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**The ‘Wayfinders’ of Abortion Access: Analyzing the Interstitial Affective  
Care of Volunteer Case Managers at the Chicago Abortion Fund**

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### **Abstract**

The increasing hostility of the abortion access landscape and economic impact of the COVID-19 pandemic have increased stressors for organizations bridging access to abortion care, such as the Chicago Abortion Fund (CAF). Through interviews with 12 current, and one recently retired, CAF Case Managers (CMs), this paper analyzes the emotional support offered in CM-caller interactions through the theoretical lens of what I call *interstitial affective care*. This specific

mode of care work exists in the cracks of an intentionally flawed system that challenges the bounds of care possible and the capacity of caregivers. Stressful, uncertain, or isolating situations arising from oppressive societal structures are managed by CMs both through affective labor in order to reassure callers of their competency, and through care work that prioritizes holding space for callers as they navigate a stigmatized geography of care. In examining the work of CMs on CAF's helpline, the impact of non-clinical, sustained care becomes clear, as well as the need to invest in abortion funds as sites that understand pathways to identify/overcome a host of barriers to abortion care and a broader liberated future that includes accessible, affirming abortion care.

### **Introduction**

Each Monday, Wednesday, and Friday, two volunteer case managers at the Chicago Abortion Fund open a spreadsheet filled with names, zip codes, gestations, appointment times, and phone numbers – each line representing a person who has called the helpline to receive assistance in funding their abortion. One by one, each volunteer will call four to five grantees for their shift, with the support of the staff member on call. In total, staff and volunteers may collectively support upwards of 100 people per week with vouchers for their appointments, as well as supporting with gas money, childcare, time off work, or any travel arrangements. However, interactions between case managers and grantees cannot be reduced to a monetary transaction, or even a logistical lift. Financial and practical assistance is combined with less tangible emotional support to meet a wider range of individual needs outside of procedural funding – a commitment known within the abortion fund network as ‘wrap-around’ or ‘whole person’ support. The care relationships forged during the initial intake, and subsequent follow

up, vary in intensity and form as case managers seek to identify and address the needs of their callers through providing this wraparound emotional, logistical, and financial support.

This paper explores the strategies and conceptualizations of care work by volunteer Case Managers on the Chicago Abortion Fund manage and their origins. My analysis shows that CAF CMs can be conceptualized as providing *interstitial affective care*, a term that will be developed using the CAF helpline as a case study. *Interstitial affective care* is exemplified as CAF CMs mitigate existing systemic failures beyond their organization's material capacity by reassuring and making space for grantees, even in the face of stress and uncertainty. This care is especially relevant in a landscape where accessing abortion care is stigmatized and heavily politicized., which will be explored below and will, in part, describe the care work performed by CMs. I have chosen the term '*interstitial affective care*' to emphasize that this specific management of emotions, both personally and with callers, is part of a temporary, non-ideal organizational coping strategy that seeks to mitigate a currently/historically hostile abortion landscape.

Looking at the current work within health policy and health services, abortion funds are primarily conceptualized as venues for accessing research subjects.<sup>i</sup> Scholars have largely ignored the workers and volunteers who do abortion funding work. By focusing on how CMs approach the work of mitigating barriers to abortion access for pregnant people who do not want to be pregnant, my thesis contributes to literature in the sociology of reproduction concerned with abortion access in the U.S. Below I show how CAF volunteers and staff *must* be experts on navigating an intentionally hard-to-navigate landscape, and they provide non-clinical support for callers that may extend beyond funding, for wrap-around care. These attributes are not exclusive to CAF, but they are not reflected in current sociological scholarship on abortion access.

My research shows that abortion funders navigate interstices between care work, or the tending of people and their needs via intimate labor (Parreñas & Boris, 2010, pp. 3); a

politicized abortion care landscape; and the possibilities/limitations of mutual aid. For the purposes of this research, I define *interstitial affective care* as a project of personal and interpersonal emotional management that seeks to mitigate cracks (interstices) within a much larger, more flawed care landscape. By employing interstitial affective care in the practice of directly funding abortion through mutual aid, CMs manage certain gaps within a currently insufficient, and even actively suppressive and violent, abortion care system.

### **Background**

The strategies and conceptualizations of care work by volunteer Case Managers on the Chicago Abortion Fund helpline are framed by a political environment that is, in many ways, hostile to abortion access. In order to manage this hostility, critical social theory suggests that in helping people overcome barriers to care, CMs engage with intersectional reproductive justice and the complexity of reproductive ‘choice,’ as well as concepts related to affect studies, emotional labor, and mutual aid.

### **The Abortion Access Landscape**

The right to abortion access is under attack in the United States. By July 2021, one month before I began collecting data, state policy trends showed the worst year on record for abortion rights in the United States – with 90 restrictions enacted in six months, surpassing the 89 restrictions passed in the entirety of 2011 (Nash et al., 2021). Two key elements of the hostile abortion access landscape are political repression via abortion bans based on estimated gestational age, and state and federal policies banning or restricting insurance coverage for abortion care.

### ***Gestational Stage-Based Bans***

In October of 2021, Senate Bill 8, what is effectively a 5 to 6-week abortion ban (prohibiting abortion “upon detection of embryonic cardiac activity,” with exemptions only for “medical emergencies”), went into effect in Texas, prohibiting anyone from performing an abortion or “aid[ing] and abet[ting]” access to abortion care after this arbitrary cut off, at the risk of being sued (White et al., 2021). In December 2021, a conservative-majority Supreme Court of the United States heard *Dobbs v. Jackson Women’s Health Organization*, a case that challenges a 15-week abortion ban in Mississippi (Howe, 2021). If the challenge is unsuccessful, as is projected, the ruling would overturn the precedent set in *Roe v. Wade* and *Planned Parenthood v. Casey* that affirms a constitutional right to abortion care “before the fetus can survive outside the womb” (Howe, 2021). The Supreme Court is set to make a decision on this case in June 2022, though, as will be demonstrated below, the legality of abortion care is not synonymous with access for many. As interviews for this study were conducted in September and October of 2021, these upcoming threats to the legality of abortion were apparent to interviewed case managers.

### ***Insurance Coverage Bans***

The navigation of insurance coverage and anti-abortion restrictions in certain states also heavily impacts the nature of the work on CAF’s helpline. In terms of political barriers to care, the Hyde Amendment limits resources to abortions for those who need financial assistance via insurance:

Medicaid is a program that assists individuals with limited incomes with medical costs, yet policies such as the Hyde Amendment restrict use of this program for abortion care.

The Hyde Amendment restricts federal funding for abortion in state-based Medicaid insurance programs to only those procedures provided in cases of rape, incest, and threats to the life of the patient, forcing Medicaid patients with limited resources to pay out-of-pocket. [...] To help ensure Medicaid recipients can access abortion alongside other health services, some states use their own revenues to cover care beyond the Hyde exceptions. (Hasselbacher et al., 2021)

On the federal level, the Hyde Amendment impacts Medicaid and Medicare, as well as federal employee and military health insurance plans. Illinois is a ‘pro-choice’ state surrounded by a more hostile region in the Midwest. In Illinois, the passage of House Bill 40 in 2017 mandated IL Medicaid coverage of abortion (Hasselbacher et al., 2021). In 2019, the passage of Senate Bill 25 (also known as the Reproductive Health Act) required private insurance plans to cover abortion care at the same rate of other maternal healthcare<sup>ii</sup> (*Support the Illinois Reproductive Health Act*, 2021). While many Illinoisans have been able to access free or reduced-cost care, people still fall through the cracks. Private insurance companies, in many cases, found loopholes to avoid providing abortion coverage, and people who are dual eligible for Medicaid and Medicare are often denied coverage for abortion due to of the Hyde Amendment.

The majority of CAF callers come from outside of Illinois. The fund works with clinics in Illinois, Ohio, Wisconsin, Indiana, Nebraska, and Kentucky, and with callers from across the country (Chicago Abortion Fund). Each state has varying conditions to navigate, and unique barriers to contend with that may change depending on the origin of the caller, their insurance status, and the clinic they choose. For example, below (Table 1) is a comparison between Indiana and Illinois, the two states that house the majority of the clinics that CAF works with.

Table 1

*ABORTION ACCESS BARRIERS IN ILLINOIS AND INDIANA*

	Illinois	Indiana
Gestational age limit for abortion procedures	After “viability,” generally defined as approximately 24 weeks; two IL clinics will take clients at 26 weeks	Legally 20 weeks (barring exceptional circumstances), but no clinics within the state perform abortions past 13.6 weeks – dilatation and extraction (D&E) abortions, usually performed after 13-15 weeks gestation, are legally prohibited <sup>iii</sup>
Medically unnecessary requirements	None	Mandatory 18 hour waiting period and mandatory ultrasound; Mandated counseling includes information on “fetal pain”
Approximate cost of abortion care prior to 10 weeks gestation <sup>iv</sup>	\$480	\$900
Youth-Specific Barriers	No required parental notification or consent starting in June 2022 due to PNA repeal <sup>a</sup>	Required parental consent of abortion, can only be circumvented via judicial bypass process
Public Insurance Coverage	Legally able to use IL Medicaid, unless you are covered by both Medicaid and Medicare due to billing complications <ul style="list-style-type: none"> <li>• Able to use IL Medicaid for a free procedure at certain registered locations</li> <li>• Able to be eligible for free care under Medicaid Presumptive Eligibility at Family Planning Associates or IL Planned Parenthood locations</li> </ul>	No Medicaid coverage of abortion; public funds may be utilized in cases of “life endangerment, rape, and incest,” or if there is a “threat to the patient’s physical health”



Private Insurance Coverage <sup>v</sup>	Must cover abortion care at the same rate as maternal care, though providers not based in Illinois are not obligated to provide coverage	Indiana has no provision guaranteeing or restricting insurance coverage of abortion
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<sup>a</sup>*SB 2190, 2022*

*Note.* Adapted from “An Overview of Abortion Laws,” 2022. Copyright 2016 by Guttmacher Institute.

A lack of consistent insurance coverage, even in states where private insurance is able to cover abortion care, leaves many in the cracks of pro-abortion legislation. Long waits to approve Medicaid applications, strict eligibility requirements, a lack of uniformity of private plans, and the inability to use any coverage in some states, leave people facing an unplanned, upfront cost of hundreds to thousands of dollars to access essential, time sensitive care. The chart above demonstrates just a sliver of the complex information that case managers must collect, disseminate, and navigate when working with callers.

## **Implications of Critical Social Theory for Abortion Funding Case Management**

This research explores the concept of care work in stigmatized healthcare settings, specifically seeking to understand the motivations, self- and community-care practices, and role of the larger abortion landscape in abortion funding case management. *Interstitial affective care* provides a lens in which to analyze this work. In order to construct a theoretical grounding for this term – both as it relates to abortion funding, and more generally – two lines of social theory must be explored. First, I will explain the larger movement ties of abortion justice, and how this commitment is theoretically linked to a much larger fight for liberation (and therefore recognition of an interconnected set of injustices). Next, I will outline multiple theories of affective or emotional labor, and/or community care work that each partially have contributed to the foundations of my theoretical concept of *interstitial affective care*.

### ***Intersectional Reproductive Justice and The Complexity of Reproductive ‘Choice’***

The National Network of Abortion Funds, including the Chicago Abortion Fund, explicitly centers reproductive justice in their organizational mission<sup>vi</sup>. The conceptual framework of reproductive justice and reproductive rights have been parsed out in the academic sphere by theorists and organizers alike. Reproductive justice co-founder Loretta Ross recounts that, “[the Black founding mothers of reproductive justice] placed [themselves] in the center of [their] analysis and made the case that while abortion was a crucial resource for [them, they] also needed health care, education, jobs, day care, and the right to motherhood” (Ross & Solinger, 2017, p. 64). She asserts that reproductive justice cannot be “isolated [...] from other social

justice issues,” and that “the decision to become a mother— or not—” is “extremely relevant” to “issues such as economics, immigration, and incarceration” (p. 64).

A rights-based framework, beyond its single-issue focus failing to address intersectionality, is also tactically flawed. “Women’s” rights movements rely on a “logic of inclusion,” wherein rights create the fiction of a sovereign individual, constructing the ‘problem’ that people who are oppressed need only to be included in the systems that less oppressed people are a part of – rather than transforming any material conditions or culture (Brown, 2000, pp. 208-229). In addition, accessing these rights, once they are codified, also requires material wealth or time, meaning that the people who are most marginalized are least likely to be able to secure and assert certain rights (pp. 208-229). Lawyer and abolitionist organizer Dean Spade offers a definition of reproductive justice that includes a critique of individualistic rights-based frameworks:

The articulation of reproductive justice as concerned with population control turns away from the individual-rights narrative that centers the question of whether the government is affirmatively and explicitly blocking a given woman from accessing abortion or contraception. Instead it argues that all of the conditions that determine reproductive possibilities— subjection to criminalization, displacement, immigration enforcement, and environmental destruction; the unequal distribution of wealth and access to health care; and more— are the terrain of contestation about the politics of reproduction.

(2013, pp. 1036-37)

Both of the definitions – that of Spade and that of Ross and Solinger – agree that reproductive justice is intersectional, centering the most marginalized on several axes of oppression, while making it clear that a focus on individual rights narrows the possibility of reproductive advocacy.

A multi-layered reproductive justice framework also troubles the reduction of abortion access to individual choice. Rosalind Petchesky, in reconciling both social and individual dimensions of the struggle for reproductive control, argues that “reproductive freedom [...] is irreducibly social and individual at the same time, it operates ‘at the core of social life’ as well as within and upon women’s bodies” (1980, pp. 665). In contemporary discourse, this interplay between the control of social structures and individual autonomy in a struggle to assert reproductive freedom has been further applied to all people who can get pregnant, regardless of gender. Petchesky’s argument is directly in conversation with a reproductive justice framework that centers both individual needs and the intersecting systemic conditions that prevent access to those needs. These larger, systemic conditions can be tied to the larger concept of ‘reproductive governance’ offered by Lynn M. Morgan (2019), which refers to the ways in which various institutional actors regulate and control reproduction and population, using legislation, morality, economics, ethics, or coercion. A reproductive justice framework asks us to broaden our categorization of the actors enacting reproductive governance to include any body or social control measure that may impact a person’s (or people’s) ability to fulfill their reproductive, caretaking, or basic survival needs, among others.

### *Affective Labor and Radical Care*

Alongside larger movement commitments to advancing reproductive justice, abortion funds have a very practical function: funding abortion and supporting those who reach out to them in accessing care. During the funding process, case managers provide more than just financial support to callers; additionally, grantees may receive logistical support (transportation, lodging, childcare, etc.), administrative support (connections to other abortion funds, information

about insurance coverage, or more technical information about how to advocate for more resources), and, as will be primarily discussed in this paper, emotional support.

In order to further explore emotional support specifically, the conceptual frameworks of *restitutive intimacy* or *emotional labor* serve as apt starting points in current literature. In *The Look of a Woman*, Eric Plemmons speaks about the “geography of care,” the “specifics of place [that] shape the conditions of the care that is given there” (2017, p. 74), surrounding Facial Feminization Surgery (FFS). He writes that the specific historical context of FFS and current societal treatment of trans\* individuals – marked with neglectful, punitive, inaccessible medicine – gives rise to conditions for a “restitutive intimacy” for those who can afford and access care. Restitutive intimacy is “[e]xpressly shaped by the troubled past of inadequate and predatory surgical interventions for trans-people and formulating itself in contrast to it, the success of FFS depends upon its characterization as an act of compassion, an intimacy whose enactment of selfactualization is also a form of restitution, of justice done” (p. 72). Abortion care is similarly culturally stigmatized and has a history (and present) of both criminalization and legislative restrictions, as well as dangerous malpractice or misinformation for those who cannot/could not access care due to legal, financial, cultural, or logistical barriers. The work of supporting people facing those barriers in their journey to access safe abortions cannot be separated from the historical and larger social contexts of abortion care.

An alternate possibility in framing this type of care could be that of emotional or affective labor. Emotional labor, as theorized by Arlie Hochschild, is seen when we suppress or manage our feelings to feel an emotion that is suitable for a job, a crucial task in direct service, and is completed through “bodily or mental acts” (Hochschild, 2013, p. 25). While emotional labor does take effort, this emotional suppression or management is not always negative, or unwilling. In her essay “Can Emotional Labor Be Fun?,” Hochschild primarily examines workers who care

for children and the elderly. In characterizing the emotional labor of these care workers, Hochschild concludes that a natural affinity for the work they engage with, when coupled with the gratification of being able to have a meaningful impact on another person and meet their needs, may allow for the enjoyment of emotional labor. This enjoyment may occur alongside suppression of any negative emotions – as this suppression is done expressly to “[cultivate] warm, trusting, resilient relationships with clients” (p. 27). However, Hochschild concludes that many factors interfere with the enjoyment of emotional labor, contributing to alienation and dissatisfaction. The most relevant factor to the volunteer case managers is the problem of a “broken system;” in other words, a stressful care landscape, due to a lack of resources, may prevent workers from feeling pride, and instead “force [them] to manage [their] feelings about doing [their] job in a broken care system” (p. 28). Michelle Murphy connects the concepts of emotional labor, care work, and reproductive labor, to speak on what she calls ‘affective labor.’ While the politics of care are generally regarded to have a positive affect, Murphy focuses on a definition of ‘care’ that means to be worried, unsettled, troubled, uneasy, etc. Affective labor is not necessarily capitalistic or monetized, but it is always gendered and often undervalued, despite being necessary for individual/collective survival (Murphy, 2015, pp. 717–737). The term ‘*affective vulnerability*’ was created by Clara Fischer to describe a movement strategy undertaken by Irish pro-abortion organizers leading up to the repeal of the Eighth Amendment and subsequent legalization of abortion in the country (Fischer, 2020, pp. 985-987). She documents the strategy of visibility – of making public something that had previously been shamed and hidden – through the “[airing of] often devastating stories concerning the most intimate and private parts of their lives in order to redress public policy failures” (pp. 998). These stories unearthed the cruelty of abortion restrictions by providing a platform for people to express how political barriers placed them in physical and emotional

distress. The nature of these stories as typically private matters, involving “pregnancies [...] experiences of miscarriage, sexual violence, and a host of emotionally challenging topics,” made these disclosures even more impactful, as the act of publicly sharing them in order to make change seemed to connote even more of a burden made necessary by the state (pp. 1000).

Care work is political work, even when done interpersonally. *In Uninsured in Chicago: How the Social Safety Net Leaves Latinos Behind*, Robert Vargas outlines barriers to health insurance enrollment for the Latinx community, specifically outlining the racialized and gendered experience of applying for Medicaid for Chicago’s Latinx population. Vargas discusses the importance of interpersonal interactions when advancing public support, outlining how “faceto-face” strategies in which American Care Act (ACA) navigators aligned with community nonprofits – people who are not “a cop nor a cold, public aid bureaucrat” – are able to walk people through the process of applying for coverage (Vargas, 2022, pp. 34). Vargas describes a successful navigator as someone who is able to “cultivate and communicate patience, understanding, and empathy,” especially when working with individuals who have experienced criminalization relating to a lack of adequate healthcare, or who are unable to access private healthcare through an employer due to prior criminalization (pp. 18). Otherwise, some are left to enter the informal economy, buying and/or selling prescription medication or engaging in theft to access the care they need – care that can be life or death (pp. 19-22). Vargas’ description positions the affective work of navigators to create a trusting and comfortable environment as crucial in expanding Medicaid coverage to marginalized, and historically/disproportionately criminalized and targeted, communities. He also makes clear a ‘crack’ existing at the intersection of healthcare, economic status, criminalization, and race – people are unable to access the care they need due to systemic barriers, and individual navigators are able to provide support to mitigate these barriers.

When characterizing the work done on the helpline as a whole, including emotional lifts, the Chicago Abortion Fund connects abortion funding to mutual aid, making those who work on the helpline distributors of such aid. Dean Spade defines mutual aid as: “[...] collective coordination to meet each other’s needs, usually from an awareness that the systems we have in place are not going to meet them. Those systems, in fact, have often created the crisis, or are making things worse” (Spade, 2020, p. 4). Within this grounding, Spade explicitly names, “raising money to pay for abortions for those who can’t afford them” (p. 4). Mutual aid directly connects to building power, as, unlike many charity-based organizations, these spaces “[see] the systems, not the people suffering in them, as the problem,” a framing that “can help people move from shame to anger and defiance” (p. 8). Abortion funds fill the cracks of a failed system, not only in material support by funding abortions, providing transportation to clinics, providing childcare, navigating insurance eligibility, etc., but also in providing this care in an affirming way. This approach is starkly opposed to charity models, whose means testing and eligibility requirements “usually promote racist and sexist tropes” (p. 13). Spade writes, “in this context of [...] forced dependency on hostile systems, mutual aid— where we choose to help each other out, share things, and put time and resources into caring for the most vulnerable— is a radical act” (p. 5).

## **Methods**

From August to September of 2021, I conducted interviews with the 12 current volunteer Case Managers (CMs) at the Chicago Abortion Fund (CAF) and one recently retired CM. I asked each interviewee 11 questions covering their experience and commitment as a CM, the emotional support they provide on the helpline, and their visions of reproductive justice. Due to my ability to interview 100% of the defined research population at that point in time, I can generalize about the



volunteer CMs at the Chicago Abortion Fund. However, my findings are unlikely to represent the experiences of volunteer abortion funders at other abortion funds like CAF. The intellectual merit of this study comes from the novel social theory that I generate from my analysis of participants' interview responses: *interstitial affective care*.

My interview data was gathered in one-on-one interview settings with each interviewee – three of these interviews were conducted in person, while the remaining ten were conducted via Zoom due to travel limitations or safety concerns relating to the COVID-19 pandemic. All interviews were all recorded using Zoom, if online, or the Voice Memos iPhone application, if in-person. The audio was transcribed with Otter.ai, then coded using a flexible coding method in Dedoose. This coding method involved separating each interview with question codes, then developing themes based on what emerged as threads within the question buckets (Deterding and Waters 2018). In collecting this data, I have employed abductive analysis – I do not claim objectivity, as I constructed the set of questions as well as my personal takeaways in collaboration with the data and my own experiences, allowing my own positionality to drive my understanding of what I collected (Timmermans and Tavory 2012).

My own experience navigating work on the helpline led me to focus on the role of emotions in abortion funding work, thereby aiding me in forming my questions and in relating to my interviewees. Often, we would temporarily break the traditional interviewer/interviewee divide and freely converse about our shared experiences. My involvement in the Chicago Abortion Fund positions me not as an impartial researcher, but instead a member of the community who is also struggling with and living through these questions. I carry with me a deep passion for reproductive justice and funding abortion, and a commitment to uplifting the experiences of those advancing access to abortion care.

### Interstitial Affective Care

The labor that Chicago Abortion Fund Case Managers engage in on the CAF helpline exemplifies and puts into practice aspects of previously discussed theoretical frameworks of *restitutive intimacy* (Plemons), *emotional labor* (Hochschild), *affective labor* (Murphy), *affective vulnerability* (Fischer), and *mutual aid work* (Spade). In order to understand the specific liberatory care/mutual aid work undertaken by CMs, the inherent limitations on reproductive choice due to connections with several modes of power, privilege, and community must be considered. Previous conceptualizations of the connections between care, labor, and affect do not completely encompass the voluntary, and primarily personal/political motivations of the labor CMs undertake, and the legacy and continuation of abortion stigma as it impacts caller and CM experiences. This is the point at which I begin to conceptualize *interstitial affective care*, care work that exists within the cracks, or interstices, of the current abortion landscape system by necessity and seeks to live by principles of a liberated world.

Abortion funding is situated within a stigmatized geography of abortion care, and therefore abortion funders are reifying a commitment to a stigmatized political struggle through their work, in which all actors (caller and case manager) have a personal vested interest – especially those who have had or are seeking abortions. The vulnerability showcased and managed on the helpline *is* political, despite often occurring within interpersonal interactions that seem far removed from advocacy work, legislative offices, and courtrooms. Rather than being directly politically motivated as in the sense of affective vulnerability discussed by Fischer (what we might call ‘advocacy’), openly discussing a stigmatized procedure holds power even between two people on a private call. Holding down callers in the face of a complex care landscape *is* political praxis. As indicated by Hochschild’s conceptualization of emotional labor, the work of managing emotions, though sometimes difficult, may also be extremely rewarding as it is tied to

larger political commitments and visions of a ‘better’ world. In fact, as Hochschild indicates, emotional management is often negative due to a broken system, something that Murphy indicates may be tied to a lack of investment in care structures.

Vargas describes the importance of the emotional management work of non-profit-affiliated ‘navigators’ to create a comfortable/trusting environment in order to connect ‘system-avoidant’ individuals (or, alternatively, people who have been disproportionately marginalized and criminalized by the state) to Medicaid. Abortion care is specifically not covered by Medicaid, or any insurance at all, for the majority of callers on the Chicago Abortion Fund helpline who are coming from outside of Illinois, primarily across the Midwest and South (*Chicago Abortion Fund*). As people who need abortions must pay for their procedures upfront, a lack of insurance coverage causes an already time-sensitive procedure to be made more stressful by high costs, political barriers like state-wide bans and medically unnecessary restrictions, and a shifting landscape that criminalizes pregnant people. This hostile *geography of care* (Plemmons, 2017) is mitigated by abortion funds, and exhibits a specific gap in abortion care, much like the gaps in healthcare access described by Vargas. Rather than relying on the informal support methods that Vargas describes – such as risking criminalization through self-managed abortions via an informal economy – people who are seeking to end their pregnancy are able to rely on abortion funds when federal or state support is not even an option. Funds not only provide tangible mutual aid support where state and federal safety networks like Medicaid coverage fail, but also remain cognizant of the stigma surrounding abortion access to create an affirming, person-centered, and reassuring environment. This is especially important, as abortion bans, are “felt the most by people already marginalized and oppressed by structural inequities and lack of abortion access, including people with low incomes, people of color, young people and LGBTQ people” (Nash et al., 2021). Thus, abortion funds support people who are *already being left behind* by state

support systems, and who are disproportionately impacted by income inequality, structural racism, ageism, and heteropatriarchy.

A commitment to a larger vision of liberation for all, articulated organizationally by CAF, as well as by individual volunteer case managers, as ‘reproductive justice,’ is crucial in case managers’ conceptions of their work alongside immediate barrier mitigation. This commitment, as well as the unique position of abortion funding within this intersectional project, is the basis for my conceptualization of CM work as *interstitial affective care*. Abortion funding, as well as the specific emotional support provided by case managers, mitigates current harmful, intentional, and interconnected flaws in the access landscape – and without a multi-faceted liberatory orientation, this type of large-scale crisis/hardship intervention will never end. As *interstitial affective care* is necessarily shaped by the limitations of several overlapping oppressive structures, organizational, and individual, capacity is limited in fully addressing all barriers to true reproductive justice. This can be seen in the continuous and historic criminalization of people seeking to end their pregnancies, and therefore calls upon a specific restitutive intimacy (Plemmons), in which CMs are accounting for the larger stigmatization of abortion as they provide services. These caregivers cannot, however, completely shield callers from barriers to care, and other interconnected injustices that impact their ability to get an abortion and secure bodily autonomy. Accordingly, CMs control the space that they can through managing their own emotions and, by extension, those of their callers, in an affective project.

In doing their work, CMs strive to create a calm, reassuring space in the midst of a potentially messy and chaotic experience (for both the caller and the CM), and remain available to callers until they receive the care they need. The remainder of this results section will elucidate, based on testimonies from CAF volunteer CMs, how case managers orient themselves and the challenges of their work within a larger political struggle. This struggle includes a project

of destigmatizing abortion care through affirmation and interpersonal connection. CMs' experiences of providing emotional support are shaped by the inherent limitations of mutual aid, and the stressors of working in the 'cracks' of a system that is deeply flawed. These conditions lead to the use of *interstitial affective care* strategies that will be explored below: case managers (1) manage their own emotions and the emotions of callers as they navigate an increasingly frustrating and precarious access landscape, while projecting a calm and assured disposition throughout any caller interactions, and (2) remain malleable in the face of a landscape that can be rigidly hostile, to accommodate the emotional support needs of callers who may be struggling in accessing stigmatized care.

### **Projection of Confidence in the Face of a Hostile Landscape**

As defined by Ross and Solinger, drawing upon a legacy of Black feminist organizing, reproductive justice affirms the intersectional nature of reproduction, and, more specifically, the fight for liberation regarding reproduction. This framework is also apparent in recent calls for 'abortion justice<sup>vii</sup>,' a term that hones in on the specificity of social/political targeting of abortion care while maintaining a broader justice-oriented framework that extends beyond the right to abortion. When asked why they do the work, most case managers pointed to a larger vision of bringing about a world with reproductive justice, and that a regular commitment to providing direct service combatted feelings of helplessness or personal distress. Madeline shared that to her, her work as a CM is a "tangible thing" that she can do that "helps [her] deal with her anger about the world." Trisha also cited the fulfilling nature of "making some kind of difference in someone's life," despite it being "emotionally taxing" work. She also brought in broader movement motivations:

It feels too important to not come back to. I feel deeply personally committed to this mission of ensuring that people have bodily autonomy and the right to make decisions about their health, their family's health, etc. And abortion services are like central to that.

The work feels rewarding to CMs, both on an interpersonal level, helping another individual, and as it relates to their vision of the future they want to achieve. Both Trisha and Madeline's testimonies make it clear that the work feels rewarding as a result of these personal commitments, exemplifying Hochschild's claim that emotional management can, in fact, be positive. While the CMs I interviewed come from varying positionalities – different racial/ethnic backgrounds, gender identities (all identified as women or trans\*/non-binary), ages, socioeconomic classes – each felt a deeply personal stake in ensuring bodily autonomy and reproductive justice for all, and they each felt like their work at CAF contributed to this goal. That being said, case managers' experiences with a 'whole person' approach to navigating caller's care journeys demonstrate that a single-issue fight for abortion, or broader reproductive, justice is impossible.

### ***The Limitations of Abortion Funding***

Threats to the legality of abortion care are compounded with other barriers to care, all symptoms of what CM Rabiah describes as “our white supremacist, capitalistic society.” This structural view of barriers – as more than individual laws or restrictions, but rather intrinsic inequalities under our current system that also impede abortion care access – was common across conversations. Rabiah recounted a particularly difficult call she received in which the caller was “managing a pregnancy that [she wanted] to terminate, there [was] a domestic violence situation, and [she was] recovering from a wound.” She went on to say:

It's just these layers, upon layers, upon layers that just remind you that people are really struggling, just in general. And so, we meet them in these very specific moments for this very specific need. But the complexities of their backstories are sometimes enormous.

The callers on the Chicago Abortion Fund helpline are whole people, and as such, interact with systems of oppression that limit their access to abortion care beyond legality, as well as inflict violence upon other facets of their lives. Operating under a reproductive justice framework, the right to choose if, when, and how you start a family is inextricable from an intersectional web of systemic oppression. In this instance alone, Rabiah touches upon a need for gun violence prevention, broader healthcare access, eradication of socioeconomic inequalities, and patriarchal violence – while the Chicago Abortion Fund has a very specific purpose of assisting with abortion care access. The scope of support that a case manager is able to provide is inadequate to address the full range of needs of any given caller, even if the cost of their appointment is fully covered. This break between caller needs and organizational/personal capacity can be emotionally draining for CMs. Dominique, though she told me that the majority of her cases are a “net positive,” meaning that stress is outweighed by the appreciation of the caller and impact of the support, highlighted these situations as the hardest part of case management emotionally:

The moments [when cases are] kind of a net negative are where we were not able to fully fulfill the need [...] because the needs just so greatly exceed our capacity. The moments where I'm just like, *fuck*, are when there are all these other converging factors informing the person's decision to access reproductive healthcare in that moment. I'm like, damn, you have so much going on and *I'm hurting with you as you navigate that*, and I'm confronting my own inability to assist you and I'm confronting all those things informing that. I think that's where I'm like, oh damn, either we were not able to, or we simply

never could... it's not in CAF's capacity to fix... the world, basically. So, I think *those are the moments where it does feel like labor or like I feel the weight of output*. [emphasis added]

The effects of increased barriers – political, financial, and logistical – have emotional impacts on the people routinely navigating these barriers on behalf of callers. Dominique relayed that she is “hurting with” those that she is working with – absorbing the pain of an inadequate and exclusionary system and flagging those moments as the most laborious. The tension of *interstitial affective care* is that while the work is important in mitigating crises caused by systemic failures, as demonstrated in the previous section, these ‘cracks’ run much deeper than individual caregivers can address. This does not mean that the services are unimportant – in fact they are crucial – but they do not dismantle the broken system that necessitates the care in the first place. The stress of navigating this inadequacy alongside callers shows that *interstitial affective care* is not only indicative of the labor of caring for another person, but also the specific emotional weight of repeatedly confronting the barriers of a flawed system.

Dominique was not alone in this experience—several case managers described holding the weight of barriers to care, and these barriers are internalized and become deeply personal. These heavy feelings have increased in the midst of an increasingly hostile abortion access landscape. Lydia, when asked about the changes on the helpline since she started, said that it is “clear that so many other states and other clinics are getting swamped, shutting down don't have capacity,” and therefore “more people are traveling further, they're having to pay more.” She paused and ended with: “It's depressing. It's just what everyone has been predicting would happen. It's happening.” Restrictions on abortion access, especially as they are linked to sustained efforts to strip the legality of abortion nationwide, have both tangible effects on people's ability to access to care,



and also create stress for those who are positioned to support access to care in the face of such restrictions. Volunteer case managers at CAF each take, on average, 4-5 calls every 2 weeks. Anecdotally, around half of these cases tend to be more ‘difficult’ cases, whether logistically, financially, or emotionally.

Many CMs discussed the COVID-19 pandemic as a shift in the scale of need they were seeing on the helpline, both in number of callers, and the individual needs of those callers. The pandemic has caused changes in the ability to have a support person accompany patients during their appointments, and at times, the ability to rely on daycares or school for childcare, which can serve as an added cost. Fears of travel, restrictions on abortion via telemedicine in many states, and reluctance to visit healthcare settings also effected access to care. Rabiah explained that another reality of this pandemic – job instability and economic crises – have specifically exacerbated financial need. She noticed that “before the pandemic there were people who were out of work, but in [mostly] a transitional way;” however, “given where we are [with the pandemic], and where things have been, [extended unemployment has] been more noticeable,” and people have less disposable income. Dani reflected this connection, sharing that “most of [their] callers need their whole procedure covered these days,” connecting this to their observation that “people [calling the helpline] have been unemployed” during the pandemic. To Dani, in the midst of an economic and health crisis, it “feels like the dial’s getting turned up on some of these things.” As many private insurance companies do not cover abortion, even in the state of Illinois with the passage of the Reproductive Health Act, unemployment is more significant in abortion care in terms of disposable income than insurance access. This leaves case managers to strategize on how to cover larger gaps – whether through connecting the caller (or advocating on their behalf) to access additional funding<sup>viii</sup>, asking for solidarity pledges from

other funds (or connecting the caller to the fund), or increasing the CAF standard voucher amount with supervisor approval. These limitations exhibit what Hochschild deems a ‘broken care system,’ or what I term ‘interstices,’ under/within which individual care workers must manage their own feelings in order to continue providing services. This emotional management, primarily enacted through a projection of confidence, will be explored in the following section.

### *Presentation of Competence*

The frustration of having resources to support only one intervention needed for some callers is managed in part through a projection of competence relating to needs within the scope of abortion access. Given the limitations to abortion funding across the entirety of the healthcare landscape, the increased economic hardships of the ongoing COVID-19 pandemic, and the intersecting types of violence enacted on pregnant people due to patriarchal/white supremacist structures, CMs are tasked with supporting people through increasingly complicated, and sometimes insurmountable, barriers to care. These barriers generally put pressure on CMs – Chelsea shares that, during her time on the helpline, she sometimes even felt “stressed or anxious” when asking for increases in funding, primarily because she worried what would happen if she exhausted all options. She held this worry, “because [she wanted] to make sure that [the grantees] can get everything they need, and they're not going to have to worry about it.” This attempt to absorb some of the worry that callers may be feeling indicates that the work of a case manager can be a project of emotional management. In the face an increasingly complicated abortion access landscape, case managers are given hours of training and pages of documents to begin to navigate. Accordingly, one emotion that case managers are equipped to assuage is that of feeling overwhelmed or worried by a complex landscape. As CM Rabiah states, “one of the things about this work is that there is no typical shift. And that is just because there's no typical

group of any of our clients.” While there is no singular call experience, the CM’s I spoke with largely characterized the majority of personal emotional management they undertook on the helpline as a project of projecting confidence and calmness despite potentially experiencing aforementioned frustrations, stress, and uncertainty. Aalap describes being “usually really tired” after their shifts, after spending time making an effort to “be extra nice and try to make the person feel really comfortable.” Lousia similarly would characterize her work as maintaining “steadiness” and “cheerfulness,” specifically, she said:

The way that I'm communicating, when I'm on these calls that is the emotional support side is [conveying] like, *we have a plan*. There are details that we're going to talk about together. And by the end of this phone call, you're going to know what it is, you're going to know what to expect from me, and you're going to know how to get in touch with me if you need more things. I think it's like words like confidence, calm, assurance. That's the word, being self-assured, reassuring you, reassurance that this is going to be okay.

These CMs again point to an understanding of the difficulty of accessing abortion, and the gravity of being, as much as possible, a positive, worry-free piece of a potentially stressful, frustrating, or worrying process. *Steadiness, comfort, wayfinding*— these affective goals of these case managers creates a counter-narrative about what it means to access abortion care, against a backdrop of cultural stigmatization and political/socio-economic hostility. CMs work hard to be a positive and helpful part of their callers’ abortion stories, both by creating a welcoming space for them, and by being committed to supporting the person until they are able to get the care they need.

## **A Project of Destigmatization**

In managing emotional support, case managers generally presented two main forms of engagement with callers: previously discussed general assurance and displays of competence, and more emotionally challenging support in times of distress or recounting of traumatic circumstances. These emotionally challenging cases, where the caller showed significant distress, were the minority, with most cases being more logistical. All case managers interviewed identified both types of engagement; though most found their work to be certainly emotional in part, others focused more on their ability to solve problems related to accessing care (i.e. an air of competence), rather than deliberately opening space for emotionality. All CMs interviewed mentioned that, when the situation arose, a part of their work was just being there to listen to their callers.

## ***Navigating Emotional Difficulty***

When supporting callers through distress, whether these struggles arise surrounding abortion, the process of abortion care access, or external factors, CMs may choose to offer their personal experience, and all CMs interviewed mentioned the necessity to make space for these feelings. While these responses may seem unremarkable, in a cultural context where abortion is stigmatized, demonized, and silenced, the act of making space for hearing and sharing abortion stories is a form of radical care. Some CMs who had an abortion, or abortions, mentioned sharing their own abortion experiences while speaking with callers. CM Victoria spoke more on this:

Sometimes people want to know how the appointment will be, or they've told me they're a little scared. In those times if I'm on the phone with them and they're telling me they're

scared, I can explain what it is like, depending on if they're taking the medical pill or the surgical. I've had both, so I can explain how I went through it and how everyone deals with it a little bit differently. But once I let them know that I've had an abortion – I tell them to let me know if [they] have any questions ... [and send] CAF resources for them to look over, and normally that makes them feel a little better knowing that they have someone to reach out to with questions. And they don't feel strange asking those questions to, unlike maybe someone at the clinic, and they can reach out to me, since I've already spoken to them.

Victoria's disclosure acts both as a way to assuage fears or provide information and as a point of connection between herself and callers. While not all CMs have had abortions, this potentially vulnerable act of sharing one's story can lessen abortion stigma and open up a more comfortable dialogue for a caller to ask potentially vulnerable questions or share their own experience.

Managing this may be emotionally taxing or can be an exercise in setting boundaries and being intentional about when to insert personal history. CM Rabiah spoke to this point, saying that sharing her own abortion experience was something she became comfortable with over time, and that she still chooses to do so intentionally, "because [she] never want[s] it to be the case that there is any either comparison or shifting of the focus." The stigma surrounding abortion care extends into abortion storytelling, making this type of disclosure potentially more difficult, but also more meaningful when putting a voice and person behind a procedure that is often obscured, seen as a source of shame, or demonized in larger narratives. While it may not always seem appropriate or needed to share one's story, it can provide political and emotional grounding as well. Brianna shared that she "always say[s] that an abortion saved [her] life, and [she] really

believe[s] that that's true for other people.” Victoria shared how her experience shapes the way she views the work she does:

I experienced a Crisis Pregnancy Center<sup>ix</sup> when I was going through my first abortion and was able to realize how they manipulate. [CPCs are] manipulative and told me I shouldn't do what I was doing. I was able to use that to change how I provide practical support, because I never want a caller to feel like they have to do this. I just became more mindful. [...] I didn't really know what abortion funds were until I got into the work. That was really sad, because that's something I probably would have reached out to. And so once I found out what they were, I was like, that's what I wanted to get to have. They're there to help people, but a lot of people didn't know what they were, or that the resource was there. When I was going through mine, I would have totally reached out to them.

CMs who have had abortions also are firsthand able to relate to callers accessing care and understand what the care journey can mean – both in terms of having life-saving impacts, and in being exposed to bad-faith actors or other barriers. This contributes both to these CMs' personal motivations in volunteering, as well as informs the experiences they want their callers to have. Another way that CMs combat abortion stigma is through listening to callers speak on their own struggles in accessing with, or grappling with the decision to access, abortion care.

Rabiah brings up a specific call that stuck with her:

I don't remember what it was, but it was before she started talking, you could hear something catch. And she started crying and talked about how she was keeping all of this to herself and was really ashamed and was really struggling with how this decision was against her faith. But she knew that she couldn't move forward with a pregnancy. And it was, for me, it was one of those moments that was reminding me that people are showing

up in all of these spaces, right? Going to work, showing up for your kids, whatever, carrying all of these emotional burdens. And the idea that with a perfect stranger who was really just trying to get help financially, [she] was willing and able to be vulnerable to share that was really striking. [...] So that call in particular was hard because she was struggling so hard and didn't have anyone to talk to. And when we hung up the phone, I knew that she was going to go back to not having anybody to talk to.

Several case managers repeated this sense that some callers lack a support network, and therefore they practiced holding space for callers. Aalap told me that they have “had a few people who are pretty isolated and so being able to talk to someone about it [is important].” Alexis noted that “a lot of these experiences people aren't necessarily sharing with their immediate support group, or a lot of the times they don't have one, so they end up divulging a lot of information that's very intimate that I'm sure that they wouldn't do in ordinary circumstances.” Dani shared that “when callers get on the phone with you, you're oftentimes the only person who they can speak candidly to about what's going on with them.” They went on to say, “the person just needs to share everything – and I don't think that they need me to fix everything, [...] they just need somebody to hear all the things that are going on and why it is so complicated for them right now.” Due to widespread abortion stigma – that may manifest in a more intense and overt manner in certain communities due to varying social/cultural conditions – CMs can be a singular source, or one of few sources, of support for callers. The plethora of barriers that people who need abortion care may face only serve to exacerbate an already difficult process. Abortion stigma can prohibit people from accessing care (in situations where an anti-abortion spouse or parent is able to restrict movement), but more often this stigma prevents people from accessing their own care networks, to have people in their corner while navigating a complex abortion access landscape.

While, according to a widely cited 2017 study by the Guttmacher Institute, nearly one in four “women” will have an abortion in their lifetime, abortion is not proportionately discussed in the public sphere; even when it is, it is not discussed in the same way as other healthcare due to politicization and resulting stigma. Abortion is surely not often discussed with a complete stranger. In creating a space to speak on emotions, stressors, and difficulties that may come up when accessing stigmatized care, CAF’s helpline provides relief for those situated within a culture of silence regarding abortion care.

These potential feelings of isolation are only exacerbated by a complex access landscape. Chicago Abortion Fund CMs are not only there to break down isolation and stigmatization by listening to, affirming, and sharing their own stories with callers; in addition, CMs literally are available to their assigned callers throughout the entire care-seeking process:

[T]o seek medical care is inappropriately complex, ... so I think one of the things that I would like for people to know is that, yes, abortion funds provide funding. And yes, they provide advocacy. But they also serve as something of a *wayfinder*, *as a concierge*, *as a liaison*, right, that says, we know this system is bullshit, we know that it's going to be complicated for no reason, we know that people at every turn are going to be trying to make it harder for you. So not only do we know that, but *we are not going to let you go through that by yourself*. And sometimes that's not needed, right? Because maybe all that's needed is a voucher and some information. But I think the piece that maybe isn't as clear ... is this piece around navigating a system at a potentially vulnerable time for people who may or may not have been socialized or educated to navigate these kinds of systems that says, like, *we got you, we got you*. [emphasis added]



As Rabiah points out, while some callers only require financial support, abortion fund volunteers are equipped to provide the less tangible support of understanding the range of barriers callers face. This solidarity entails not just an exchange of resources and information, but also a commitment to being available and sticking by that person until they get the care they need. As a strategy to directly combat the possible isolation and confusion of navigating abortion access in the United States, case managers stay in contact with them while funds are being gathered, after the voucher is sent, all the way until they are able to access the care they need, if they choose. Sometimes, these relationships can last for months post-procedure, as described by Alexis: “one of the longest experiences that went afterwards, probably like six months after I had spoken to them, and they were just kind of, they were lonely. And I definitely got the sense of that, and we did keep in contact for a little bit afterwards. And then I think they just got to a better mental health space overall. So, they didn't feel the need to reach out anymore.”<sup>x</sup> The caller-CM relationships are not limited to resource distribution – CMs can also be a part of their callers’ emotional or mental support system. Care, then, is broadened to be need-based and flexible, rather than prescriptive – actually filling existing gaps rather than assuming them.

### **Discussion and Conclusion**

This paper explores the strategies and conceptualizations of care work by volunteer Case Managers on the Chicago Abortion Fund manage and their origins. In summary, CAF case managers perform *interstitial affective care* work on the helpline, in which they attempt to mitigate existing systemic failures beyond their organization’s material capacity by reassuring and making space for grantees, even in the face of their own stress and uncertainty. Due to the *interstitial* nature of the work – situated within, and operating against, a racial capitalist, patriarchal context – these stressors and uncertainties cannot be eradicated without

transformative change. This horizon goal of transformative change in the form of reproductive justice, in conjunction with the more immediate gratification of helping callers overcome barriers to receiving abortion care, is highly motivational for CMs as they are personally and politically committed to movement work as volunteers.

This research is limited in the sense that it is unable to make broad claims on abortion funds as a whole, as only CAF volunteer CMs were interviewed. Beyond this, I was limited by time and resources, as I could only interview each Case Manager once, and was unable to speak with CAF staff who also work on the helpline, who could have added a different perspective as they take a larger percentage of monthly calls than volunteers. I am also situated within CAF, which may bias my analysis.

The stakes of this research are twofold: the first is to understand the strategies of care in the distribution of mutual aid within the interstices of a broken care system, and the next is to glean reflections on policy and larger movement concerns from experts in abortion access. Insofar as theoretical implications – all liberatory work is intersectional, and all organizing work is interpersonal (and therefore, in varying degrees, necessitating care and interpersonal emotional management). The reality of individual capacity is that one person or organization cannot fill all of the cracks in our system. This is intentional, and points to the need for large-scale transformation. However, utilizing *interstitial affective care* to further explore emotional management as it relates to doing short-term crisis management in an environment that needs transformative change can point to crucial survival and care strategies across movements. This conversation can be extended to other forms of organizing work, in terms of connecting larger political motivations and volunteer labor, as well as to other abortion providers, funders, and direct service providers.

The CAF case managers I spoke with directly interface and form connections with those for whom abortion remains inaccessible, even though abortion is broadly, if not tenuously, legal under *Roe v. Wade* at the time of writing. Navigating financial barriers, social barriers, and logistical barriers – the people working on CAF’s helpline should be regarded in future research as experts in identifying gaps in abortion-related legislation, as well as in navigating access to care in contexts where it would be prohibited in a post-Roe reality. More specifically relating to my case study, next steps into considering the impact and concentrated movement knowledge of abortion funds could include analyzing other forms of support, or a broader analysis of the abortion fund mutual aid model. The model and commitments undertaken by the Chicago Abortion Fund center the humanity of those navigating barriers to abortion, as they regard callers as people first, and therefore consider a broad spectrum of needs. The interstitial nature of the work places emotional weight on those who are mitigating current systemic inadequacies. In light of this, time and resources should be invested into networks of support for these caretakers – though true systemic change is the only way to eradicate barriers, and therefore these stressors. Until this systemic change is realized, sustained person-to-person emotional support (*interstitial affective care*) in addition to material support is clearly crucial as people access stigmatized/politically targeted care and may be unable to access their existing support networks due to external or internalized abortion stigma.

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### Notes

<sup>i</sup> Two ongoing study examples involving CAF include interview data collected from CAF grantees receiving care in Illinois led by Aalap Bommaraju at the University of Cincinnati (the Shaping Change study), as well as an ongoing survey study to explore the abortion seeking experience of Indianans by Ibis Reproductive Health. These studies are crucial in understanding current challenges to accessing care in Illinois and Indiana but they do not take up abortion funding work itself as the object of analysis.

<sup>ii</sup> The RHA also eliminated a host of restrictive mainly abortion-related enjoined laws in the Illinois constitution, securing the legality of abortion, and the future of HB 40, in the case that Roe fell. This can be seen as part of a strategy of offensive preparation for the end of Roe by proabortion advocates in Illinois, which is being continued through efforts like the Regional Logistics Center that CAF is currently collaborating with Planned Parenthood on.

<sup>iii</sup> In the legal text, dilatation and extraction (D&E) abortions are referred to as ‘partial birth abortions,’ a generally inflammatory and stigmatizing term used by anti-abortion politicians. This is not accepted medical terminology.

<sup>iv</sup> Approximate procedure costs are based on my experience navigating care as a case manager on the CAF helpline, as clinics do not generally publicize this information. When searching “how much does an abortion cost” on Google, the first result is from a My Future Approved, an organization that runs two Crisis Pregnancy Centers (CPCs) in Illinois, which are identified on this [CPC map](#), a project from the University of Georgia affiliated with RISE. The map claims to identify CPCs, “(also known as ‘fake women's health centers’) in your area. CPCs primarily aim to prevent people from having abortions” (Swartzendruber & Lambert 2018).

<sup>v</sup> Case Manager Chelsea worked on RHA passage and shared: “Being able to know that Illinois passed the Reproductive Health Act, and that meant that certain types of insurance companies,

which would be most insurances, should cover abortion care, but then over the past year to absolutely see that not happening. And for all the solutions to making that happen to be very bureaucratic and slow-moving solutions, was something I noticed in the past year or two. That was really disappointing and made me feel very helpless because I was part of the efforts to support that passage.” This information, along with the listing of MPE-eligible clinics, is based on my experience/knowledge as a CM.

<sup>vi</sup> The mission listed on the National Network of Abortion Funds website reads: “The National Network of Abortion Funds builds power with members to remove financial and logistical barriers to abortion access by centering people who have abortions and organizing at the intersections of racial, economic, and reproductive justice.”

<sup>vii</sup> CAF helped plan the Chicago march and rally for the national #RallyForAbortionJustice on October 2, 2021 in response to the passage of SB 8 in Texas.

<sup>viii</sup> Typically, if the caller is a Medicaid recipient, this funding is accessed through the National Abortion Federation (or NAF, if the appointment is at an independent clinic), or the Justice Fund (if the appointment is at a Planned Parenthood location). This funding is means-tested by income and household size, save certain exemptions (if private insurance should help cover gaps, as in IL, but does not; if the caller is houseless; if the caller is covered by their parent’s insurance plan but must maintain secrecy; if the caller has experienced assault, etc.). If the caller is ineligible, CMs will connect the caller to additional abortion funds in their home state/region, or increase the standard CAF pledge to cover a remaining gap after the callers’ contribution.

<sup>ix</sup> See note *iv* for a brief definition of CPCs and a map of CPCs across the country (Swartzendruber & Lambert 2018).

<sup>x</sup> Some callers have become involved with CAF organizationally as volunteers, abortion storytellers, participants in post-abortion community circles, or even, in the case of the former CAF Executive Director Brittany Mostiller, as leaders within the reproductive justice movement.