

THE *Final Straw*

A WEEKLY ANARCHIST SHOW

The Final Straw is a weekly anarchist and anti-authoritarian radio show bringing you voices and ideas from struggle around the world. Since 2010, we've been broadcasting from occupied Tsalagi land in Southern Appalachia (Asheville, NC).

We also frequently feature commentary (serious and humorous) by anarchist prisoner, Sean Swain.

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The Battle for Abortion and Reproductive Autonomy with Bay Ostrach

The Final Straw Radio - Jan 10, 2022



This week on the show, we sat down with Bayla Ostrach, an activist, anarchist, longtime defender, provider of and researcher around issues of reproductive healthcare. We speak about experiences researching and working on the issue in Catalunya, the battle for abortion and reproductive autonomy in the so-called US, the challenges faced by independent clinics against the business model of clinic chains like Planned Parenthood, legal and material pressure and attacks by anti-abortion extremists as well as the cultural and political struggle to defend and expand the ability for people to get safe, affordable, full spectrum and stigma-free abortion and reproductive care more broadly.

Illustration by Marne Grahman

Content warning, because we are discussing a stigmatized series of medical procedures adjacent to sexual, social and political violence, listeners should be advised and we'll put warnings in a few places during the episode. If you are hearing the radio version and want to hear a longer version of this show, and to listen at your own pace, check out our full podcast at our website, to be followed in about a week by a transcript for easy reading & a zine for printing.

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lot is people coming into the clinic have been googling. If this does not illustrate what people go through to get an abortion, I cannot tell you how many patients I've had who I am literally doing their intake for them to have an abortion and then they asked me questions that are like, "so is it true that..." and then they say something that they've read on the internet that they believe is going to happen to them that has permanent lasting effects. And they think it's going to happen to them and they're there in the clinic anyway. Luckily they asked and so I have the opportunity to debunk it and say "absolutely not." We would never do that to you. That this is not going to have that permanent effect and then I can give them the accurate information. But the amount of stuff on the internet about abortion that's just not true and super horrifying. I encourage people, just don't even go down that road. I think that answered that question.

Bursts – TFSR: Yeah, very well. And we can host files, either between our archive.org account or on the website, depending on the size. Are there any topics that we missed, which you wanted to cover just in closing?

Bayla: I think this was great. No, this was great. Thank you so much. Awesome

Bursts – TFSR: Bay, thank you so much for having this conversation and all the work that you do. I think is going to be a really good resource for folks.

William – TFSR: I have such a deep appreciation for you taking the time and for you doing the work that you do on such a culturally sensitive topic, and I want to recognize that and thank you so much.

formation of what I was describing about the role of independent clinics, how much and what type of care they provide, and how threatened they are, how many clinics have been closing. It's kind of like a good reality check, and a good picture of the actual landscape of care and full spectrum care in the United States. Another site that I recommend is AbortionFunds.org. Just practically speaking, in terms of if you or anyone you know is looking to get an abortion now or at any point in the future, that's a great resource for finding funding. And I should back up and say Abortion Care Network also has a listing of all of their clinics. So if you need to find a clinic, Abortion Care Network is a great resource. I mentioned Sister Song before their website is SisterSong.net. They're fantastic. And then locally for people that are listening in North Carolina or this part of the country. We have the Carolina Abortion Fund, which is our specific local fund, and that's just CarolinaAbortionFund.org And then kind of more regionally, there's the Access Reproductive Care Southeast Fund, which does not include North Carolina, but I think it's South Carolina, Georgia, Tennessee, Louisiana, and I might be forgetting another state. But that is a fund that the person I was just speaking about, Roula Abisamra, who co-wrote the chapter on abortion stigmas syndemics with me. She co-founded that fund and does a lot of work with them. They're fantastic. And their website is ARC-southeast.org.

And then otherwise, I have links that I can share for y'all to put in the show notes. There's a summary from the Guttmacher foundation - that is an assessment of what would happen in different states if Roe falls. With the caveat that the Guttmacher Institute has excellent and very accessible summaries of different research on abortion and sexual and reproductive health but their employment practices are garbage as an organization, they're very problematic. I'll share a link, kind of an exposé of what's been going on with their toxic work culture for a long time. So I feel very complicated about recommending them. They're an important resource for information, but they are treating a lot of workers there very badly. So I never quite know what to do with that. And then I can also share links for the website where I have those quotes about Reproductive Justice, and also link for the book that I mentioned about the history of the self health movement.

And then I'd also say in general avoid just Googling abortion because most of what is on the internet is bad and stigmatizing and inaccurate and scary. Like when I was talking before about having to deprogram patients from things that protesters say... the other thing that happens a

William – TFSR: To begin, would you just say your name, if desired, your pronouns and any affiliations you have, either politically or socially?

Bayla Ostrach: Sure. Thank you so much for having me. The name that I write under and do research under is Bayla Ostrach. In activist spaces, most people know me as Bay and my pronouns are they/them. And affiliations... I was thinking about this when I saw your email. These days, my affiliations are pretty hyper local. So I think for the purposes of the show, I'll just leave it at that.

William – TFSR: Cool, so we're here to talk about the overarching topic of abortion and abortion access. And I know you've written a bunch about this. How did you come to be doing the work you're doing around this topic?

Bayla: Right. I had written up some notes about the work that I have done in abortion care and abortion research. But the way you framed that... I had to think back of how I actually ended up working in my first clinic, and I was trying to remember. I started working in abortion care in 1999. I think it was because a friend that I had grown up with was working at the clinic, it was a feminist clinic. Way back then there was a whole network of what were explicitly called "feminist women's health centers." It did unfortunately have the name women in it at the time, we weren't as aware of language around gender in those days, but it had been founded by something called the Federation of Feminist Women's Health Centers. And there were a bunch of these clinics. There's only one left, it's in Atlanta. But this was in Eugene, Oregon, and a friend was working there and they needed somebody bilingual. And she called me up and she said "Hey, do you want to come work at this clinic with me? We need somebody bilingual." I think I didn't think very much about what the work would be, I just was in a job that I didn't love and I thought, sure that sounds great. And I went to the interview, and they asked me a lot of questions about what I thought about abortion. To be honest, I hadn't thought very much about it. I was a feminist, I considered myself pro-choice and I just hadn't thought that much about it. And I started working in an abortion clinic. Then the rest is history.

I've worked directly in abortion care starting in 1999. And since then, I've worked in - I was doing this math - I've worked in seven clinics in two states in two countries. That first clinic that I worked at very

abruptly closed in 2002. Pretty much we were not even told that it was going to close. We just came to work one day and the clinic was shut down. And so those of us who worked at the clinic started a fund and hotline, and that still exists. It's now called the Northwest Access Fund. And then I went on to work at another clinic and nine years into working in abortion care and funding advocacy, I was recruited to start doing research as an applied medical anthropologist. And so since then, I've been doing that research., mostly about how migrant and low income pregnant people access abortion through state funded systems in the US and in Catalunya. And I was doing that as my primary research focus until I moved to North Carolina in 2017. I'm still analyzing some of the data that I'd already collected in Catalunya. And I'm also developing a book based on interviews that I did with people that worked at feminist and independent clinics from the 80s, up until 2012, about experiences that they've had with anti abortion violence.

Bursts – TFSR: Cool. We totally would like to ask a little bit more about some of those experiences and definitions of terms like “independent and feminist clinics”. I had sort of a big overarching question to begin with, though. So the US white supremacist settler colonial state has a history of on the one hand denying people of marginalized communities reproductive autonomy through forced sterilization, lack of access to resources, forced separation of families and youth. And, on the other hand, by being able to use the state to withhold access to birth control. To the degree your experience allows, can you talk about abortion and birth control access currently, how it's weaponized either rhetorically or materially around marginalization in this context?

Bayla: Yeah, this is a really important question. I'm glad you asked it. And I will speak to how I think about this. I can't talk about it very much in terms of my own work other than specific pieces that have touched on it, but I want to lift up the work of other people who do this work and are thinking and talking about it in ways that should guide all of our work on it. And specifically, what I want to mention is what you're talking about and how we should all think about it, which is Reproductive Justice. The framework that was founded by Loretta Ross and is being championed by Loretta Ross and a lot of other women of color. An organization that I hope people are aware of it's based in the south and it continually works on this topic: Sister Song. They do this work and they challenge other

abortion stigma has contributed, I think a little bit to this promotion of medication abortion, to the exclusion of instrumental abortion, because of the idea that medication abortion is something you can do privately by yourself, no one will know. So then you're doing something because you think it can be made more concealable, fewer people, maybe will find out, nobody will see you walking into the clinic, but then you're also doing a procedure that has a higher risk of complications. And then if you need follow up care, it might be harder to find somewhere to go because more clinics are closing, because of the emphasis on medication abortion. So I know that's complicated, and I'm happy to explain more about it. But it's also this very specific kind of academic description of something. So I'm happy to talk more about it, but we also don't have to.

William – TFSR: Thank you so much for going into it. Super, super fascinating work and I am really stoked personally just to read more about it and understand it further because it's just such an undeniable fact that these things have such a profound impact on people's bodies, people's minds, which is a part of their body and all of that stuff.

Those are all the the like pre-scripted questions that we had. And I really just want to thank you so much for taking the time out of your day to speak with us about this topic. Can you tell folks how they can read your writing? Are there any resources you would recommend for further reading and research? And are there any projects or networks you would recommend folks getting involved in?

Bayla: Totally, thank you. Yeah, this has been super fun. This is not an area of my work that I have gotten to talk about as much lately, so I really enjoyed it. I'm kind of doing other work here and so I always love the opportunity to come back into this part of my work. I'll start with the resources and other things that I'd recommend related to this. And then I think, as far as my work, we can talk more about that I don't know what your capabilities are of how much you can post or share things. There are things I can share that you could just directly post and then otherwise, some of it is on websites that are not entirely accessible, because they're academic types of sites. But I can also probably make some things more accessible that are the specific pieces of work I talked about here.

The sites that I would recommend are the Abortion Care Network. Absolutely. It's just AbortionCareNetwork.org. That's the National Association of Independent Clinics. And that's where they have a lot of in-

by abortion stigma. And what we started realizing is that there's something specific that happens to pregnancy because of abortion stigma that the pregnancy itself becomes pathologized. That's kind of the first piece of this. In the context of abortion stigma, even the pregnancy itself is pathologized. That unplanned or ill timed or unintended pregnancy itself, from the get go is already pathologized. So somebody who might otherwise go to the emergency room for care, for example, or go to their regular doctor for care. Often, people who've had an abortion, don't ever tell their primary care doctor that they had an abortion. They're not going to seek care in regular circumstances. They're not going to go the places they would normally go for care, because there's such pervasive abortion stigma in our culture and in society, that they don't want anyone to know that they had an abortion. And so if someone is having abortion complications, if they're in that very rare category, where they have continued bleeding, or they have an infection, or something is going on., they're much less likely to seek care in the usual venues. So in that way, that complication might get worse, or it might not resolve, they might not be able to get the care that they need, because the pregnancy itself has already been pathologized by the stigma. That's one of the ways that this works.

Another way that it can work is abortion stigma itself can mean that people are further along by the time they get care, because it can take longer for them to figure out where to go because information about where to go is not easily available. Like we talked about before, there are fewer clinics that offer later care, so it can take longer to raise money for transportation to get there, you have to take time off work, you have to figure out childcare. So because of abortion stigma, somebody might be further along, and they're going to be fewer places for them to go and though the risk of complications is very low, it does increase in later weeks of pregnancy. And so someone is slightly more likely to have complications in a second trimester procedure. There's this catch 22, where, because of stigma, you're more likely to be further along, because of stigma, you're more likely to then need a procedure that has a slightly higher risk of complications. And so in that way, also, there's this interaction between the gestation of pregnancy and the risk of complications.

And then finally, another way that this works... what I'm speaking from here is a whole chapter that we wrote about this that's a 30 page long chapter where we walk people through kind of each of these dynamics. Another way that this operates, is kind of specifically what I've been talking about what this Planned Parenthood phenomenon where, in some ways

social justice movements to expand their work to include Reproductive Justice.

I imagine that y'all have talked about it and I think your listeners probably have heard of this. But I think these days, a lot of other important terms, "Reproductive Justice" and "Intersectionality" kind of get thrown in without people necessarily having thought through all the things that it means. So if you'll indulge me, I wanted to give a definition of Reproductive Justice, because I think that starts to answer a lot of different pieces of what you brought up.

So there's the general definition from Loretta Ross and from Sister Song. But I found a kind of a longer explanation from the Illinois Caucus of Adolescent Health website that I can share with you all to post up in the show notes. But I really liked how they spelled more of it out, and I think it speaks to what you're asking. And so Reproductive Justice broadly, is a framework to address how race, gender, class, ability, nationality, and sexuality intersect. But this website also defines it as "*a movement guided by the belief that real choice and control over ourselves in our bodies is achieved when we have the power and resources to make our own decisions. RJ seeks to build space in which individuals have access to the rights and resources they need to create the families they want. Furthermore, recognizes that the fight for reproductive freedom is linked to the struggles for immigrant, worker, and queer rights, economic and environmental justice, an end to violence against women and girls, and access to health care and education that affirms our identities and our bodies.*" And the three basic tenets include: "*the right to have children, and to decide how many and under what conditions you could birth*"; "*The right to not have children*"; "*And the right to parent one's own children in safe and healthy environments.*" And again, that was from the Illinois Caucus of Adolescent Health.

I think that's directly linked to abortion access and access to safe and effective contraception. Because for any of us that are physically biologically capable of getting pregnant, until we're assured of universal housing, universal health care, universal basic income, freedom from state surveillance, etc, I could go on and on... there are always going to be people that because of structurally produced poverty, because of state sanctioned disproportionately racist violence, then it's enacted by agencies like Department of Social Services, Child Protective Services, there are always going to be people that would like to parent but know that they're at increased risk of having their children taken away. And just generally not being able to parent the way that they wish to. So as long as

there are people that would like to parent now, or at some point in the future, but know that there are all of these forms of state violence, that are going to make it so they can't parent the way that they want to or can't parent safely, there has to be the option of safe, effective and accessible contraception, and the option of safe high quality abortion, whether it's legal or not. And I would add to that, not just safe high quality abortion, but safe high quality abortion especially beyond the first trimester, that has to exist. AND for anyone that just doesn't want to parent. So it can be that you don't want to parent now it can be that you don't want to parent at all, and that's fundamental to Reproductive Justice.

I was thinking about this, it and it reminded me of a thing that has come up over and over in my research in Catalunya has been pregnant people that will say the same thing over and over. And this is the context of the global recession. I was doing my research there initially, after what's being called the global recession there people kept calling it "la crisis" - the crisis - the economic crisis. And people would say to me, while they were seeking a publicly funded abortion, often people already had one child would almost verbatim over and over many different people would say, "I'd rather have one child and care for it well then have two that suffer." And I was hearing that through five years of data collection, in a setting that has one of the better social safety nets that we could even imagine. These are folks that have universal health care, right? There's national health care. There's a national health care system, that's part of what I was studying. This is a place where free public education starts at age three. So people aren't having to pay for preschool, they're not having to pay for kindergarten, there's much more subsidies for childcare, there's much more subsidies for housing. It's a much better situation, arguably, in which to parent and yet people were still saying that they didn't feel that they could economically afford to have another child.

I mentioned that it's a different situation than the US but I think I was hearing so much from people about economic reasons why they didn't feel that they could parent or parent another child. And so whether it's abortion, whether it's contraception, whatever it might be, if people are in a situation where because of the circumstances of the state, it is not safe or appropriate, or you just don't want to parent there has to be a way to avoid doing that. Either before you're pregnant or once you're pregnant.

William – TFSR: Thank you so much for that answer to that question.

walk by a ton of protesters the first time they came in... are you gonna want to go through that again to come back for follow up? Maybe, maybe not.

And the way that that fits into a syndemic, what we started thinking through is: for something to be a syndemic, there has to be at least two biological factors that are interacting in some way. And that has to be occurring because of a larger structural condition. And so where we propose this as an abortion stigmas syndemic is that I was working with Merrill Singer and another colleague. Cher Lerman and I, we were putting together a collection of chapters about different stigma caused syndemics, basically different disease interactions that were caused by stigma as the structural condition. And so I went to Roula and I said, "Hey, do you want to dig deeper into this? Let's think about what are some ways that there are biological interactions that are caused by abortion stigma?"

And the first thing we had to reckon with was: is pregnancy itself a disease? It's not, right? Feminist scholars have fought for a long time to de-pathologize pregnancy and to say that pregnancy in and of itself is not a disease. And so we had to first kind of like revise the definition of syndemics a little bit and say "it doesn't just have to be a disease it can be a biological condition." So we can talk about how pregnancy as a biological condition, interacts with possible abortion complications. Which also want to say from the get go are very rare. Abortion when performed in a safe setting, when it's high quality care is extremely safe. Complications are very rare. But when they do occur, the types of complications that are most common are: an infection which is easily treated with antibiotics, or continue bleeding. Typical and I should probably have done a content warning for talking about abortion complications and bleeding. So if you're squeamish, this is maybe also not for you.

But pretty typically after a high quality, safe abortion, it would be pretty typical to have some cramping and bleeding. Cramping for a couple days, and typically bleeding similar to a menstrual cycle for a week or two weeks, depending on how far along you were. But more than that would be not very typical. And that, again, is speaking about instrumental abortion. Medication abortion is a totally different story. People tend to have much more cramping and bleeding for a pretty long time and it's much harder to give people an idea of what's normal, because it varies a lot. But I'm talking specifically about instrumental abortion.

So we started talking about what are the specific interactions between pregnancy and any of these complications that we think are caused

And generally, those occur in circumstances of inequality, as you can imagine. There have been hundreds that have been identified. This is now a huge body of work in anthropology and public health and other fields. It's complex and it's not always done accurately. I would say that there's a lot of things out there that are referred to as syndemics that actually don't meet the definition. There's some examples on the CDC website, because they're so good at everything lately... But this particular syndemic, I've worked with him quite a bit in this area. And this particular one is one that I identified with my colleague, Roula AbiSamra, who's in Atlanta, and actually does excellent work with an abortion fund there. I'll make sure to share the website with y'all.

Roula and I both worked in abortion clinics for a long time. And she also worked with the National Abortion Federation for a while. And so she and I were talking a lot over the years, it's been decades now, about abortion stigma and some of the effects that it has that we had noticed. Then we started talking about why some people do or don't come back for follow up care. Many clinics will encourage everyone to come back for a follow up appointment, or people can come back for a follow up appointment if they're concerned that they have any complications or anything that's not resolving. This, to me, is one of the hallmarks of a feminist or independent clinic is telling people here are all the things you can expect "this is what would be a normal amount of bleeding or cramping after a procedure. If it lasts longer than this amount of time, or if it's more than this amount, if we would like you to call us. This is when it would probably be a good idea to come back..." And then essentially trusting the person to know their body enough to know whether or not they feel like they want or need to come back.

So one of the things that Roula and I talked a lot about was like what seems to determine when somebody is pretty clearly having a complication that is outside the range of what we have indicated would be typical, and when they do or don't come back. And it was very clear to us that stigma had a lot to do with that. So for example, somebody who had not gotten a lot of support, or had actively been being pressured by a partner or friends or family beforehand, somebody had not wanted them to have the abortion, we were noticing a trend in our clinics and with our patients that if somebody hadn't gotten enough support for their decision in the first place, it seemed like they were less likely to come back for follow up if they were having complications. And then some other things that we would notice is if there were a lot of protesters and someone had had to

I think that there's so much there. And obviously this has been a topic of discussion for a long time in anarchist and Reproductive Justice communities.

One thing that comes up immediately to mind, at least for a lot of folks when thinking about abortion access is the issue of clinics. But sometimes I find for lots of folks, the thinking begins and ends with Planned Parenthood and clinic protests. Would you talk about why clinics are important as a public space of encounter and symbolic presentation of the audacious sharing of reproductive autonomy?

Bayla: Thank you for asking that. Absolutely. And I put together some stats on independent clinics. Because you're right, so often for liberals, and for antis, right? Planned Parenthood, it's like Kleenex, right? It's the name brand. An important corollary to that, I will say, one of the clinics that I worked at the longest, one of my favorite clinics that I ever worked at, we referred to Planned Parenthood as Walmart. It's the Walmart of reproductive health care. Most people that I work with in the United States that do abortion work, that's how we talk about Planned Parenthood. It's everywhere. It's the thing that people know. You can go there. You can get reproductive health care there. It is going to be low quality. You're not going to get good care. It's a business, it's a corporate chain. That's what Planned Parenthood is. It's the corporate chain of reproductive health care.

Similar to Walmart workers are not necessarily treated well. They're not necessarily trained well, you're not going to get the highest quality product. And much like Walmart, it tends to put the local small business independent clinics out of business. And so this is kind of like a two part answer. This is tricky, right? Because abortion clinics are absolutely important, because without abortion clinics we don't have access to safe high quality abortion, especially beyond the first trimester. But not all clinics are created equal. Not all clinics are the same. They need to be protected, they need to be defended. Because if we don't have clinics, we don't have abortion, it's that simple. If all we have is Planned Parenthood, we don't have access to safe, high quality abortion beyond the first trimester, because that's not what Planned Parenthood is.

And clinics, I think people aren't aware of them. They don't know that they're there, so they don't know to protect them. Because there's been so much anti abortion violence. There's been so such a threat against clinics. That it's sort of the M.O. of clinics to fly under the radar. We don't

tend to have big banners outside that say “get your abortion here.” That’s not super safe. And so from the perspective of protecting clinic, staff, providers, and patients, an independent clinic is likely to be pretty non-descript. It’s not likely to have really obvious signage. Whereas a more corporate clinic might have more obvious branding and more obvious signage. And so the clinics that have a bigger budget, the corporate chain clinics, the clinics that have a bigger overhead and admin, they can afford to be a little bit more visible. Then that’s what people are going to know and be aware of.

So people are less likely to be aware of the feminist clinics, which is probably why they’re not around anymore. They’re less likely to be aware of an independent clinic. They’re not as many of them anymore, they’ve been closing down. But any opportunity I can take to make people aware of independent clinics... 60% of clinics in the United States that offer care beyond the first trimester are independent clinics. Independent clinics provide care to three out of five patients who have an abortion in the United States. To 79% of all clinics that provide care at or after 22 weeks of gestation are independents. And 100% of clinics that provide care after 26 weeks are independents. That being said 113 independent clinics closed between 2016 and 2021. And 34 independents were forced to close just in the past two years. 74% of those provided care after the first trimester.

So on the one hand, the majority of care and especially the majority of later care is being provided by independent clinics. But that’s also the clinics that are being forced to close down and that’s what we’re losing. So we are losing access to this incredibly important, independent, high quality care. That is also sort of the only option for care after the first trimester. When people think of Planned Parenthood, they’re thinking of the thing that is sort of most visible, but is actually not where the majority of care and especially where later care is being provided.

What Planned Parenthood primarily does is offer something called medication abortion or what I refer to as “pharmacologic abortion.” So what Planned Parenthood primarily does - 51% of their clinics only offer pharmacologic abortion. What we know, there’s research there’s published research on this, so this is not just anecdotal. There is published research that very often medication abortion is offered without adequate counseling, without adequate informed consent, without people really being told what to expect, without being told that it has higher complication rates. So the promotion of medication abortion in the United States

Bursts – TFSR: And also, just to add in, I really appreciate the fact when you can say “I don’t have an answer to this.” Because you’re doing so much to enrich my personal knowledge on this, and you’re making really interesting arguments and bringing up really interesting things that I think is super fruitful. So I just want to say on record that not having the answer is a great thing to be able to say. It’s complex.

One thing that we were talking about the impacts that shame has on people and the experience that they have out of getting an abortion and maybe if they have feels about it afterwards and and having to jump through the hoops. There’s a concept, I think it’s called “syndemics” that talks about the actual biological effects in addition to or in connection to the psychological impacts of having to go through stressful situations, such as jumping through a bunch of hoops, being overly scrutinized, having to face people going through the door of a clinic, pelting you with stuff or yelling terrible things at you or whatever. Can you talk a bit about the sort of biological outcome of the social state that people who want to get an abortion, what they’re put through?

Bayla: Yeah, this might take a minute because it is part of a larger theoretical framework that was developed by my doctoral advisor and mentor, and continuing co author and friend, and then I extended upon it with another colleague. So I all kind of want to back up and like define the framework and then talk more about it. And for folks listening, this is also probably going to be the most sort of researchy part of this. So if you’re not into explanations of biological interactions caused by structural conditions you can can fast forward. But what you’re referring to is some work that I shared with y’all on abortion stigma syndemics. So syndemics, broadly, is a theoretical framework developed by Merrill Singer, who’s a critical medical anthropologist. And he’s founded several theoretical frameworks going back to the 80’s that are explicitly Marxist. He was well known for developing theoretical approaches within medical anthropology that explicitly examine power relationships within healthcare, and that affect health through power inequality. So within that, he developed a concept in the late 80’s, or early 90’s, called syndemics, which is it’s a blend of the words “synergy” and “epidemic.” He framed this to give us a way to look at times when multiple diseases or biological conditions interact in a way that makes both worse. And that that is caused by a structural or social condition.

legal abortion in the state that still has a ton of restrictions?

Bursts – TFSR: Yeah, and maybe to unpack just a tiny bit. I know critiques about the push for gay marriage, such as the publishing project *Against Equality* was making was that a lot of people are making the argument that “look if we have gay marriage, we can have access to visitation rights for people that we care about. We can have easier access to children that we are co parenting that are not maybe our biological own, but our partner’s, or access to a means for citizenship, or better being able to share money and pass on money after we pass, or to make medical decisions about the person we care about.” And yeah, gay marriage doesn’t answer those things or share health care access that somebody has in their job, that the HMOs offer to spouses. Sure that works if you are someone who has a job that gives you access to health care that can be shared with your family members. But for everyone else, that doesn’t help with immigration issues, it doesn’t help with access to health care, and these other things. Is that right, what you’re pointing to?

Bayla: Yeah, and I think actually that helps me draw a clearer conclusion than I even had before, which is great. So gay marriage does that, why can’t everyone have that without gay marriage? That shouldn’t be something that is reliant on marriage. Why can’t everyone have those things? And I think that’s part of what I’m thinking too about abortion is if the only way that someone can get an abortion is by going through all of these hoops. Is that really the kind of abortion that we want to have be legal? And I’m not saying that I would prefer illegal abortion. Let me be very clear. I’m not saying I’d rather that it not be legal so that we have to figure out what to do, because I still don’t have an answer to that. But I think it is really troubling. If we keep giving up more and more ground, and we keep... Again, this is not a perfect parallel, but if the only way that you can decide who visits you in the hospital is by being married, is that what we want? And if the only way someone can get an abortion is by having to jump through all of these hoops of waiting periods, and mandatory counseling, a mandatory ultrasound, I should say mandatory *viewing of ultrasound*. So that’s another way that that’s twisted as though we don’t do an ultrasound otherwise. But we’re sort of allowing there to be an idea that you can only have something in a certain way rather than demanding that everyone have access to it, no matter what.

has actually been part and parcel of losing access to later abortion care and losing access to high quality - what gets called “surgical,” but I prefer to call “instrumental” abortion care - which is the aspiration procedure that’s very quick. It’s in clinic. You walk into the clinic pregnant, you walk out of the clinic and you’re not pregnant anymore. Which is not the case with medication abortion. With medication abortion, you take two medications that induces a miscarriage, and that can go on with bleeding and cramping and other side effects, often for several weeks. And so these days, when people think of Planned Parenthood, they’re thinking of something that while visible, is actually not offering the majority of high quality safe abortion care, and especially is not where you’re going to get later care.

William – TFSR: Thank you for that framing. I was really influenced by having talks with you about Planned Parenthood and all of these distinctions between the different kinds of clinics that are out there. I think that often in the anarchist imaginary, the response to the inaccessibility of clinics and sort of the corporate nature of Planned Parenthood itself is to employ at home or independent treatments. In your opinion, how can folks approach this topic? And how do you approach this topic? And how does it fit into the wider topic of clinic access?

Bayla: So, I want to acknowledge first of all, this is a tricky topic. And so I want to be very clear that as a feminist, as an abortion provider, as an anarchist, I absolutely support anyone listening to do whatever is best for them and their body. And I’m not here to tell anybody what to do. So if there’s somebody out there listening, who has done an at home abortion, has had a medication abortion... whatever you’ve done is great. I am super happy for anybody to do whatever is best for them in their body. And I’m not at all here to tell anybody that their experience wasn’t what it was. I have handed people the medications to do a medication abortion, I’ve been a provider for a medication abortion. I have been present for 1000s of instrumental abortions. I have assisted with all these different kinds of abortions. So what I’m speaking from is research. I’m also speaking from my experience as a provider. And I am speaking from talking with many people who’ve had both kinds of procedures. My focus in what I’m about to say, is about access for everyone. So thinking not just about one individual person making a decision, but about resources available to everyone.

The concern that I have about at home abortion, and in particular, when it gets framed as “self-managed abortion” is that if people begin to see that as a solution, whether it’s a solution to legal restrictions, which I know we’re going to talk about. Whatever it is that we see that as the solution to, in many ways that contributes to the problem that Planned Parenthood has already created, which is pressure on independent, full spectrum clinics that are providing later procedures. The pressure on them to close and the numbers of clinics that are closing. The more that we start to see medication abortion, which is what at home or “self-managed abortion” is the more that we start to see being by yourself taking pills, inducing a miscarriage, letting that pregnancy pass on your own. The more that we start to see that as the only option, then we are not fighting to keep clinics open. And this is the fear that I have.

There are still independent clinics. We still have independent clinics. There are clinics out there that are providing abortion all the way from as soon as you find out you’re pregnant, four weeks from your last menstruation, all the way up to whatever is considered the legal limit, which right now is 24 weeks and beyond. When I was talking before about clinics that provide care after 26 weeks, there are circumstances where you can get an abortion after 24 weeks, depending on different medical situations, depending on fetal death. There are situations where you can get a later procedure and you have to have somewhere to go to do that. And the more that people order pills off the internet, get a friend to get pills across the border somewhere. The more that we have that phenomenon going on and people see that as the answer. That is going to be the answer for some people. There are circumstances where that is a great option.

An example I cited when we talked before in situations of intimate partner violence, if it absolutely has to look like a miscarriage, I think that is one of the situations where I have counseled people and encourage them to consider medication abortion. If it needs to look like a miscarriage. There’s a lot of places in the world where there truly is no legal instrumental abortion available. There’s just not a clinic to go to. And so being able to get those folks pills is going to be a great option. I’ve talked to people who’ve had an instrumental abortion and they’ve had a home birth and they really know what the experience is like of going through a birth or miscarriage at home and they are 100% down to do that. I think there are situations where it’s fine. What I worry about is folks that have never been counseled on what it is actually going to be like, how long it’s going to take, the 5% chance that you’re going to have to have an instru-

they were either dealing with a ton of harassment from a partner or family member or protesters. So most the time when people feel something other than relief, it’s because they were not supported in their decision. But I do wonder if the experience of what people have to go through to get the abortion changes what that experience is like. Where we may have had a generation soon after Roe, where it felt more empowering, where it felt like “Oh, I’m able to do this thing. Now it’s legal. Now it’s a choice.” Which is also problematic, I’m saying choice in quotes. If it’s something I can do now, and I have the ability to do it, and I wonder now if you’re somebody that’s having to go to the clinic three different times, you’re having to go through mandatory counseling, you’re having to look at the ultrasound, you’re having to be told all these things that are not true.

I have not worked in a clinic where I’ve had to put someone through that, because I’ve only worked in settings where there aren’t all those restrictions. But I know what it’s like to sit with someone do informed consent for them to have the opportunity to make a lot of decisions for them to tell me what they want certain things to be like, to be able to tell them what’s going to happen. And to see the look on someone’s face when the experience is not as bad as they thought it was going to be. When they assume that it’s going to be awful and then they say to me at the moment they’re leaving “Wow, that was way better than I thought it was going to be. I actually feel pretty good about this.” And then I’m imagining what it would be like to have to put someone through all of these things that happen in a lot of states. And I wouldn’t want to have to put a patient through that. And I can’t imagine that it makes it a very positive experience.

So I do think we’ve given up a lot of ground. And again, like the last question, I don’t know what the answer to that is. And it feels like that’s something that isn’t just coming from the right it feels like some of that is the responsibility of a liberal, left giving up ground and and bear with me because I’m thinking this through out loud. It feels a little bit like gay marriage. It feels a little bit like taking what we can get that’s like the lowest common denominator, instead of actually fighting for what everybody needs and deserves. We still have legal abortion, but for who? And who actually is able to access it? And who benefits from it? People were so excited about gay marriage, but who did it primarily benefit? White gay cis men. There’s a lot of people for whom that doesn’t do as much good. I think there’s some interesting economic parallels of like, who do you have to be to be able to jump through all those hoops and actually benefit from

keep putting off”

But I think you’re absolutely right, that we’ve now backed ourselves into a corner like there’s so many places where there’s so many hoops to jump through. And there’s so much that has to be done. That it’s effectively as though were not legal because it’s not accessible. And so it kind of doesn’t matter. These things that people have to go through. And I think that that’s done a larger thing, which is to reinforce so much abortion stigma that now people who are getting an abortion, believe that they’re doing something that’s wrong. There’s so much internalized abortion stigma. Abortion stigma has become so culturally normalized. Because the way that it’s talked about in the media, the way that it’s covered in the news, so much of what happens, makes it appear as though you have to be having the right kind of abortion, for one. So there’s this sense that the only persons that are okay, are the ones that meet all these criteria. There’s the idea that you have to tell the right kind of story to get an abortion. And I think in particular, some of what happens is that when people have to go through this mandated counseling, that almost always consists of completely inaccurate, biased information. When people are forced to see an ultrasound, obviously, that is reinforcing all kinds of ideas about “fetal personhood.” What someone then has to go through to get that abortion by the time they’re actually getting that abortion, rather than it reinforcing an idea of autonomy or empowerment, it is many times probably just reinforcing a lot of internalized stigma.

And so I wonder, if we now have a generation or a couple generations of people who were able to get an abortion. Most people in the United States that are able to get pregnant will have at least one abortion in their lifetime. That has been true since at least the 70’s. For as long as we’ve been keeping abortion statistics. Every clinic that performs abortions, has to report abortion statistics every year. And so we know at least since 1973, that everyone in the United States who’s able to get pregnant has at least one abortion in their lifetime. And half of those people have more than one. Those numbers have not changed. Those numbers are really not changing.

What I think probably is changing is how people feel about that experience. I want to be clear, I’m like not quoting research right now. I’m going completely off the cuff. And I don’t want to say that people regret their abortion, there’s very clear research on that. The primary feeling that people feel after an abortion, 99% of the time is relief. The small percentage of people that feel anything other than relief, it’s largely because

mental abortion again afterward, because you have retained products of conception that you haven’t completely passed, the possibility that you’ll still be pregnant afterward...

I’ve had patients where they did a medication abortion at four or five weeks gestation. And then I see them at the clinic when they’re 17 or 18 weeks pregnant, because it didn’t work, and they didn’t realize it. And then they’re having a second trimester abortion, also. And so in particular, I worry about people who are having a medication abortion, because they have had medical trauma, which is a real thing. I’ve had a lot of people who when they come in for medication abortion, they say that the reason they want a medication abortion is because they want to avoid a pelvic exam, which is 100% real. I totally understand why people would not want to have a pelvic exam. But I really worry about the people that have a medication abortion, because they didn’t want to have a pelvic exam and then if that medication abortion doesn’t work, then they’ve gone through that entire process, and still are going to end up having to go through with an instrumental procedure, because you definitely can’t carry the term after a medication abortion.

So there’s all these things. And I know I’m saying a lot of things here. So let me try to back up and make a more coherent statement: My fear is that if we start to see at home “self managed abortion” as the solution, a couple of things will happen. It’ll be another reason that full spectrum clinics that provide later care won’t be able to stay open, because if a lot of people that otherwise might have gone to an independent clinic and are instead getting pills off the internet, and having an at home miscarriage... it’s a weird thing for me to say as an anarchist, but that’s losing business for clinics that we really, really need. We need independent clinics for the folks that can’t take pills and have a miscarriage at home. For somebody that isn’t just four or five weeks pregnant, for somebody that is beyond the first trimester. And that’s not an option for them.

So a little bit of this is thinking about everybody else and thinking if there’s an independent clinics that you can drive to, there’s an abortion fund available that you can call and they’ll pay for your procedure, they’ll help you get money for gas. If you can get to an independent clinic, and you can go there that is going to keep that clinic open for everyone else, for the person that’s further along, the person that can’t get those pills and take them at home because it’s not going to work.

I also just feel like there’s a lot of people who don’t know what it’s going to be like. I think there’s a little bit of language around it right now

where it gets romanticized as this empowering thing that you can have this abortion by yourself on your own. I would love for people to also think about how empowering it can be to be in an independent clinic, where there's somebody there with you, letting you know that, "this is what's happening, do you want it to be this way or this way?" And you're getting to make a lot of decisions about what that looks like. And also, there's somebody there telling you "hey, that's completely normal. This is okay, that amount of bleeding is normal. This is what you can expect to happen next." As opposed to being at home where you may not know what to expect. You may not know how much bleeding is normal, you may not know how to recognize if there's a complication. And so I think there's this little bit of, I would say, even sort of neoliberal framing of saying self managed and the idea that Why is it only empowering if it's something that you do by yourself?

Bursts – TFSR: Yeah, I think that's really well put and I really appreciate the framing of using the term neoliberalism in there and how just how alienating that can be. And for you giving space to say that people should be able to access this how they want to. but as you say, if the infrastructure isn't there to access, if somebody does want the counseling, does want the support and the in-person interaction, then we need to support that infrastructure existing.

Because you've brought up the terms "feminist clinic" and "independent clinic," can you talk about the distinction between these, and why it's an important line to draw? And also, just because I like really complicated questions... What's the relevance of these models to keeping workers a part of the discourse of their safety in their work environment? How do these shape the clinic's operations? And can you talk about the importance of leaving space for patients to decide what type of specific procedure or be supported coming out of the clinic environment with the decision to actually not get an abortion if that's what's right for them?

Bayla: Absolutely. And I feel incredibly privileged and lucky. I think my timing was just lucky that I happen to have gotten to work in both feminist and independent clinics. I want to be clear, too. Not all Planned Parenthood's are the same. I think there actually happens to be a really good Planned Parenthood affiliate in Asheville. We're lucky that way. And I think that's because there have been now two clinic managers in a row

rights for so long. I don't know what the answer to that is. Because it's really hard in this country, when most of us have not had an experience of being somewhere that has a different political system to imagine what that would look like. Right?

William – TFSR: Yeah, indeed. I think that's such an important perspective, though. Hyper focusing on legality... I think you don't really have to look very far to see legal structures which don't really serve anyone, because you can't put them into practice, because it just materially doesn't work that way often.

I did want to talk about this sort of cultural shift that's been happening, or that we've located within the last little while, and I do want to give a ****content warning****, I'm going to be just mentioning the unfortunate realities of rape and incest in this in this question.

Would you speak on the shift, which has occurred from sort of the goal being so called Free and Legal access 100% of the time, to quote, access only after certain processes, such as counseling, or after certain circumstances, such as rape or incest? What is happening here? And what does it mean in the context of access and how we as a culture are thinking about abortion?

Bayla: Thank you. Yeah, that's super important. What is happening here? I think part of what's happening here is, again, having lost a lot of ground by focusing on the kind of chipping away at access. It feels like there's been this very gradual giving up ground by buying into a hope that "well, if we let them get this, then we can keep this." So the calculus of "well the waiting period is maybe the necessary evil to still be able to have abortion be legal, maybe this counseling thing is the necessary evil" and sort of not seeing the encroachment that is happening over time. I don't want to second guess, in any given state, in any given legislative fight, in each of these moments, I am sure that people were fighting really hard to not have to let that happen and that at the end of the day in whatever backroom, whatever lobbying was happening, whatever calculating the likely votes, that in that moment, it felt like that was what had to happen and the alternative was that there would be no legal abortion at all. And that's really hard to say. I wasn't there. It's really hard for me to make that call of "Would it be better to have legal abortion with all of these contingencies and all these hoops? Or to have stood ground and been willing to give up legal abortion and then figure out what we do without it being legal and the thing we

no nothing. If you could get to a clinic, you could get an abortion. And in Catalunya, the law had just been liberalized. So, it was much more accessible, it was legal under many more circumstances. And it had just been included in the public health system. I was doing research into different settings where it was as easy as it should be, as it could be and yet, I still documented a lot of obstacles and people having to wait long periods of time and make a bunch of different visits to social services offices to get the paperwork that would get that public funding.

And so, it's very hard for me sometimes. A lot of the conversation around abortion is about legal restrictions. And then I stepped back and I think there's a lot of times where legal kind of doesn't matter. Legal doesn't matter if it's not accessible. Then also, sometimes access doesn't matter if it's going to take a long time, right? Especially if you're somewhere where the legal restriction is about how far along you are. As an anarchist, it's funny to me to spend time thinking about legal restrictions, when it's so much about the practicality and I don't know what the answer is practically, if it isn't "self managed at home abortion." Because what I want to do is say "we'll just open our own clinics." Because I know that clinics are what we need. I know that what we need is a place where people can get full spectrum abortion, including in the second trimester. I know we can't give up clinics, and I don't know what it looks like to have our own clinics, and to maintain high quality full spectrum abortion outside of a legal framework, and without the state interfering. This is a constant point of confusion for me. So, I don't have like a clear or good answer.

I do know that everywhere I've ever worked with people in an abortion setting. We've talked a lot about wanting to open our own clinic. That's an ongoing conversation that I have with people all the time, "How are we gonna open our own clinic? If Roe falls, how do we open our own clinic? What does that look like?" And I don't know the answer. I think it is important for people to keep in mind that if the Supreme Court decision goes the way that people are afraid it will and the way it looks like it will there still going to be 24 states that will protect abortion rights, at least for now at the state level. And then it'll be even more important, then, to protect abortion rights in those states and not let them be further undermined, either legally or practically. Then it'll be even more important to keep those clinics open in whatever way that looks like. By defending those clinics physically. By not letting them go out of business by having a whole bunch of Planned Parenthood's offering medication abortion down the street. But I think we've lost a lot of ground by focusing just on legal

there that have been really committed to having that clinic be different than other Planned Parenthood's. And they've really invested in a lot of time and staff training and thinking a lot about how to run a truly patient-centered clinic. How to not have it be so focused on the business model. So, I also want to say Planned Parenthood as a corporation is what I have a problem with, not necessarily a specific individual, Planned Parenthood clinic or particular staff. And so also, if there's people out there who've had a good experience out of Planned Parenthood, I'm so glad for you. I'm really glad for you. And if you have been to Planned Parenthood, where you feel like the staff treated you well, and you've had a good experience, and it was high quality care, let people know. Spread the word! Same thing, if you've been to an independent abortion clinic, and it wasn't good, complain. Contact the management, also let your friends know about that.

So just because there are these kind of generalizations and terms that overall, in my experience as a researcher and working in clinics that broadly, I believe better care is provided at independent clinics and broadly, I believe that Planned Parenthood's business practices are terrible and that broadly, I believe that Planned Parenthood as a corporation, is reducing the quality of reproductive health care... That doesn't mean that someone individually hasn't had a good experience, right? What these terms mean to me...

Feminist clinics: that was a very explicit movement. It was a very specific, intentional movement that started in the late 70s, through something that is sometimes referred to as the self health movement. HEALTH not self help, but self health. And there's an excellent book about this by Sandra Morgan, it's called *Into Our Own Hands*. And again, gendered language, it was called the women's self help movement. But you know, folks weren't thinking as much as they should have been about it. I will also say the first place that I ever learned anything about gender-affirming care, or transgender health, or really the first place I ever heard anything about trans anything was in a feminist clinic. Some of the first places I ever heard about, like, queer-affirming health care was at a feminist clinic. The feminist clinic that I worked at in the late 90s, there was something called the lesbian friendly provider list that was literally a Word doc with a list of providers that somebody could call us and be like "hey, I want to go to a provider that's not going to be super homophobic. Who should I go to?" Then we would pull out this list and say "are you looking for primary care? What kind of care are you looking for?" And we vetted these

providers to make sure they weren't going to be homophobic.

So, feminist clinics came out of this movement in the 70s, where folks got really tired of not being believed about their bodies and not being trusted about their bodies. And having mostly cis men physicians, tell them that they were wrong or that they were crazy. And so a bunch of folks across the United States, there's a few kind of like, well known names (Carol Downer was one of the founders of this movement) got together, and we're like "we're going to start our own clinics." And they brought in physicians, and they basically treated the physicians as hired techs. So it was mostly women running their own clinics and being lay health workers. They called themselves lay health workers, they didn't necessarily have any medical certifications, but they kind of learned everything they could about how bodies work. And they decided what were the things they needed physicians for and what were the things they didn't need physicians for. And when they needed a physician, they told the physician "we're in charge, you do what we tell you to. You are not the boss." And they would bring in the the physicians as hired techs, really.

And so to me a major distinction of the feminist clinic is that it's a different power relationship. It's a different hierarchy. The physician doesn't run the show, and the patient is in charge. I mean, I think that's really what's very different. And it feels different in a feminist clinic. The patient is always given a lot of options, the patient is told, sometimes, in too much detail, everything that's going to happen and asked a lot of questions about it. I mean, that is one thing that looking back, what I've interviewed a bunch of my former co-workers who worked at feminist clinics in independent clinics, and one of the things that people have said, looking back is "Wow, we took up so much of people's time. We assumed that everybody wanted to know everything about everything. And maybe one of the choices we could have given people is "do you want to know absolutely everything about everything? Or like how much information do you want?" Because often would take hours to do just a pretty like basic appointment.

I think one of the tenants of the feminist clinic is that it might be what we now gets referred to as patient-centered, that now is a basic expectation in healthcare, but back then was pretty unusual. There didn't used to be a lot of explaining of medications or procedures or what was going to happen. And so I think in the 70's and 80's, and even into the 90's, to have a healthcare provider talk to a patient and say "This is what we think is going on. Here are the options for treatments. We could do this,

far right party in Spain that's been gaining in popularity. They're incredibly anti-immigrant. People that are at Vox rallies will be doing the full on Fascist salute. They're wandering around in Falangist outfits and have the old Falangist flag. There's some wild stuff there. They're very into Franco, and they hang out with the old school pro-Franco folks. And they're super anti immigrant, and also very anti-abortion. They've been trying to get the law that liberalized abortion access overturned. And they're working closely with the traditional far right party to do that. Nothing ever stays within borders. We often think that these trends are specific only to one country, or to one continent, or whatever, and really should probably be paying more attention to trends globally.

Bursts – TFSR: Thank you for that on-the-spot question.

So, the last 50 years has seen the growing of a strange amalgam of the religious far right, which we've been speaking about, in particular in the so-called US formulating of a culture war against a gambit of other issues including: sexuality, bodily autonomy and gender parity. That right wing movement has heaved huge amounts of money and political power to stymie access to reproductive choice through local state and federal law, to reverse Roe v. Wade, or disentangle access to abortion or birth control, even from international humanitarian aid that the US provides. Can you talk about the impact of things like clinics zonings law, heartbeat bills, trigger laws, and the stacking of the Supreme Court. All these like legal issues that feel well beyond the scope of in some ways, a direct action approach towards things? How might an anarchist approach to these issues look?

Bayla: That's such a hard question. I'm struggling with this. Because when y'all first reached out about this, it was in the midst of some of the Supreme Court stuff that was going on. And I was like "I don't want to talk about the legal stuff." Because this is hard for me, right? So much of my work has been about access in places where there aren't legal restrictions. I've been doing research in two settings where there were basically no legal restrictions and where abortion was paid for in a public health system or the equivalent thereof.

I did research in Oregon, where Oregon is one of.. I'm not going to get the number right now, but at the time it was one of 36 states where the state Medicaid program covered abortion. And there were no legal restrictions. There was no waiting period, there was no counseling, there's

forcement being involved in clinic defense, which is a thing I have complicated feelings about. But you know, this is not a new thing for the sort of... I don't even know what you call them, but the kind of Christian fundamentalist pro birth people to be anti abortion, and to have that kind of link up with the scary, violent militia element. I don't have a really well articulated analysis of where the ideology lines up, other than it meets in some pretty obvious misogynistic, white supremacist, not wanting to be outnumbered, wanting the right kind of people to have more babies sort of rhetoric.

We can think of things like the Quiverfull movement. There's a very far right Christian fundamentalists who think that it is a sin to have an opportunity for pregnancy that does not result in pregnancy. So I'm sure there's something there. I don't know of it specifically, but it would not surprise me if there's some links being made.

Bursts – TFSR: Yeah, and I think that group that you were thinking about in the Knoxville area is the Legion of St. Ambrose, which is a Romanian Orthodox influenced far-right group that kind of splintered off of the Traditionalist Workers Party that was based in eastern Tennessee for a bit. And yeah, this is generationally, even from back in the 70's or 80's, when David Lane of the white nationalist terrorist group The Order coined those "14 words." It's about territory. And it's about... I'm not gonna repeat them... But it's about gaining territory, that the sovereignty is in the hands, specifically of white folks, and reproducing, more and more white folks. A thing that's been getting more traction throughout the global far-right has been this idea of the great replacement. Which is a French New Right idea that's been influencing all sorts of groups from Atomwaffen and The Base and League of the South. It's all across there.

Yeah. Anyway, reproductive feature-ism. It's all freaky, I don't know...

Bayla: And it fits in really well with all the very anti immigrant stuff, too. I always think about what are the parallels in Catalunya and in Europe, generally. And this is Vox's whole thing, right? This is another conversation I would love to have another day is how the terms Fascist and Neofascist are very relative, depending on where you are, because people try to refer to Vox as Neofascist, and I'm like "no, they're just Fascists." I don't know why you bother with Neo in front of that. But Vox is this extremely

we could do this, we could do this, here are the side effects, what would you prefer?" That was not typical. So that was feminist clinics, and there were many of them across the United States. And there was a whole Federation of them.

And another thing about the the Federation of Feminist Women's Health Centers, they didn't just provide care, they also did a lot of advocacy. So they taught things like cervical self-exam. There was a slideshow that used to travel all over the United States showing people pictures of a whole bunch of different cervixes. The biggest diversity of people you can imagine to just kind of normalize different bodies and normalize people seeing their own cervix. I think it's become very stereotypical thing in a lot of TV shows and movies about cervical self-exam, but that's where it came from. And it also taught people a lot of alternatives to hormonal contraception. It taught people about kind of learning their own cycles, and alternatives to, especially for people of color that felt like there had been a lot of coercive sterilization, and coercive contraception, and perhaps were very leery of mainstream contraception, what were some alternative contraceptive practices that didn't rely on hormones. A lot of that came out of feminist clinics. And I think of independent clinics in some ways as being kind of the offshoot of that. When the feminist clinic business model didn't survive the 90's, and largely didn't survive because of the anti abortion violence. Because the costs of securing clinics against bombing and arson and attacks and killings of doctors, when it became so expensive to do everything that needed to be done to keep clinics safe, and feminist clinics kind of couldn't stay open, many independent clinics were started by doctors who had been trained in feminist clinics.

So, independent clinic just means... it's what it sounds like, it's not a chain, or it's a small number of clinics, maybe owned by the same person. But independent clinics more often tend to be either physician run, or managed by a smaller group of people. But it's not. It's not like Planned Parenthood, it's not corporate. When is it independent and when is it a chain? Like, if you own more than a certain number of clinics are you still independent? But I guess partly I know it when I see it. I don't know if that's fair to say.

There's something called the Abortion Care Network, which is the National Association of Independent Clinics. So I'm sure they have specific criteria by which they define independent, but I tend to think of independent clinics as there's still a large degree of informed consent, patient decision making. It's more about the quality of the care and not as

much about the revenue that's generated. It's much more about the care that's provided. That it's full-spectrum, that includes second trimester. Often independent clinics also offer other care. Often independent clinics have gender-affirming care, often have other reproductive health services, some independent clinics also do prenatal care and sometimes they'll also have like birthing services available.

Bursts – TFSR: Yeah, that's all super helpful information. And I'm glad that you brought up the term informed-consent. That feels like a total game changer between some of the different models and how health-care was administered to people, as opposed to the shift that people pushed really hard for the 60's and 70's and 80's, for actually having a say in how medicine was practiced on their bodies.

So the area that we live in is really interesting, interesting is pretty terrible, in some ways. We may have pretty good administration of the local Planned Parenthood at the moment. But also in the 90's this was an area that had Eric Rudolph, who bombed the Olympics in Atlanta, also had been conducting violence against clinics throughout this part of Appalachia, before finally being caught by authorities. That's a story that can be told all across America, the violence that occurs by right-wing extremists against clinics, and as you said, against clinic doctors and employees, and just intimidating people on the way in. Not to say that there is not a difference between someone who actually engages the violence versus someone who intimidates but I think that's a spectrum. Can you talk a little bit about what clinic defense to your understanding looks like right now either around here around the US and how it's changed its appearance?

Bayla: Yeah. Thank you for that. And I have this very strong memory of.. If people know what a fax machine looks like, the faxes that would come in from the National Abortion Federation that were our security alerts of the clinic. I remember the fax that came through with the picture of Rudolph reminding us probably daily that he hadn't been caught yet. That picture is very clear in my mind, letting us know that he was still on the loose. So it was very interesting to me when I moved here and realized how close I was to where he had been caught. And just these moments of my life that connected. I remember standing there in the clinic reception area, getting the faxes off the fax machine, looking for somebody's insurance verification form being like oop... "there's Rudolph again, he's still on

much influence those formations have, but they do tend to dovetail somewhat with the religious far-right. And also there was that Patriot Front leaked audio that they were going to show up at the anti abortion march in Chicago yesterday and next week in DC. And also there was recently a fire at a clinic in Knoxville that I don't know if they ruled as arson, but do you have anything to say about how the focus on anti-choice, forced-birthers or whatever, how that is changing right now given current political context? And it's okay if not.

Bayla: No, I appreciate that. Thank you. Yeah. I'm glad that you mentioned Knoxville, because I'd meant to bring that up. And I forgot that. I think it has been determined that it was. I don't know if it's been determined arson, but I think it was determined that it was not accidental. It seems like it was it was a fire that was set. And that is a clinic that's been a target of a lot of harassment for years. I was trying to think back. I know there was some point in the past few years, around the same time that there had also been a lot of harassment here locally at Firestorm... I'm losing track of years because of COVID. But it feels like it was maybe late 2019, or that summer that there had been a lot of Proud Boys that were showing up in Asheville, and there seemed to be some link between some of the Proud Boys and then some other militia groups. Some specific Christian militia group that had been seen in both Asheville and Knoxville. And there was some thought that that had been part of who had been harassing that same clinic previously.

So, I do think there's something to this. But there's also a long history of this, right? Like a very, very, very long history. Like if we want to go way back. Part of the Third Reich was they had awards that were given to Aryan women that had more than a certain number of children. There was a specific emphasis and monetary award for German women who had more than a certain number of children, I forget how many. But this is in the same era, as the very sort of earliest days of the Holocaust was this rewarding the right kind of childbearing. And then if we go back, not as far, some of the largest, most violent anti-abortion organizations in the 90s were things like "the Army of God," where people were showing up at huge anti abortion protests with all of their children and people with many, many, many children would put all of their very young kids in the very front lines of these anti-abortion protests, and have small children standing in front of law enforcement vehicles and stuff.

Again, we can talk all day long about how we feel about law en-

something about anti-abortion protesters harassing a local clinic, the first thing to do would be to contact the clinic where you notice protesters and ask clinic leadership what they would like in terms of support, ask them if they are interested in having escorts, ask them if there's any kind of existing organization that is coordinating that. Think about whether there's an existing local organization that you could work with, but definitely don't just show up because then you're kind of one more unanticipated entity, one more wildcard that the clinic is having to figure out "who are you," otherwise, it can just kind of escalate things. I can think of plenty of other things that people can do that might be helpful.

One of the hardest things, every clinic I've ever worked at as a staff person, is figuring out where to park. You don't want to park at the clinic, because then the protesters are gonna see your license plates, they're gonna see you coming and going every day. If they get your license plate, they can get your home address. So we were constantly trying to figure out somewhere nearby that we could park and walk to the clinic that was a short enough distance that we weren't leaving ourselves vulnerable for a long time walking back and forth, but where our car was kind of out of sight. So honestly, if you live near a clinic that's getting a lot of protests activity, if you've got a spot where clinic workers could park next to your house, in your driveway, somewhere that's less visible to the protesters but near the clinic, that would be something to offer the clinic. And then beyond that, one simple thing that people can absolutely do, if they're in an economic situation to do it is to donate to abortion funds. Because you have to assume that any independent clinic near you is having to put a lot of money into security. And that means they aren't able to discount procedures for people that absolutely need to come for care but can't afford it. So the more that you can support abortion funds that can offset some of the money that clinics are having to spend on security.

William – TFSR: Thank you so much for going into how people can support or engaged this issue. We did have a question that was a follow up to what you were talking about about clinic defense but I think that you answered that question really well and we'll post those suggestions in the show notes too.

Is there anything to say about... well maybe not... when you were talking me and Bursts we're going back and forth in notes to each other about how reproductive issues are being hyper focused on by the burgeoning modern fascist formations. It's easy to inflate how

the loose." Yeah, if that tells you anything about what it's like to work in a clinic, you're just kind of going about your daily patient care, and then also getting these constant reminders that there's somebody out there that would try to kill you.

And that's part of what motivated the project that I was speaking about before where I've been interviewing people that worked in feminist and independent clinics over a 30 year period about anti-abortion violence. And really the question I've been asking people is, "how do we do this? What is it like to go to work every day? How do you make sense of it?" That was really my question. "How did you, how did we make sense of this kind of constant threat of violence and harassment? And how did we keep doing this work? What was it that allowed us to continue doing this work, knowing that there were this constant waves of violence, constant threats, and knowing that there was always this potential for violence directed at us because of this work that we do?" And so that's what I was really interested in. Because I sort of knew how I was doing it. But I didn't know if that was the same for my co workers. And so this is a really interesting question. I think. Is it different? Has it changed? Or does it just kind of come in waves and sometimes it dies down sometimes spikes again. I don't know that a lot does change. I think it's just sometimes we pay more or less attention to it.

What I tend to think is that we pay less attention to the anti-abortion violence, when there's more legislative attacks in the news. And then when there's not as much of a legislative focus, then maybe there's more energy to pay attention to the anti-abortion violence, I think there's a lot more attention when there is an actual, you know, act of violence. And then we kind of get lulled into a false sense of security, when there hasn't been a clinic attack for a little while. But I don't I don't know that actually has changed a lot. It's been a little while since I've updated it, but I sort of have this timeline, going back to the 80's of kind of some of the major attacks, and where, and when, and who. And it feels more like it's just kind of this ongoing pattern that rises and falls and rises and falls.

One interesting thing, that it makes sense when you think about it, is that anti-abortion violence, the targets clinics, the waves tend to follow Democratic and Republican presidential administrations, so they tend to increase under a Democratic presidential administration in decrease under a Republican administration. The one exception to that is that anti abortion violence didn't actually decline under Trump, which is not surprising. And so in terms of how we defend clinics, a lot of what

happened, as I alluded to before, is that in the 80's, and 90's, clinics had to spend a lot of money responding to these attacks. So you would hear of another clinic that was attacked in a particular way, it would make you realize a gap that you had in your security. So, an example that a lot of people mentioned to me in interviews was, there was a particular attack that made a lot of clinics realize that they didn't have bulletproof glass around the reception area. And I think this was the attack in Boston where receptionist was killed. So that's when a bunch of clinics were like "Oh shit, we have to have bulletproof glass on the reception area." And so it was this very reactive thing. Okay, this thing happens, and someone is hurt in this way. And a bunch of other clinics realize "oh, well, we need to be prepared for that thing that we hadn't thought about." And so it was sort of this constant whack-a-mole.

Well, every time you're having to spend a bunch of money on cameras, or fencing, or bulletproof glass or a buzzer system, or you decide that you need to have one of your staff people specifically checking IDs, that is suddenly resources that are being devoted to that piece of the work, to that kind of addressing staff and patient safety, that is money that you might otherwise have been spending on going out into the community and doing sexual and reproductive health education in a particular community that hadn't had access to that that might have been money that you'd have been spending on having a fund to subsidize procedures for survivors of assault. It might have been money that you had been providing transportation grants for patients that were coming from further away. It might have been money that you had been paying your employees more or you might have been able to pay your employees more so you might have had less turnover. So you might have had staff that were less burnt out and more resilient. It might have been money that you could offer services other than just abortion, you might have been able to add gender-affirming care, right? So I think it's kind of this calculus, especially for feminist clinics, where there was a point for some clinics where they're like "We just can't do this anymore. Like we're having to think so much and spend so much money on security, that we're not able to continue operating in the way that we want to and provide the care that we want to provide."

And that was something that I heard a lot from people who'd been there kind of towards the end of a lot of feminist clinics was, it just felt unsustainable. Because we never knew what was going to be the next thing that would happen that would either be a direct attack on our clinic, or

that would happen to someone else that meant we would have to then think about how we would prevent that happening to us. And we weren't getting to provide care that we wanted. And I think this is also another way that for independent clinics, they never know where the next attack is going to come from, is it going to be anti-abortion violence? Is it going to be a legislative restriction? Is it going to be Planned Parenthood moving in down the street and starting to offer medication abortion, and then that full spectrum independent clinic can't stay open. And so kind of never knowing what the next thing is going to be is another form of stress. Then at the same time, you have protesters outside harassing your patients, and so then every patient that walks in the door, you have to spend the first 10 minutes of their appointment deprogramming all the things that the protester just told them is going to happen to them in that appointment.

So what I'm saying altogether, is I don't think clinic defense is necessarily different. I think every clinic having to figure out what are they dealing with in that exact moment, and it's a lot of reaction, and that just becomes very exhausting. It can become very expensive, it's very time consuming. What clinic's defense might look like, wherever a person is at any given moment, it can vary in the moment, but I think the constant is that it just is incredibly time consuming and exhausting for clinic staff. It's very hard to plan for. I know part of how we started talking about doing this interview is there has been an undercurrent locally of very, very well intended, radical folks wanting to support the local clinic when there had been an escalation in protest activity. And there was some talk of people wanting to show up and counter protest and I was chiming in saying "please don't do that. That is actually very stressful for clinic staff. It often escalates things. That is what you don't want to do," because then that's another unknown. That's another "oh no, now we have to figure out what this is."

In terms of clinics, events, the things that we know actually are helpful is something that is a very organized, coordinated escorting effort. In places where I've seen this work really well, it's often a group that's "Medical Students for Choice" in a place where there's a medical school. It's like a formal national organization called Medical Students for Choice. And one of the primary things that they do is advocate for medical school training and abortion practices. Then they'll also go and escort at local clinics. They'll organize medical students to escort. I've seen other places where there's an organization approach was clergy. I kind of doubt we would get that here, but you never know. If people really are wanting to do