research, but that is not to say that pressure on access to contraception is the only inspiration for the the current feminist movement. The uptick in organized marches, strikes, peaceful protests, in response to attacks on female health care access from the government, which beg the question of whether or not we have arrived at a fourth wave of feminism, was prompted by the demand for reproductive justice, racial justice,

equality and respect from the government, gender-based violence, LGBTQIA rights, immigration rights, and more (NPR, 2017). The push into this next wave hinges on whether or not threats to contraception is enough to politically band *all* women together, regardless of social position, race, class, or political ideology. This topic will be explored in this research.

Available Contraception

Contraceptive technology has vastly improved in the six decades since the FDA approved Enovid, both in advancing The Pill and introducing new technology and devices. Barrier contraceptives², which were most popular before Margaret Sanger pioneered medical contraceptives, have become more accessible and more effective. This is largely due to the greater information provided on how to safely use such devices, which include male condoms, female condoms, cervical caps, diaphragms, contraceptive sponges with spermicide, and contraceptive foams/creams/jellies/films/suppositories (Planned Parenthood, 2012). While not a device, male and female sterilization (voluntary vasectomy for men or tubal ligation for women) also qualifies as a form of barrier contraception. While these barrier contraceptives offer many options and are available for purchase without a prescription in drug stores and supermarkets, some but not all protect against sexually transmitted diseases (STDs) and sexually transmitted infections (STIs).

² Devices that aim to prevent pregnancy by physically preventing sperm from entering the uterus

Furthermore, they have varying levels of effectiveness, which can fluctuate depending on the user's knowledge and experience using them.

Beyond advancements in barrier contraceptives, a myriad of contraceptive devices have been introduced to the public. The Pill is an example of a hormonal contraceptive, which "use[s] hormones to regulate or stop ovulation and prevent pregnancy" (*National Institutes of Health, 2017*). Beyond The Pill, options for hormonal birth control now include the birth control implant³, the patch⁴, the shot⁵, the vaginal ring⁶, and the Intrauterine Device (IUD)⁷. For some women, putting added hormones into their body is not desirable, either based on personal preference or an aversion to minor side effects (see table below). For these women, there are some device options beyond barrier methods, including a copper IUD⁸, which has no hormones but utilizes copper as a natural spermicide. Other forms of birth control that do not rely on hormones or require medical supervision and/or prescriptions are still popular, but are often the least effective. These methods

³ Small rod inserted into a woman's arm that releases hormones into the body to prevent pregnancy

⁴ A transdermal contraceptive patch that one wears on the skin, which releases hormones that prevent pregnancy. The patch needs to be replaced every three weeks.

⁵ The depo shot is an injection that must be administered by a nurse or doctor every three months. It injects hormones into the bloodstream, which prevent ovulation.

⁶ The birth control ring is a small, flexible ring worn inside the vagina that prevents pregnancy by releasing hormones into the body.

⁷ A tiny device that's inserted into the uterus by a doctor to prevent pregnancy and can last from three to seven years depending on the type.

⁸ A copper IUD differs from the hormonal IUD in that it has no added hormones.

include abstinence/outercourse, withdrawal, and fertility awareness methods, or tracking one's ovulation.

Beyond personal preferences, these preventative contraception options have varying levels of accuracy. I have chosen to exclude emergency contraceptives from this research, as it is not preventative contraception and it is available over the

CONTRACEPTIVE METHOD CHOICE

Most effective method used in the past month by U.S. women, 2012

METHOD	No. of users	% of women aged 15-44	% of women at risk of unintended pregnancy	% of contraceptive users
Pill	9,720,000	16.0	23.3	25.9
Tubal (female) sterilization	9,443,000	15.5	22.6	25.1
Male condom	5,739,000	9.4	13.7	15.3
IUD	3,884,000	6.4	9.3	10.3
Vasectomy (male sterilization)	3,084,000	5.1	7.4	8.2
Withdrawal	1,817,000	3.0	4.4	4.8
Injectable	1,697,000	2.8	4.1	4.5
Vaginal ring	759,000	1.2	1.8	2.0
Fertility awareness-based methods	509,000	0.8	1.2	1.4
Implant	492,000	0.8	1.2	1.3
Patch	217,000	0.4	0.5	0.6
Emergency contraception	91,000	0.2	0.2	0.2
Other methods*	133,000	0.2	0.3	0.4
No method, at risk of unintended pregnancy	4,175,000	6.9	10.0	na
No method, not at risk	19,126,000	31.4	na	na
Total	60,887,000	100.0	100.0	100.0

NOTE: "At risk" refers to women who are sexually active; not pregnant, seeking to become pregnant, or postpartum; and not noncontraceptively sterile. na=not applicable. *Includes diaphragm, female condom, foam, cervical cap, sponge, suppository, jelly/cream and other methods.

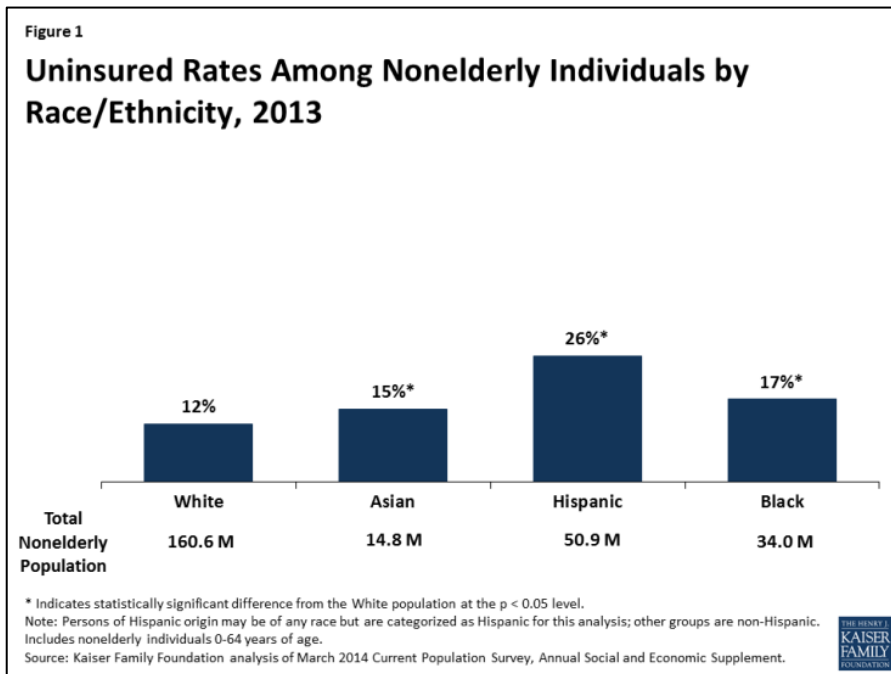
www.guttmacher.org

counter. The level of effectiveness is dependent on several factors, including proper use, education, and sometimes interference of other drugs. However, for sexually active individuals, the use of modern contraceptives is more effective in preventing pregnancy than not using

any method. According to the Guttmacher institute's "Unintended Pregnancy in the United States" fact sheet, "two-thirds of U.S. women (68%) at risk of unintended pregnancy who use contraceptives consistently and correctly ... account for only 5% of all unintended pregnancies." There are other discriminants in this data, including who exactly has access to the varying types of contraception.

Health Care Coverage

The American Healthcare system is convoluted and is riddled with paradoxes, regardless of whether or not an individual is seeking out contraception. Americans can access health insurance through their employers, the private market, or through government programs (Guttmacher Institute, 2004). It seems as though class and opportunity stratify these options, as most hourly workers are not offered coverage through their employers and then can't afford private care. These individuals are then directed to government programs, such as Medicaid. The Affordable Care Act (ACA), also commonly known as "Obamacare," is the comprehensive health care reform law enacted in 2010. It was aimed to make affordable health insurance available to more people, expand Medicaid, lower health care costs and improve system efficiency. It's rolling out expanded coverage so far that, according to the *New York Times* in 2017, roughly twenty million people had gained health insurance since its implementation (Bakalar, 2010). However, these are blanket figures that become more telling once they are broken down further.



Historically, non-white and low-income citizens have had lower access to health care and health care insurance, which the ACA aimed to change and, to a certain extent, it succeeded in doing. All racial groups

showed gains, but people of color have experienced greater increases in coverage than whites⁹, most likely due to the fact that whites had greater coverage to begin with. Despite the increased coverage for people of color, racial disparities still persist, particularly for Hispanic citizens, with 1 in 4 lacking coverage in 2013 (KFF, 2018). As far as income levels are concerned, there was a general increase in coverage, as both public and private coverage expanded. According to the Center on Budget and Policy Priorities, “8.5 million fewer individuals with household incomes under \$50,000 were uninsured in 2015 than in 2013, as were 4 million fewer individuals with incomes over \$50,000,” (Broaddus, Park, 2016). These expansions allowed more women of reproductive age from all demographics and backgrounds to have the health coverage they need to access prescription contraceptives.

⁹ To view these statistics broken down into elderly, nonelderly, and children, go to the Kaiser Family Foundation. <https://www.kff.org/disparities-policy/issue-brief/health-coverage-by-race-and-ethnicity-changes-under-the-aca/>

Another provision of the ACA was the guarantee of insurance coverage of all birth control methods with no additional out-of-pocket cost, regardless of the patient's geographic location or type of insurance. The National Women's Law Center reports that across the country, "Over 55 million women now have coverage of birth control and other preventive services without out-of-pocket costs" (NWLC, 2017).

Methodology:

Contraception is a topic intrinsically tied to the female experience and, as such, it would be impossible to accurately represent the topic without speaking directly to women about their experiences with and without it. This led me to conduct in-depth interviews with individuals who identify as women on Gettysburg College campus. Participants were asked to participate in a conversation about their experiences with contraception throughout their lives, and where they view the future of contraception heading, whether that be in the technology, the politics surrounding it, or in their personal decisions to utilize it. *See questionnaire in annex.* My intention was to engage in a thought provoking discussion with the participants in order to inspire them to share their personal experiences with me, but I underestimated how much each woman had to say about the topic. I have found that asking women to share their experiences on topics that often seem too 'taboo' for everyday conversation, simply for the sake of listening to them earnestly, opens the floodgates to impactful and important conversations.

In order to build my sample, I began by emailing women’s groups, clubs, and interested professors on campus. Only a few of these emails elicited responses, with

Emailed:	Response?
YAF	3 memebers interviewing
College republican	president interviewing
college dems	no
LASA	1 member response
BSU	no
Sorority Presidents	no
Political Science Professor	yes
Political Science Professor	no
Asian Student Alliance	no
Brown Nipple Collective	no
China Club	no
Chi Omega	yes

the most enthusiastic response

coming from the college’s

“Young Americans for Freedom

club (hereafter YAF), the most

conservative group on campus.

In total, I conducted 11

interviews with women on

Gettysburg College’s campus. Of the eleven women who were interviewed, eight identified as white, two identified as Latina, and one identified as African American.

The eleven women were all aged between nineteen and twenty-one. I did not take notes during my conversations with these women in the hope of creating an authentic dialogue, but I audio-recorded each conversation¹⁰ and used an online transcriber to create individual transcriptions for each interview.

It was my suspicion that opening the door to a discussion of this sort, particularly a confidential discussion, would be a freeing experience for the women who participated. Often times, giving women an outlet such as this to talk about women’s issues is sufficient encouragement to share their stories and opinions. In participating in these discussions, I quickly realized that I could not completely

¹⁰ Consent for audio recording obtained through written consent from and verbal consent at the start of each interview

divorce myself from the research, as I am a member of the community this research is focused on. This manifested itself in my conversations with research participants and my inclusion of my experiences in my analysis.

I utilized interview memos in order to find common trends throughout all the women's experiences. This helped me to create a broader understanding of the general attitudes among college-aged women and flesh out both parallels and divergent experiences. Being so close to the research, I went into this research with certain expectations about the results and the women I would be interviewing. To a certain extent, this was a limitation in the sense that it led me to ask all the wrong questions at the onset of my research. I quickly learned that I needed to make a point of neutralizing the questions I asked, seeking out participants of a wide range of backgrounds, and constantly checking my reactions and preconceived notions.

To interpret these personal accounts, I have focused on reading literature that provides statistical data evidence and literature that paints broader portraits of attitudes towards contraception throughout American history. As the guiding question I've followed has been "how did we get here?" It is my hope that the broader literature and data will reflect the small sample I have collected on Gettysburg College's Campus. Beyond this, I hope it offsets the limitation of the sample I gathered Gettysburg College, primarily white, upper-middle class, straight, cisgendered women. It is important to my research that I make a conscious effort to observe how women from different backgrounds and communities interact with

contraception. This is a cornerstone of my Feminist Standpoint Theory approach to the research, the recognition of socially situated knowledge and the unique perspectives at each power dimension, particularly within marginalized groups.

Limitations:

As previously mentioned, the main limitation of my study is the white-middle to upper class status of my sample, as per the demographic of Gettysburg College. I am including whiteness and class belonging as a focus in my research in the sense this it is intrinsically connected to all women's experiences, but I do not have the ability to speak with a representative sample of all women. To counter this issue, I have focused on research and data that focuses on disparities between race, class, and geographic location.

Interviews:

In speaking to Gettysburg college students about their experiences with birth control, I've learned much about the nature of my research, as well as the anticipations I brought into this work. I found my expectation to be that access to contraception is a topic on the forefront of women's political agenda, simply because women inherently have to think about their relationship to contraception at some point. However, the women who volunteered to take part in the interviews challenged this belief and highlighted the myriad of political alliances of young women today.

As previously mentioned, due to the demographics of the Gettysburg College student body, which according to the school's website is 84% white, this cannot just

be a study in policy and attitudes surrounding contraception. It must also be a study about whiteness and socioeconomic privilege. Beyond an academic understanding of privilege, which their education has afforded them, many women interviewed have not had to apply a deeper understanding of their privilege into their own lives and discourses. In regards to contraception, this then shapes how they imagine all women's experiences accessing it. If privileged women imagine all experiences to reflect their own, they will not see systems working against those with less privilege. Patricia Hill Collins discuss this issue of how one's experiences shape their ideas, yet that experience cannot be singular, as "embracing a paradigm of race, class, and gender as interlocking systems of oppression" allows one to re-conceptualize systems of oppression and domination (Hill Collins, 1990, 221-238). In order to have a greater understanding of the experiences of women trying to access contraception, women have to understand experiences beyond their own class, race, and social position.

Types of Contraception Used

Of the eleven women interviewed, ten had previously or currently use medical contraception. Of those ten women, all had used the oral contraceptive pill, which many women had an 'if it isn't broken, don't fix it' feeling about. Only one of the ten women had sought out a more permanent contraceptive solution in the Depo Provera shot. This woman, who will be referred to as Nina, a pseudonym, is from New York City and identifies as black and Puerto Rican. She sought out the Depo shot because she had a hard time remembering to take her contraceptive pill

everyday, but found that she greatly preferred the shot for its convenience, non-daily use and lack of side effects such as weight gain, or bruising as with the bar implant. However, after two years of use, her doctor informed her that she could only be on it for so long, due to worries over fertility, which she expressed significant disappointment and frustration with.

When it came to the IUD, which has gained a lot of traction in recent years, a majority of women interviewed expressed great hesitance about using it. When asked about it, Nina expressed the negative experiences some others had reported with its use, but she also said “I just don’t know how I feel about a material up inside me and then have to get it changed... I just don’t have time for that.” This fear of a foreign object inside their body that couldn’t be seen or easily removed was a fear cited by all eleven women when asked about the IUD. Personally, I went off of the contraceptive pill and had a Kyleena brand IUD¹¹ inserted during the process of doing these interviews. I made this decision because I did not get a regular period with the pill, and struggled to remember to take it regularly. The idea of a foreign entity in my body does not bother me, but the insertion process, though short, was painful. I am still within the 3-6 month adjustment period and I experience painful cramping around my period, which comes more regularly now. Beyond this, I feel deeply fortunate that I do not have to worry about taking a pill everyday or worry about missing a pill.

Deciding Whether or not to Use Contraception

¹¹ Hormonal IUD, lasts up to 5 years

As previously mentioned, reasons for taking contraception are widely varied, and the women interviewed expressed many. Five women stated they began using contraception to combat acne, regulate their periods, alleviate painful cramping, or a combination of those reasons. One woman, Anne, said it was a last resort after experiencing crippling pain during her period, which caused her to miss up to four days of school per month. Four women began taking contraception because they were beginning to, thinking about, or had previously been having sex. One participant began taking contraception as a protective measure after experiencing sexual assault.

Samantha, who was the only participant who had never used contraception of any kind, cited a couple of reasons as to why. Her immediate response to being asked why and how she had made the decision to not use any contraception was “definitely my religious beliefs about sex,” although she wanted to stress that she’s “not one of those people waiting until marriage.” She was currently in a relationship, but felt as though she wasn’t ready to have sex and therefore didn’t need contraception. She had heard of other reasons to take contraception, such as for acne, but didn’t feel as though she needed it.

Conservative Women

Another aspect of diversity that I had not thought about at the onset of my research was political diversity. My understanding of how women feel about contraception was limited by my own political beliefs and by the beliefs of those whom I surround myself with. I made a concerted effort to interview women all

across the political spectrum, and found the interviews with those whose opinions vastly differed from mine to be some of the most captivating. The women who identified as politically conservative, four in total, had very compelling and well thought-out ideas and opinions regarding contraception, politics and how they intertwine. Interestingly, all four women believed that all women should have access to birth control and had, generally, what one would describe as liberal views on contraception and women's sexual health, yet their beliefs became sharply conservative when discussing the politics relating to it.

Samantha, who was the only participant to not use contraception, continually cited her conservative household and Catholic education as what shaped her view of contraception. Without prompting, she quickly brought up Planned Parenthood and a presentation in her Tenth Grade Catholic Morality class about "13 Horrifying Facts about Margaret Sanger." She vehemently opposed Planned Parenthood because she is strictly pro-life, and although it's not all they do, they still perform abortions and she "can't stomach" the idea that taxpayer dollars could help fund them, even indirectly. She also cited articles she read, which she admitted seemed "conspiracy-esque" that state Planned Parenthood's resources (condoms and other barrier contraceptives) are of poor quality and they sway women toward choosing abortions. Another woman, Anne, currently serves in a leadership role of a conservative club on campus, who had been on the birth control pill for nine years. Anne's mother brought her to the gynecologist at a relatively young age due to her extreme pain during periods and eventually encouraged her to start the pill to curb her cramping. While she feels as though all women should have access to

contraception, she doesn't feel as though it's enough of a necessity to be covered under employer's health care plans.

In addition, the interviews with these women highlighted the plight of college-aged conservative women in the Trump-era, in that they are often asked to choose between their identity as a conservative and their beliefs as a woman. As many women have been emboldened by the election to share and act on their political beliefs in conservative circles, many women conservative women have been shamed for their opinions. While several conservative women were interviewed, both Samantha and Anne expressed their diverging thoughts as women and their thoughts as conservatives. Samantha put it very simply, stating, "Yeah, I get a lot of shit." In her experience as a leader of a conservative club on campus, Anne explained her dilemma as being accused of "thinking less conservatively" when her opinions differ from her predominantly male club. However, classmates and friends ask her, "As a woman, how could you hold these socially conservative ideals", challenging the same beliefs other conservatives accuse of being "not conservative enough." The demand to perform as one or the other calls to Audre Lorde's theory of performativity, the idea of choosing one aspect of your identity and performing as society would expect you to perform. What does one do when society tells them two parts of their identity simply aren't compatible?

If this conservative student leader feels such pressure to think a certain way or censor what she says because of her gender, the pressure on conservative elected female officials must be drastic. In July of 2017, Senate Majority Leader Mitch McConnell led a vote to repeal the ACA without any replacement in order to

pressure the senate into passing a healthcare bill, which, according to a Washington Post article, had been written by only men (Phillips, 2017). While both men and women had issues with this bill, it was three female Republican senators, Shelley Moore Capito (W.Va.), Susan Collins (Maine) and Lisa Murkowski (Alaska) who shut down the vote. The GOP's decision to omit women from debates and draftings of healthcare bills highlights "the party's lack of diversity, especially in the Senate, where 47 out of 52 Republicans are men," (Phillips, 2017). Despite the fact that four women serve as republican senators, still only three voted against the repeal of the ACA, which directly and negatively impacted all women. Conservative women, like all women, hold their beliefs for a myriad of reasons, all of which are valid. Excluding their voices from political and public conversations does a disservice to all women, particularly when there are so few conservative female leaders.

Insurance as a Barrier

Many interviewees cited their main obstacle as their parents' or guardian's insurance and the tendency of prescriptions' costs and coverage to vary month by month. Yet research shows that those who are unmarried, hourly workers, living in urban areas, and are not white, are significantly less likely to even have health coverage (Medalia and Smith 2014). According to the *Women's Health Issues'* research *Women, Private Health Insurance, and the Affordable Care Act,* "those without health insurance are twice as likely than women with either public or private insurance to experience cost barriers that force them to forgo or split prescriptions (Salganicoff and Sobel, 2015). Naturally, splitting or skipping

contraceptive prescriptions increases the odds of unintended pregnancy, which creates a snowball effect in, not only cost, but also ability in to work. As so many rely on their employer for health coverage, those who are already at a disadvantage will continue to be disadvantaged without policy change geared to expand health coverage.

Sarah, a nineteen-year-old white woman who was interviewed, expressed several times how she relies on her father for her contraceptive prescription, healthcare, and out of pocket expense, and the privilege this lends her. She said that, because of this, she's never had an issue accessing contraception but one month, without warning or explanation her prescription cost hiked up to \$780. This led her to ask, "Well, what if you don't have parents who are willing to pay that? Then what?" Another interviewee, Olivia, a white woman from New York City, explained the issue she had with maintaining her coverage outside of New York State. While her oral contraceptive prescription cost her \$20 for a three-month pack in New York, her same prescription cost her \$175 for a one-month prescription in Gettysburg, Pennsylvania. Again, she was able to pay for the prescription that first month, but then had to change the brand of her contraception to lower the cost.

These are two women who had the economic ability to view these price jumps as an annoyance, rather than a harsh boundary, as they were still able to pay the increased cost, but their experience does not reflect the majority outside of the Gettysburg College Campus.

One can see the effects of the Trump Administration's actions already coming into view as women's, particularly college women's, access to birth control has been politically threatened for the first time in a considerable amount of time. For women between the ages of 18 and 25, this is likely the first time their access to contraception has been threatened in the years they've had to consider it. My assumption was that these women would be politically activated by the increased attacks on their healthcare coverage, specifically regarding contraception. It is impossible to ignore that, although the cuts aim at healthcare coverage, women are disproportionately impacted.

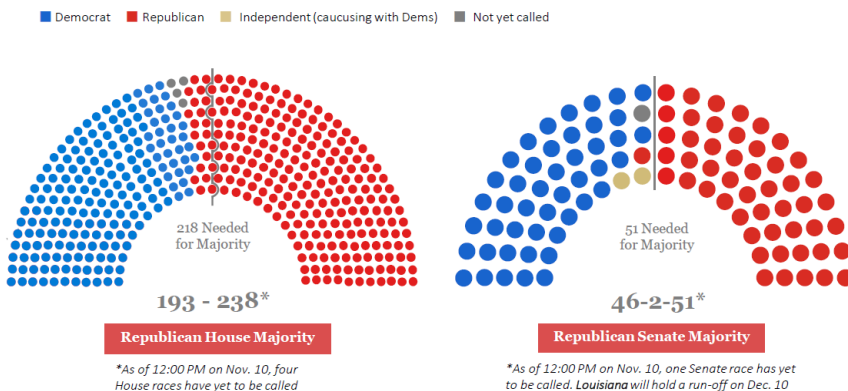
Following the 2016 U.S. presidential election, calls for women to obtain long-acting reversible contraception (LARC), including intrauterine devices and subdermal implants, began trending on social media. Judge and Borrero found that in 2158 completed surveys, the most prevalent concerns were "birth control will cost more or cost too much" (91%), "Planned Parenthood or other family planning clinics will close" (69%), and "abortion will be less accessible or not an option" (68%). Among the participants, 9.4% had started a new birth control method in response to the election (*American Journal of Obstetrics and Gynecology*, 2017), indicating that this election has awoken a fear that may lead to political action. This would seem to confirm my suspicions.

It has been clear that a key initiative of the current republican agenda will be women’s sexual and reproductive health - in its first days of session, the US House of Representatives passed HR 7, a bill that would deny insurance coverage of abortion care to millions of women (NPR, 2017). This being said, these anti-woman government actions are receiving government actions pushing in the opposite direction and increased pressure from women across the country. Overwhelming data shows that more women and minority citizens are running for office across the country, for example applications to Emerge America training courses for women candidates are up 87% from 2016 to 2017 (CNN, 2017). Political change is inevitable, but the health care policy changes that will be made under the current administration are unclear at this point.

In a time where women can organize and communicate so easily, they have been able to spark social movements and public conversations about women’s issues. As previously discussed, these movements and discourses have been

Republicans keep the Senate and limit Democratic gains in the house in 2016 elections

Party control at beginning of 115th Congress (2017-2019)



extremely successful in that they are visible, adaptable and inclusive for all women, and continued. However, they

haven’t led to policy changes, which is likely due, in large part, to the fact that

Trump is in office with a republican majority across the board. As progressive bills for women and minorities are typical proposed by democratic officials, it has been nearly impossible for anything somewhat blue to be passed.

Conclusion

In talking to women on Gettysburg College's campus, I have learned that, regardless of political affiliation or their personal political agendas, these women are listening to what happens in our government. However, women must be able to have conversations with individuals who have conflicting opinions with their own and listen to women outside of their learned realms. I believe we are on the cusp of a fourth wave of feminism, whether or not we actually progress into a fourth wave is up to all of us who make up the movement. As we continue through this time of uncertainty in our politics, the feminist movement of 2018 must distil its message and focus. I believe this is a wave characterized by outright governmental opposition, intersectionality, a promotion of previously marginalized women/non-binary/queer individuals, and the election of these individuals into public office. Third wave feminism opened the door to many of these ideas, but what will set fourth wave feminism apart will, and must be, be political action. The third wave of feminism successfully incited social change, now it is necessary for American policy to catch up.

Contraception is so integral to this Fourth Wave, because while it is far from being the only issue within the current women's movement, it is one that has been repeatedly attacked by our government throughout history. While recent threats to

women's access to contraception have helped to mobilize discussion and popular women's social movements, it is not enough for women to perceive themselves as women first, before their race, sexual identity, class, or political affiliation. In order for all women to put the issue of health care coverage of preventative medical contraception at the forefront of their political agenda, something drastic and sweeping must occur at the hands of the government. Without this prioritization of political action and reaction, we will not be able to enter a true Fourth Wave of Feminism.

*Annex**Interview Guide*

1. I've recently been trying to think back to how I first learned of contraception and I've had a really hard time pinpointing exactly what it was. Do you remember the first time you learned what birth control was?
2. Do you feel as though there are any taboos surrounding women's use of contraception?
3. What do you know of the history of women's access to birth control?
4. Do you feel birth control is generally pretty accessible today?
5. Have you ever been or are you currently on any contraceptive medication? If so, what kind?
 - a. What were your feelings about it?
6. How did you make the decision to start using medical contraception?
Alternatively – How did you make the decision to not use medical contraception?
 - a. Are you happy with your decision regarding birth control in your life?
7. Do you think birth control has had an impact on your life? How?
 - a. Some think of the pill and other contraceptive medication as a burden, others feel it has brought liberation for women, what are your thoughts on this?
8. Recently there has been a lot of debate around whether or not birth control should be included in insurance plans, whether employers should include it

- in health plans, etc. What is your stance on employers including birth control in employees' health plans?
- a. What are your thoughts about cases where companies state that covering contraception goes against their religious beliefs, such as Hobby Lobby?
9. Considering these recent threats on access to birth control, do you feel any differently about your personal relationship with contraception?
- a. Some data show an increase in women seeking out more permanent contraceptive devices, such as the IUD or the implant, since the last presidential election. What do you make of this? Have you ever considered this?

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