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“Without bodily autonomy we are not free”: Exploring women’s concerns about future access to contraception following the 2016 U.S. Presidential Election

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Abstract

Objective—Following the 2016 U.S. Presidential Election, social media posts and news stories amplified concerns about the potential for reduced access to contraception under the incoming administration, and urged women to seek long-acting reversible contraception (LARC). We aimed to describe women’s concerns about future access to contraception, in their own words.

Study Design—A social-media based, anonymous online survey assessing thoughts and concerns about future access to contraception was distributed to reproductive-aged U.S. women for one week in mid-January 2017. Participants who were concerned about future access to contraception could share their thoughts and feelings in an open-ended comments box. We qualitatively analyzed 449 written responses for content and themes, with the goal of characterizing key concerns.

Results—Women who provided written comments had a mean age of 28 years; 85% were white, 88% had at least a college degree, and 93% identified as Democratic or Democratic-leaning. Women were highly concerned about future affordability of contraceptive methods due to potential loss of insurance, reduced insurance coverage for contraceptive methods, and reduced access to low-cost care at Planned Parenthood. Many also worried about increased restrictions on abortion.

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Participants' concerns regarding access to contraception and abortion centered around themes of reproductive and bodily autonomy, which women described as fundamental rights.

Conclusions—Women in this study expressed considerable fear and uncertainty regarding their future access to contraception and abortion following the 2016 U.S. Presidential Election. The potential for restricted access to affordable contraception and abortion was viewed as an unacceptable limitation on bodily autonomy.

Keywords

access; contraception; election; concern

1. Introduction

In the weeks following the 2016 United States Presidential Election, women expressed considerable concern about future access to contraception. A flurry of social media posts urged women to seek long-acting reversible contraception (LARC), including intrauterine devices (IUDs) and subdermal implants, before the new administration took office [1]. News articles raised awareness about the potential impact of political promises to repeal the Affordable Care Act (ACA) and defund Planned Parenthood, and reinforced concerns about decreased or eliminated insurance coverage for contraceptive methods [2, 3]. Consistent with the fervor seen online, women's health providers reported increased demand for LARC and shared stories of patients anxious about their contraceptive options [2, 4]. These anecdotal reports were corroborated by health systems data revealing increased IUD-related appointments in November and December 2016 compared to the previous year [5].

To better understand the nature of women's concerns driving contraceptive decision making in the post-election period, we conducted an anonymous online survey in mid-January, 2017. In a social media-based convenience sample of 2158 U.S. women ages 15–44, 42% of women had concerns about their future access to contraception, and over 5% had changed to LARC in the two months following the election. Democratic party affiliation was a strong predictor of both concerns and method changes [6].

Survey participants with concerns about future access to contraception also had the opportunity to share additional thoughts or feelings in an open-ended comments box. Women's written comments reflected their emotions, concerns and fears surrounding future contraceptive options and availability, and we were struck by the detailed character of these responses. We therefore performed a qualitative analysis of these written responses, with the goal of describing the nature of concerns raised by participants in their own words.

2. Materials and Methods

2.1 Data Collection

We distributed an anonymous online survey between January 17 and January 24, 2017. We reached U.S.-based, female social media users ages 15–44 using paid, targeted advertising on Facebook and Instagram; the University of Pittsburgh's Center for Women's Health Research and Innovation (CWHRI) also shared the study link on its Facebook page, with

subsequent snowball sampling. Advertisements invited potential participants to complete the “Post-Election Birth Control Survey.” Clicking on a study advertisement directed individuals to the survey, which was hosted on University of Pittsburgh-licensed Qualtrics. Women 15–44 years old with reproductive capacity (i.e. not menopausal and with no history of hysterectomy or infertility) living in the United States were eligible to participate. All participants provided informed consent, and inclusion and exclusion criteria were assessed using five yes/no screening questions. No identifying information was collected. This study was approved by the institutional review board at the University of Pittsburgh.

Multiple choice questions assessed potential concerns about future access to contraception, the specific nature of concerns, contraceptive method changes since the election, and sociodemographic characteristics, including political party affiliation [7]. Of 2453 participants who provided informed consent, 2299 were eligible for participation after screening (96%), and 2158 submitted completed surveys, for a completion rate of 94%. Surveys were considered complete and included in analysis if participants progressed through the main survey items and answered at least one demographic question.

Participants who indicated that they had concerns about future access to contraception were directed to a select-all-that-apply item assessing the specific nature of those concerns, and were then asked to “please share any other thoughts or feelings you have about your future access to birth control” in an open-ended comments box (Figure). Written responses from this comments section were compiled for qualitative data analysis.

2.2 Data Analysis

Descriptive statistics were generated for demographic and outcome variables among the total sample and among women with concerns who did and did not provide written responses. Chi square tests were used to test differences in demographic characteristics between sample subgroups. Quantitative analyses were performed using Stata 14.

We analyzed written responses for content and themes using codes that emerged inductively from the data, meaning that we created codes based on what participants said rather than based upon preconceived notions of what participants might say [8]. Two coders (C.J. and T.W.) independently coded the first 95 responses (20%), then established a joint codebook with definitions and rules for application, which was used to code the remaining responses, with edits and additions as necessary. A total of 22 codes were developed to encompass thematic content and organize the data, with as many codes as appropriate applied to each response. All responses were double coded by C.J. and T.W. Inter-coder reliability was assessed for the second half of responses (n=230) using Cohen’s Kappa, after two rounds of training with the codebook. Kappa for individual codes ranged from 0.42–1, with an average overall Kappa of 0.75, indicating substantial agreement. Following kappa calculation, coding was adjudicated to consensus for all responses. We identified and described thematic trends by summarizing the content of each code and grouping related codes into larger themes. ATLAS.ti and Microsoft Word were used for data management and coding.

3. Results

3.1 Participant Characteristics

Among the 42% of women (n=903) who had concerns about future access to contraception, 49.7% (n=449) provided written comments and comprised our study sample. Participants had a mean age of 28 years; 85% were white, 88% had at least a college degree, and 47% had never been married (Table 1). Written responses were provided by 418 Democratic-leaning women (93.1%), 12 Independents (2.7%), and 19 Republican-leaning women (4.2%).

Compared with the total sample (n=2158), participants with concerns who provided comments were younger, less likely to be Christian, and more likely to be single, to have a yearly household income less than \$40,000, and to identify as Democratic-leaning (Table 1). Women with concerns who provided written comments were not significantly different from women with concerns who left the comments box blank for all assessed demographic characteristics except political party affiliation; 19 out of 25 Republican-leaning women with concerns wrote comments (76%), compared to 39% of Independent and 49.5% of Democratic-leaning women with concerns (p=0.015, data not shown).

Qualitative analysis of comments regarding future access to contraception revealed three major themes: women were concerned about 1) cost increases for contraceptive methods, 2) increased restrictions on abortion, and 3) the ways in which reduced access to affordable contraception and abortion impinges on reproductive and bodily autonomy. Illustrative quotes for these themes are included in the text below. All quotations are from Democratic or Democratic-leaning participants, unless otherwise indicated.

3.2 Cost-related concerns

The most frequently cited concerns regarded potential future costs of contraception, and were described by 179 women (39.9%). Many women worried that their out-of-pocket costs for contraception could increase dramatically either due to reduced insurance coverage for contraception or lack of health insurance altogether if certain provisions of the ACA were repealed. One woman explained “I am concerned that birth control will not be covered by my insurance, if I can even get insurance.” Many commented on the high cost of highly effective methods such as IUDs: “I currently use an IUD and have heard that replacing it (in 2018) may cost \$1000–\$1500 if it is not covered by insurance. As a woman, I feel I’m being penalized for making proactive, responsible family planning decisions.”

Although many women in our sample acknowledged that an increase in cost, although unwelcome, would not adversely affect their overall financial security, many expressed concern for those with fewer financial resources. One woman explained, “I had to scrimp and save for my IUD and after “ObamaCare” was enacted I looked forward to my next IUD being more affordable. Now, I see myself having to scrimp and save again for the next IUD. I am lucky that I can save for my birth control but am worried for those women who cannot.”

Others painted stark pictures of simply being unable to afford higher costs of contraceptive methods, or of having to choose between contraception and other expenses. One woman stated bluntly, “If it isn’t covered by insurance I won’t be able to afford it. Condoms aren’t trustworthy. If I can’t afford birth control I clearly cannot afford to raise a child.” The already high cost of other medications or of medical care in general was frequently noted as a barrier to being able to afford increased costs of contraception, and many women were distressed at the prospect of being forced to prioritize certain aspects of their health and wellbeing over others. One woman wrote, “I’m sensitive to side effects and have tried dozens of birth control brands. The only one that’s worked would cost over \$60/month if it weren’t for the ACA. [...] This has been one of my primary concerns since the election. I worry about it all the time.” Another stated, “I’m worried that birth control in the larger context of healthcare in general will become not affordable for me and my husband. I know that we could cover the cost, but in conjunction with seizure medication [...] I don’t want to have to choose.”

Women’s concerns about potential increased costs of contraception were further exacerbated by worries that safety net options for low-cost health care and contraception, such as Planned Parenthood or other reproductive health clinics, would be unavailable. A 23-year old woman explained, “I’m worried that I won’t have affordable access to birth control as a result of unfunding [sic] Planned Parenthood, being kicked off of my parents’ insurance before I am able to graduate college and get a stable job.” Another participant explained her fear of losing both her insurance and access to other options:

“I work for a small business that doesn’t provide insurance benefits and purchase insurance via healthcare.gov. I have pre-existing conditions, so if all or part of the ACA is repealed, I will likely lose my insurance until I can find a job with an employer that does offer that benefit. [...] I am concerned about not being able to access healthcare - either through not having insurance, or through closure of family planning clinics where I could get affordable care.”

While Democratic-leaning women accounted for the vast majority of responses, 10 of the 19 Republican-leaning women who provided written comments were specifically worried about cost increases, either for themselves or others. One Republican-leaning Independent pondered, “If my birth control increases so much that it is not affordable, and Planned Parenthood is closed (where I could access affordable birth control) then what am I going to do?”

3.3 Abortion access concerns

Although the question prompt did not specifically address abortion, 74 women (16%) used the open-ended comments box to detail their concerns about the possibility of increased restrictions on abortion in the current political climate: “On election night, the fear of being forced to have a child I don’t want or needing to use unsafe methods to have an abortion brought me to tears.”

A prevalent fear was being forced to carry a non-viable or medically dangerous pregnancy: “My husband and I are starting to think about having a child, but I’m afraid to get pregnant for fear that I won’t be able to get an abortion even if there is a medical reason (non-viable

fetus, my life is in danger).” Another woman’s concerns reflected intense personal experience:

“In my attempt to have children, I have had four miscarriages that required intervention. I had one ectopic pregnancy that seriously jeopardized my life. I am seriously concerned that there are people within the new administration who do not support abortion even when the mother’s life is threatened. As someone who believes abortion should be available without question, this is unacceptable and terrifying.”

Regarding the broader impact of increased restrictions on abortion, many women expressed concerns about abortion access for individuals with few financial resources, suggesting that wealthy women would always be able to leave the state or country to obtain an abortion if necessary. The predominant opinion was that abortions will continue to occur irrespective of their legality, and many worried about a potential rise in self-induced and unsafe abortions due to reduced access to legal abortion. One woman explained, “I fear greatly for the oppression of women and the rise of unsafe abortions. Illegal or not they will happen especially if birth control options [are] rescinded.” Another shared, “I am afraid that the new government will force us back to back alleys and home “remedies” for the control of our own bodies.”

Two Republican-leaning women shared thoughts on abortion, both describing the necessity of safe and legal abortion despite their personal or religious views. One explained, “I do not consider myself pro-choice, but I still think abortion should be legal for reasons directly and indirectly related to termination of an existing pregnancy. I definitely worry about what making abortion illegal would do for women’s rights in general, women’s health, and women’s access to contraceptives and other healthcare.” Another described the intersection of her faith and her views on abortion:

“Birth control is a difficult topic for me. As a woman, I believe in equality, healthcare, and dignity for all, regardless of gender or sexuality. As a Christian, abortion availability is an issue that deeply concerns me, for worldview and faith-based reasons that cause me to believe that life begins at conception. Do I think that women need continued access to healthcare and birth control options? Yes. Do I believe that abortion is sometimes one of those options? Yes - an answer I grieve over, but an answer I continue to give. While I am not currently sexually active, someday I may be - and I hope that birth control will be available for me and for women across the US.”

Finally, some women described fears regarding the possibility of rape, and several expressed specific concerns about limitations on abortion in cases of sexual assault. One woman questioned, “If we can’t have [birth control], and we can’t have abortions, but men are free to run around doing whatever they please to whomever they please, then where does that leave us?”

3.4 Threats to bodily and reproductive autonomy

While specific worries varied, women's concerns centered on the overarching theme that bodily and reproductive autonomy are fundamental human rights, and that access to affordable contraception and abortion is vital to the preservation of these rights: "Women, and men, should have legal access to Birth Control. It's their right as human beings to prevent pregnancy, if it is their choice." Overall, 95 responses (21.2%) contained specific references to reproductive rights, human rights, or bodily autonomy. Women voiced strong sentiments about their right to decide if and when they want or do not want to have children, and expressed fear and anger at the prospect of losing control over their fertility: "Being able to control when or if we have children is essential to the freedom of the women in this nation. Without bodily autonomy we are not free." Others reflected on the place of reproductive autonomy within the broader scope of human rights: "It is a fundamental human right to control my body. Without easy access to birth control and unrestricted abortion access, that right is taken from me."

In addition to rights and justice arguments, many respondents described the essential role of contraception in enabling women to lead fulfilling lives, contribute maximally to society, or to achieve desired educational attainment or economic security before electing to have children. For these reasons, delaying childbearing was perceived as responsible or even altruistic. One woman explained, "I'm a married woman. I can't afford children right now. I'm trying to have a fulfilling marriage while avoiding children until my family can financially afford it: being a responsible citizen by planning for our future & potential dependents." Others described how restricting access to contraception would limit their ability to thrive while impinging on reproductive autonomy: "I feel like limiting access overall is a mandate that reproduction is MY responsibility, not a male partner's, and that it's being valued over my personal future, education, and career."

In addition to controlling fertility, many women noted the role of contraception more broadly. For instance, 42 women described using contraception to manage medical conditions, including menstrual disorders (n=17), ovarian cysts (n=8), endometriosis (n=6), acne (n=5), migraines (n=5) and anemia (n=2). For these women, the prospect of restricted access to contraceptive medications represented a serious infringement on both reproductive and bodily autonomy, and elicited fears for reduced physical and emotional wellbeing. One woman explained, "Hormonal birth control regulates the frequency and severity of my menstrual cycle, as well as cramps and acne. If it becomes unavailable, especially due to cost, my wellness will be jeopardized in addition to my bodily autonomy." One Republican-leaning Independent asked, "Can we start calling it hormonal therapy instead of birth control? Can the birth control part be an off-label use? People seem to get up in arms about babies being involved, when in reality women use the pill for a variety of reasons: acne, heavy or irregular cycles, [polycystic ovary syndrome], etc."

Through the lens of reproductive and bodily autonomy, political efforts to reduce access to contraception were interpreted as misguided to outright coercive. Women described frustration at the potential for political interference in what they believe to be private and deeply personal decisions. "My doctor and I should be the ones making the medical decisions that are best for me. Not a politician," one woman explained. Another went

further, describing what she feels is political overreach regarding women's reproductive rights: "I do not feel like I am a full citizen of this country because my government does not believe I am capable of making my own moral choices. I am anxious about the future." Several women described a perceived disconnect between political processes and the reality of women's lives. "Restricting access to family planning makes no sense to me. [...] It's my strong belief that if Congress were even vaguely representative of the American populace, this wouldn't be an issue, and I'm extremely put out that something so straightforward can be made so contentious."

Still others elaborated on the perceived irony of politicians simultaneously striving to limit access to contraception and abortion: "People fight to make abortions illegal, but fight just as hard to take away something that will prevent those abortions from happening." Another suggested, "If [Republicans] want to make it harder for people to get abortions, then they should make it easier for women to access birth control other than condoms."

4. Discussion

Several themes emerged from our qualitative analysis of an open-ended survey question regarding future access to contraception in the wake of the 2016 U.S. Presidential Election. Women in our predominantly Democratic-leaning sample were highly concerned that cost increases due to decreased or eliminated insurance coverage would prohibit their use of contraceptive methods for birth control or medical reasons. Many were worried about increasing restrictions on abortion. Overall, affordable access to contraception and abortion was portrayed as vital to the protection of bodily and reproductive autonomy, which women affirmed as essential rights.

Our results indicate that the potential for increased costs of contraceptive methods is a real and salient concern for many women, even among those with employer-based insurance or relative financial stability. The fearful and emotional nature of women's worries about cost stand in stark contrast to expressions of disbelief by politicians that women have trouble affording contraception [9]. Indeed, studies have shown that cost is a significant barrier to consistent use of effective contraceptive methods [10–12]. Conversely, when cost barriers are removed, women are more likely to use prescription methods and to select highly effective methods such as IUDs and implants [10, 13], which have considerable upfront costs if paid out-of-pocket.

Contraceptive use is nearly ubiquitous among sexually active women in the United States. In 2010, greater than 99% of hetero-sexually experienced U.S. women reported having ever used any contraceptive method, and 87.5% had ever used an effective, reversible prescription method, including the pill, other hormonal methods and LARC [14]. Consistent use of effective contraceptive methods dramatically reduces the risk of unintended pregnancy, such that 95% of all unintended pregnancies are due to inconsistent use or non-use of contraception [15], and helps optimize birth spacing, potentially mitigating the increased pregnancy complications and poor neonatal outcomes associated with short interpregnancy intervals [16]. Hormonal contraceptive methods also have various non-contraceptive benefits

including treatment of menstrual disorders, endometriosis, acne and reduced risk of endometrial, ovarian, and colorectal cancer [17].

For these reasons and others, a 2011 Institute of Medicine (IOM) report commissioned by the Department of Health and Human Services concluded that contraceptive counseling and method provision are essential preventative services for women of reproductive age [18]. Following these recommendations, provisions under the Affordable Care Act mandate that health insurance plans cover the full range of prescription contraceptive methods without cost sharing. Concurrently, expanded coverage for women of reproductive age through the insurance marketplace and Medicaid expansion has led to a nearly 40% reduction in the number of uninsured women ages 18–39 between 2012 and 2015 [19]. These changes in health care policy have led to significant reductions in out-of-pocket costs for contraception [20, 21], savings which many women in our study feared to lose.

While not prompted by the question stem, many woman shared poignant fears about increased restrictions on abortion under the new Presidential administration. Recent surges in state-level anti-abortion legislation [22] and politicians' promises to overturn *Roe vs. Wade* indicate that these fears are not unfounded. Study participants expressed strong views that abortion is a necessary option to ensure women's reproductive autonomy, as well as the health and well being of women and their families. Many participants stressed that limitations on legal abortion would not reduce the number of abortions, but only make them less safe and jeopardize women's lives in the case of medically complicated or life-threatening pregnancies. This viewpoint is extensively supported by prior research indicating that restrictive abortion legislation is not associated with lower abortion rates [23, 24], and that unsafe abortion is a leading cause of maternal mortality worldwide, particularly in areas where abortion is illegal [25]. In the U.S., abortion rates have declined to a new low, with less than 1 million procedures performed in 2014 [23]. This decline is likely reflective of recent reductions in the rate of unintended pregnancy due to increased use of highly effective contraceptive methods [26–29].

From a public health perspective, increased cost burdens for contraceptive methods in the U.S. could result in a reversal of recent trends toward increasing use of effective contraception and decreasing rates of unintended pregnancy. From an individual perspective, women's fears about being forced to choose between controlling their fertility and addressing other health needs or expenses of daily living represent a limitation on reproductive freedom and, for many women in this study, a profound injustice. The ideas about rights to reproductive and bodily autonomy raised in this study, and the necessity of affordable access to contraception and abortion as part of ensuring that autonomy, fit within the larger debate as to whether healthcare should be a universal right in the United States. Participants' concerns about increased costs and decreased insurance coverage for contraception echo themes seen in media coverage of contraceptive decision making after the election, and are in line with public outcry in response to attempts to roll back provisions of the ACA, which have resulted in historic gains for women's health. The deeply personal and emotional concerns expressed by women in this study underscore the politicized nature of women's health care in the current political climate.

4.1 Limitations

As with all qualitative research, the results of this analysis are not meant to be representative or generalizable to the larger population of all U.S. women of reproductive age. The study from which written responses were drawn utilized social media-based snowball sampling, which may have favored participation of likeminded individuals with strong opinions, identification with women's groups or movements, and those with political affiliations not aligned with the current federal leadership. Indeed, women with concerns about future access to contraception represented a younger and more liberal population of women compared with the total study sample, likely reflecting the varying salience of reproductive health issues to women on different ends of the political spectrum. The generalizability of our findings is particularly limited by the characteristics of our study sample, which primarily comprised highly-educated white women, and which may have therefore excluded the voices and concerns of women of lower socioeconomic status. Given the intensity of the concerns raised by women in our sample, it is important to consider that women with fewer resources stand to lose even more with regards to affordable access to contraception and abortion, should the fears raised in this study be realized. Finally, our study is limited by our use of the term "birth control" throughout the survey to refer to the full range of contraceptive methods, without providing a clear definition of this term. This choice was made to simplify and shorten survey language, especially for mobile internet users, but may have led to variable interpretation by participants (e.g. considering the pill only). Differences in interpretation are evidenced by the range of ways in which participants engage with and refer to "birth control" in their written comments; however, this variability may also have contributed to the richness of qualitative responses. Despite these limitations, this analysis provides an in-depth look at the specific nature of women's concerns regarding future access to contraception and abortion following a divisive Presidential election with implications for health care reform.

4.2 Conclusion

The concerns raised by women in this study center around rights to reproductive and bodily autonomy, which many women felt to be threatened by potential policy changes restricting access to contraception and abortion. Women expressed strong beliefs that politics should not interfere with their ability to make personal decisions about their health and fertility.

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Implications

As the future of United States health care policy is debated, many women are concerned about the impact of policy changes on their ability to access affordable contraception and abortion, which many view as essential to the preservation of bodily and reproductive autonomy.

1. Since the 2016 U.S. Presidential Election (Nov. 8, 2016), have you had any worries about your ability to get birth control in the future?

☐ Yes
☐ No

If yes,

2. What specific concerns do you have? (select all that apply)

I worry that:

☐ I won't have health insurance
☐ I won't be able to see a doctor to get birth control
☐ Birth control will cost more or cost too much
☐ Birth control won't be available at all
☐ Planned Parenthood or other family planning clinics will close
☐ Abortion will be less accessible or not an option
☐ Other: _____

3. Please share any other thoughts or feelings you have about your future access to birth control:

Figure.
Post-Election Birth Control Survey questions

Table 1

Demographic characteristics of total study sample and participants providing written comments

	Total sample ^a n = 2158	Women with concerns who provided written comments ^d n = 449	p- value ^c
Age			<0.001
15–24	354 (16.4)	92 (20.5)	
25–34	1413 (65.6)	301 (67.0)	
35–44	386 (17.9)	56 (12.5)	
Race			0.463
White	1844 (85.9)	381 (84.9)	
Non-White	302 (14.1)	68 (15.1)	
Political Party Affiliation			<0.001
Republican/Republican-Leaning	767 (35.9)	19 (4.2)	
Independent	290 (13.6)	12 (2.7)	
Democrat/Democratic-Leaning	1080 (50.5)	418 (93.1)	
Religion			<0.001
Atheist/Non-religious	618 (28.9)	252 (56.1)	
Christian	1399 (65.3)	146 (32.5)	
Other religion	124 (5.8)	51 (11.4)	
Marital status			<0.001
Single, never married	577 (26.8)	213 (47.4)	
Married/cohabitating	1552 (72.0)	225 (50.1)	
Divorced/separated/widowed	27 (1.3)	11 (2.5)	
Education			0.049
Less than college degree	328 (15.2)	55 (12.3)	
College degree or greater	1828 (84.8)	394 (87.8)	
Income*			<0.001
\$39,999	526 (25.4)	150 (34.1)	
\$40,000 – \$79,999	790 (38.2)	166 (37.7)	
\$80,000	752 (36.4)	124 (28.2)	
Geographic region*			0.009
Northeast	562 (26.4)	145 (32.3)	
Midwest	649 (30.4)	130 (29.0)	
South	640 (30.0)	116 (25.8)	
West	282 (13.2)	57 (12.7)	

Values are n (%). Percentages may not add to 100 due to rounding.

^aMissing data among total sample: race (n=12), party affiliation (n=21), religion (n=17), marital status (n=2), education (n=2), income (n=90), geographic region (n=25)

^bMissing data among women providing written comments: income (n=9), geographic region (n=1)

^cp-values from χ -square tests