Conscientious Objection and Contraceptive Access in a Post-Roe v. Wade Illinois

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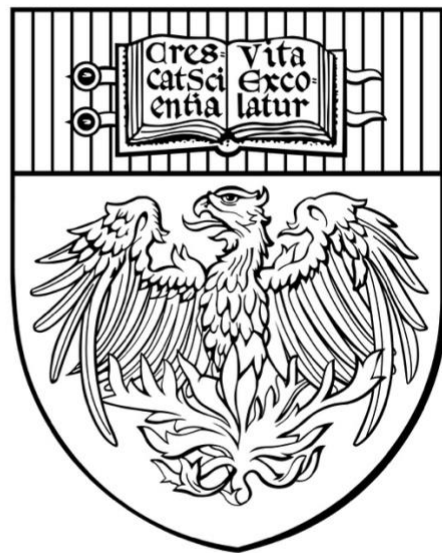

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Abstract

In medicine, conscientious objection refers to the refusal of health care professionals to provide certain services due to ethical, moral, or religious beliefs. Though often unrecognized, the practice of conscientious objection is commonplace in Illinois, a state with a significant presence of Catholic hospitals and legal clauses protecting health care professionals who refuse to provide reproductive care. Contraceptive access in Illinois has become increasingly complicated by *Dobbs v. Jackson Women's Health Organization*, a 2022 U.S. Supreme Court landmark decision which retracted the previously held federal constitutional right to abortion. This study contributes to the growing body of literature on conscientious objection to reproductive care by constructing a landscape of contraceptive access in Illinois after *Dobbs*. Interviews were conducted with fifteen health care providers and scholars of various fields in reproductive health. Relevant themes were analyzed in the context of racial, socioeconomic, and geographical disparities in contraceptive access. Results reveal the onus of seeking care to be increasingly placed on the patient, escalating conflicts between religious institutions and state legislation, and heightened stress in providers at religious institutions. These outcomes have resulted in a greater workload for reproductive care providers in secular institutions and the muddling of the definition of conscientious objection. With future threats to contraceptive access potentially looming, the policies proposed concern lawmakers, providers, and patients alike, as stakeholders in the effective delivery of reproductive care. Recommendations also address racial, socioeconomic, and geographical disparities in contraceptive access in hopes of drawing attention to an often-overlooked barrier to reproductive care access.

Keywords: conscientious objection, reproductive health, contraception, religious healthcare, Roe v. Wade, Dobbs v. Jackson, health disparities

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Table of Contents

Abstract 2

Acknowledgments 3

Conscientious Objection and Contraceptive Access in a Post-Roe v. Wade Illinois 5

Background 8

Literature Review 10

Methods 16

Findings 19

Conflicts between religious institutions and state legislation 20

Muddled definition of conscientious objection 23

Increased stress of providers in religious institutions 27

Greater workload of providers in secular institutions 30

Onus of care increasingly placed on the patient 33

Potential for future threats to contraceptive access 36

Policy Recommendations 39

Conclusion 44

References 47

Tables 54

Appendix 56

Conscientious Objection and Contraceptive Access in a Post-Roe v. Wade Illinois

Conscientious objection is defined as the refusal to perform a legal role or responsibility due to moral, religious, or other personal beliefs (Berlinger 2022). In medicine, it refers to the refusal of pharmacists, physicians, and other health care professionals to provide or participate in the delivery of certain medical services to a patient. Its practice is most often spoken of in relation to euthanasia and reproductive care procedures such as abortion, contraception, and sterilization (Mlsna 2010).

Since *Roe v. Wade* in 1973, a majority of U.S. states have adopted conscience clauses, legal clauses protecting conscientiously objecting health care providers, for abortion procedures. Illinois is one of twelve states with additionally conscience clauses for contraception (Guttmacher Institute 2022). Since the *Dobbs v. Jackson Women's Health Organization* decision held that there is no federal constitutional right to abortion, overturning previous rulings *Roe v. Wade* and *Planned Parenthood v. Casey*, the state of reproductive care access in Illinois has been in quandary. Though the right to abortion remains protected in the state, Illinois has received an unprecedented volume of patients from out of state, effectively becoming the center of Midwestern patients seeking reproductive care (Lourgos 2022). This study examines how the *Dobbs v. Jackson Women's Health Organization* Supreme Court ruling has changed the landscape of contraceptive access in Illinois, in addition to how these changes differ between religious and non-religious medical institutions.

Conscientious refusals—acts of denying medical services to patients as permitted by conscience clauses—are often practiced in religious hospitals. They are commonplace in Illinois, a state where 29.5% of hospital beds are located in Catholic health care facilities (Kaye et al. 2016). Though the *Dobbs v. Jackson Women's Health Organization* primarily centers abortion,

delegating the authority to regulate abortion to individual states, access to contraception has also become threatened. After the announcement of *Dobbs v. Jackson*, U.S. Supreme Court Justice Clarence Thomas, one of the concurring justices, called for a reconsideration of past rulings made by the Supreme Court. One of these rulings included *Griswold v. Connecticut*, a 1965 decision which adjudicated the right to contraception to be implied by the Constitution (Kornfield et al. 2022). With the threat of decreased access to contraceptives looming, given the similar legal reasoning of these rulings, the decisions of conscientious objectors—medical professionals who refuse to provide certain services—have become increasingly charged. Contraceptive access has since become central to the post-*Roe* discourse concerning reproductive care.

The decreased access to abortion after the *Dobbs* ruling has triggered an increase in demand for birth control pills and emergency contraception (Venkat et al. 2022). The increased threats to federal contraceptive access may validate and even encourage the practices of religious hospitals. The literature review conducted points to many existing barriers to contraceptive access in Illinois, which will likely increase post-*Roe v. Wade* in both religious and secular hospitals alike. Due to the different policies and practices of the two types of hospitals, however, the nature of the barriers encountered by contraceptive users in each may differ. Increased barriers to access are likely to disproportionately affect marginalized contraceptive users, including those of racial minorities, lower socioeconomic status, and non-urban areas.

Past literature on conscientious objection in medicine has been primarily situated in singular medical settings, such as pharmacies or religious hospitals. These studies examine the policies and practices of religious and secular medical institutions alone. However, conscientious objection poses a major challenge to particular contraceptive users, depending on their different

racial, socioeconomic, and geographic backgrounds. In investigating these institutions in isolation, it is difficult to fully comprehend the various bureaucratic barriers marginalized users encounter when seeking contraceptives. Additionally, few have analyzed the interactions between the two settings, which is critical for developing a holistic perspective on the barriers that contraceptive users of varying demographics face.

This paper thus seeks to compare contraceptive access across religious and secular health care institutions in a key post-*Roe* setting, the state of Illinois. With the ultimate goal of informing and advising readers on an often-overlooked bureaucratic barrier in the United States, this study analyzes how religious and secular institutions interact with each other in a state with a high presence of religious hospitals. In doing so, it provides a holistic assessment of barriers to access in Illinois, a location central to reproductive care access in the post-*Roe* Midwestern United States. Especially in a state as diverse as Illinois, conscientious objection to reproductive services disproportionately affects marginalized individuals. Examination of the conscientious objection across different medical institutions in the state is thus necessary for the exploration of racial, socioeconomic, and geographic disparities in care.

In anticipation of the dramatic decrease in reproductive care access and outcomes expected to emerge from *Dobbs*, this research study serves to contribute to the body of work currently being conducted on post-*Roe* reproductive care. In order to mitigate potentially fatal outcomes, this study seeks to gain an understanding of contraceptive users' interactions with religious and secular health care institutions. To address the research question, this study employs qualitative methods to investigate the changes that have occurred in religious and secular medical institutions after *Dobbs v. Jackson*. Interviews and seminars were thus conducted with physicians in hospitals of varying religious affiliations in Illinois, as well as scholars of

religious healthcare, reproductive care, bioethics, and medical sociology. The discussion and analysis of the findings draw attention to barriers in contraceptive access that could worsen post-*Roe* and serve as a warning for the dangers that can arise from them.

The background section of this paper discusses the *Dobbs v. Jackson* ruling, existing disparities in contraceptive access, and the ways in which conscientious objection complicates access. The literature review introduces existing research on the barriers to contraceptive access in religious and secular hospitals alike. Key themes identified from the interviews and seminars conducted are detailed in the findings section, and proposed policies emerging from the findings are discussed under the policy recommendations section. Finally, potential topics for future research and concluding remarks are noted in the conclusion.

Background

Dobbs v. Jackson Women's Health Organization was a landmark decision made by the U.S. Supreme Court in June of 2022. The ruling stated that the Constitution does not confer a right to abortion, overturning the federal protections previously ruled by *Roe v. Wade* (1973) and upheld by *Planned Parenthood v. Casey* (1992). Though many laws regulated abortion access at the state level before *Dobbs*, the decision gives individual states the complete power to regulate abortion at any stage. As of February 2023, eighteen states have imposed abortion bans (The New York Times 2023), with six more likely to follow suit (Nash & Guarnieri 2023). The ruling, which has opened the door for increased restrictions to abortion access at the level of the state, has been predicted to increase maternal mortality rates by up to 29% in those with complete bans (Stevenson et al. 2022). Other studies have documented racial, ethnic, and geographic disparities, with black, Hispanic, and rural mothers having disproportionately high maternal morbidity and

mortality rates relative to their counterparts (White & Aaronson 2022). This finding is especially prominent in abortion-restrictive states (those having laws with abortion bans after a certain gestational age, waiting periods, regulation of abortion providers, and funding) as opposed to abortion-protective states (without laws that restrict access to abortion or funding) (Williams et al. 2022). With inequalities and rates of maternal complications expected to worsen post-*Roe*, the preliminary data points to an increased need for contraceptives and family planning.

Similar social disparities have been documented for sterilization and contraception, services which reproductive care patients will increasingly depend on post-*Roe* (Dehlendorf et al. 2013; Ross 2021; ACOG 2014). The *Dobbs* decision, which has demonstrated the strength of the anti-abortion movement in the U.S., foreshadows increased threats to contraceptive access. Justice Clarence Thomas's statement that *Griswold v. Connecticut* should be overturned has taken place against the backdrop of state-level disputes over various subjects, including the provision of emergency contraception in universities, the legality of contraceptive prescriptions by pharmacists, and the federal over-the counter availability of contraceptives. Though the *Dobbs* ruling explicitly centers procedural and medication abortion, access to other reproductive care services are also under attack. Laws and policies restricting access of other reproductive services will only serve to increase the rate of maternal complications and widen existing disparities in reproductive health outcomes in the United States.

Beyond domestic boundaries, restrictions on reproductive care access in the United States also affect access in other countries, who look to the U.S. as a model for public policy. For instance, though abortion has been legal in Italy since 1978, 70.9% of physicians refuse to perform the procedure (EDJNet 2018). In Poland, where abortion is only permitted in cases of rape or threat to a woman's health, medical providers who refuse to provide a particular service

are not required by law to refer patients to a medical provider who will (Council of Europe 2017). Due to the known disparities between the theory and practice of abortion in such countries, the theory and practice of contraception become increasingly critical to examine, as a key component of global reproductive care access. By conducting a study in one of the 25 states where abortion remains legal, which I will refer to as abortion-legal states, the legal conditions of these smaller countries are thus replicated. The findings of this study may not be explicitly generalizable to other regions or countries due to varying demographics or divergent social, cultural, and political dynamics; however, in a study of conscientious refusals, examination of the most marginalized groups is nonetheless critical, as it is indicative of their social status and the well-being of a society at large.

Literature Review

Past research has discussed the institutional policies and enforcement practices of institutions where instances of conscientious objection take place. The existing literature documents the disproportionate effects of restrictive policies on marginalized patients, the religious nature of conscientious objection, and the lack of information religious hospitals provide on their reproductive care policies. Though conscientious refusals are often practiced in religious medical settings, they are also practiced in secular settings; however, there is little research comparing the two settings and how their practices interact with each other. This study thus aims to examine the different types of barriers present in each setting and the interaction between the two types of institutions. Qualitative data is obtained from physicians in religious and secular hospitals alike, as well as scholars of conscientious objection and contraception, among other topics. The analysis of the data aids in the construction of a state-wide landscape of

contraceptive access in a post-*Roe* Illinois, including the implications of ruling for racial, socioeconomic, and geographic disparities in patients' access.

Disproportionate effects of conscientious refusals on marginalized patients

Conscientious objection creates many barriers to contraceptive access in Illinois, especially among minority patients. For instance, state conscience clauses permit pharmacists to not only conscientiously refuse, but also to withhold information about emergency contraception (EC) from patients (Stein et al. 2022). Some Catholic hospitals also explicitly prohibit physicians from discussing or prescribing EC (Stein et al. 2022). The consequences of these refusals fall mostly on patients from marginalized backgrounds. In Cook County, Illinois, 10% more black and Hispanic women than white women were enrolled in Medicaid managed care plans, which are accepted mainly by religious hospitals with fewer family planning (FP) services available than non-religious hospitals (Gieseker et al. 2019). It is estimated that one in three women in the United States struggle to access birth control, with younger, African American, and indigenous women with lower resources most heavily impacted (Guttmacher Institute 2020). In states with high concentrations of religious hospitals, the burden of the restrictions imposed at religious health care hospitals thus disproportionately falls on marginalized patients. Thus, in addition to religious settings, this study will investigate the practice of conscientious objection in secular settings in order to better comprehend the obstacles contraceptive users must navigate.

These restrictions are of especially great concern given the increasing presence of religious hospitals. While the number of Catholic-affiliated hospitals increased by 22% from 2001 to 2016, the number of secular and non-Catholic-affiliated hospitals decreased by 6% in the same time period (Guiahi et al. 2019). At religious hospitals in Illinois, physicians contend with

verbal admonishments and lease agreements that prohibit contraceptive provision on church-owned land (Liu et al. 2019). If contraceptive care was denied after consultations with an ethics committee, physicians sometimes provided care to patients through workarounds, falsifying their medical records to enable them to be prescribed contraceptives (Hasselbacher et al. 2020). These workarounds, along with ambiguous policies surrounding their authority to refer or transfer patients to non-objecting providers (Stulberg et al. 2016), cause moral distress for providers (Wong et al. 2022). Given the threats both patients and providers face in light of the *Dobbs* ruling, it is imperative that this study addresses each of these stakeholders in both settings.

In terms of outcomes, variations in the referral policies and practices of different Catholic hospitals can lead to delays in care for patients (Stulberg et al. 2016). The lack of support provided by hospital authorities in religious settings greatly harms reproductive care patients, especially those of lower income or with insurance restrictions (Stulberg et al. 2014). A survey distributed to obstetrician-gynecologists practicing in religiously affiliated institutions showed that 37% reported experiencing conflict over their religiously based policies for patient care, with a rate as high as 52% in Catholic hospitals (Stulberg et al. 2012). The policies of religiously affiliated institutions thus not only inform the services physicians can provide, but also play an integral role in the decisions they can make for their patients. This study seeks to expand upon the agency of physicians by examining the type of care provided in both religious and secular institutions. It is critical to investigate the disparities in their respective practices, as the refusals patients encounter in religious settings force them to interact with both types of institutions.

Religious refusals at institutions of different affiliations

Conscientious refusals are not limited to religiously affiliated institutions. 6% of practicing pharmacists in Nevada would refuse to dispense at least one type of reproductive medication, according to a state-wide survey (Davidson et al. 2010). Within this group, it was found that practicing pharmacists' religious affiliation strongly predicted their willingness to dispense emergency contraception (Davidson et al. 2010). The percentages derived from such studies are likely higher in Illinois, a state with 6% more religious individuals and more than 10% more Catholic hospital beds than Nevada (Garcia-Ricketts et al. 2018; Pew Research 2014; Kaye et al. 2016). While conscientious refusals can occur in religious hospitals and nonaffiliated pharmacies alike, the literature cites religious beliefs as the most common motivation for these refusals. In examining the post-*Roe* landscape of contraception in Illinois, this study assumes differential practices in the two types of settings, taking it as a basis for comparison.

Greater limitations to abortion care are observed in Catholic hospitals relative to Protestant ones (Hasselbacher et al. 2020), suggesting that the frequency of conscientious refusal depends not only on affiliation status, but also religious denomination. While providers in secular and Protestant systems documented little to no barriers to contraceptive provision, those in Catholic systems describe a myriad of conflicting institutional policies and enforcement practices (Liu et al. 2019). Additionally, providers in Catholic systems generally operated under binding employment contracts that prohibited contraceptive care (Liu et al. 2019). Of women in Wisconsin who sought contraceptive or fertility care, those in counties served by Catholic "sole community hospitals"—a federal designation deeming alternative secular facilities to be prohibitively far away for patients (Uttley et al. 2013)—were three times as likely to report being turned away relative to women in other rural or urban census tracts (Kramer et al. 2021). Catholic-owned clinics were less likely than Catholic-affiliated clinics to schedule appointments

for birth control, copper intrauterine devices (IUDs), and tubal ligation (Guiahi et al. 2017). Even so, there is evidence to suggest that hormonal IUDs are provided through workarounds while implants and copper IUDs are rarely stocked at Catholic hospitals (Guiahi 2020; Guiahi et al. 2017; Guiahi et al. 2019). Particularly in Catholic systems, bureaucratic processes, institutional policies, and enforcement practices can produce significant delays for patients and compromise the quality of the care they receive. This study builds upon these findings by examining the consequences of being turned away and forced to seek care elsewhere. Additionally, it evaluates changes in these processes that have taken place since *Dobbs v. Jackson*, which has further complicated individuals' decisions to seek contraceptive care.

Patients' lack of awareness of restrictions

Past literature suggests that religious hospitals' nondisclosure of their reproductive care restrictions may be misleading, leaving patients unaware of the services they do not provide. Among 646 U.S. Catholic hospital websites examined, 139 (21%) did not disclose their Catholic identity and 494 (76%) did not cite in their mission statements the Ethical and Religious Directives for Catholic Health Care Services (ERDs, or Catholic Directives), a series of directives which interpret medical care based on Catholic moral teachings and limit the provision of certain reproductive care services in line with Catholic theology (Takahashi et al. 2019; Guiahi 2018). Of these 494 websites, 28 (4% of all hospitals) reported restrictions on care and 8 (1% of all hospitals) reported restrictions on reproductive care (Takahashi et al. 2019). Mission statements also may have limited effect on patients facing financial insecurity, for whom referrals are often overly costly (Schueler & Stulberg 2020; Stulberg et al. 2016). Similar, a study of patients on public insurance in Cook County, Illinois showed that Catholic hospitals are

overrepresented among the health care institutions that accept their plans (Schueler & Stulberg 2020; Garcia-Ricketts et al. 2019). Coupled with the limitations certain insurance plans pose, the lack of disclosure at Catholic hospitals can threaten the well-being of patients, forcing those without prior awareness of their restrictions to face refusals and delays in care.

Due to a lack of knowledge on these religious restrictions, patients may not recognize the barriers they may encounter at these institutions. The results of a national survey asking patients about perceived differences in care at Catholic and non-Catholic hospitals showed that a significant proportion did not anticipate differences between the two, even when asked explicitly about reproductive care services (Guiahi et al. 2020). Another national survey showed that one-third of women who named a Catholic hospital as their primary reproductive care provider did not recognize its religious affiliation (Wascher et al. 2018). Though women were more likely to correctly identify the hospital's affiliation when it had a religious name (e.g., one with "Saint" in it) (Wascher et al. 2018), there are instances in which secular institutions purchased by religious health care systems follow the Catholic Directives while retaining their secular name (Sepper 2018). When constraints on care are not anticipated, women seeking reproductive care are limited in their capacity to make decisions as informed consumers (Guiahi et al. 2014). In addition to limits and delays in care, religious restrictions increase the likelihood of misdiagnosis and marginalization for patients seeking contraceptives (Wong et al. 2022). In the context of a recent increase in Catholic hospital ownership, there are dangerous consequences for patients unaware of institutions' religious affiliations.

This gap in knowledge disproportionately affects women of marginalized social status. For instance, women of lower socioeconomic status are two times less likely to correctly identify a hospital as Catholic relative to their higher socioeconomic status counterparts (Stulberg et al.

2019). Those who identified the hospital's status correctly were also more skeptical of its willingness to provide birth control and tubal ligation (Stulberg et al. 2019), indicating a socioeconomic disparity in access to information on reproductive health services. Additionally, rural women surveyed in Wisconsin were more likely to believe a Catholic hospital would provide a wide range of contraceptive services relative to their urban counterparts (Kramer et al. 2021).

Though there are many barriers to contributing to this gap, reproductive care patients place high value on having the right information, according to past literature. Interviews with reproductive care patients show that women value patient autonomy and hospital religious freedom (Wascher et al. 2020). More than eighty percent of women surveyed in a national study felt it was important to know of a hospital's religious restrictions on care, especially those who were non-religious or of religious minorities (Freedman et al. 2018). The limited information religious hospitals provide serves to perpetuate the disparities encountered by marginalized patients. As more Americans seek contraceptives post-*Roe*, the process of receiving and providing contraceptives becomes complicated for patients and providers alike. As such, in addition to patients' reproductive health care knowledge, this study examines changes in the practices of medical institutions since *Dobbs* in order to propose effective recommendations for a post-*Roe* landscape.

Methods

The aim of this study is to examine changes in contraceptive access that have emerged after the *Dobbs v. Jackson* landmark decision. The analysis of the findings discusses both new and pre-existing barriers to contraceptive access in a post-*Roe* context and are also intended to

serve as a lens into broader racial, socioeconomic, and geographic healthcare disparities in contraceptive access.

To properly capture the dimension of conscience clauses for contraception, this study centers Illinois, one of the few states with such clauses. Religious hospitals have a significant presence in Illinois, and the barriers to access marginalized patients face can be well-documented in a state with high racial, religious, and socioeconomic diversity. The considerable presence of religious medical institutions and diverse demographics of Illinois are thus critical in this study. Due to these factors, Illinois essentially acts as a microcosm for other regions with similar demographics. The post-*Roe* landscape of conscientious refusal in Illinois can thus potentially generalize to other parts of the United States, or even regions in other countries. As such, focusing on this particular state will enable this study to account for the ways in which healthcare providers' or institutions' religious affiliations shape their decisions across many different states and regions.

Because public health data on post-*Dobbs* outcomes is currently lacking, this study relies on qualitative rather than quantitative methods. To test the hypothesis, data was collected through interviews with eleven scholars with varying fields of expertise as well as two seminars on reproductive justice after *Dobbs* hosted by the University of Chicago Center for Gender and Sexuality Studies. Ten of the interviews were conducted through the Zoom video communications platform and one took place over e-mail. The two seminars attended hosted a total of four scholars. The fifteen scholars' fields of expertise included conscientious objection, religion in healthcare, contraception, abortion, medical sociology, bioethics, family planning, and maternal and reproductive health. Five of them are practicing medical professionals in religious and secular settings.

All interviews were conducted voluntarily and with the consent of the interviewees. The purpose of the study explained at the outset of each interview. Questions were individually tailored to each interviewee based on their experiences and expertise. In order to compare the differential policies and practices of religious and secular settings, health care professionals were asked about their experiences providing care ("What is the process for providing contraceptive care, and how is it like navigating it?"), while interviewees based in Illinois were asked about their observations of reproductive care access within the state (e.g., "What is the significance of religious hospitals and health care systems in Illinois?", "Are there any particular cities or neighborhoods in Illinois that stand out to you with respect to reproductive care access?"). In order to assess the barriers contraceptive users must navigate in both settings, each interviewee was asked about the motivations of conscientious objecting providers, practices of conscientious objection, challenges to reproductive access after *Dobbs*, barriers to access encountered by marginalized patients, and comparisons of contraception and medical abortifacients (see Appendix). Interviewees were permitted to refuse to answer questions and to terminate the interview at any time during the process. The seminars were attended live, and their YouTube recordings were used for the purposes of transcription and coding. Interviews and seminars were transcribed using transcription software Otter.ai. The transcripts were then coded to identify key themes relevant to the research question. Themes build upon the existing findings outlined in the literature review, expanding upon the interplay between secular and religious settings and addressing the newfound discrepancies raised by the *Dobbs* ruling.

Findings

Within the data collected from the fifteen scholars, six key themes emerged as most salient: 1) heightening tensions between providers in religious healthcare institutions and the policies they operate under, 2) the definition of conscientious objection becoming increasingly complicated, 3) the increased stress of reproductive care providers in religious institutions, 4) the greater workload reproductive care providers in secular institutions face, 5) the onus of care being increasingly placed on the patient, and 6) looming threats to contraceptive access from the anti-abortion movement. Though the policies of religious healthcare institutions have remained largely unchanged post-*Roe*, they are beginning to clash with Illinois state law, which has since sought to expand contraceptive access. The internal tensions between religious hospitals and their providers' consciences have in turn complicated the definition of conscientious objection, a practice which occurs on both an individual and systemic level within the state.

In light of the restrictions *Dobbs* has imposed on abortion access, in-state demand for emergency contraception (EC) has grown. The increased demand has encouraged the practice of workarounds and created overflow into secular institutions. Out-of-state demand for abortion has also increased the burdens faced by providers in secular settings, who must manage a large quantity of both in-state and out-of-state patients post-*Roe*. As such, the burden of receiving proper contraceptive care is increasingly falling on patients themselves, especially low-income patients in rural areas. These outcomes each take place in the backdrop of increased threats to statewide contraceptive access. Taken together, the themes emphasize the importance of the clear dissemination of information to all stakeholders, including providers, patients, and legislators alike.

Conflicts between religious institutions and state legislation

Catholic hospitals and health care facilities in the United States follow the Ethical and Religious Directives (ERDs), a document written by the United States Conference for Catholic Bishops and offering guidance for health care delivery based on the Catholic Church's teachings (Catholic Health Association). Described as "a foundational guiding document for all of Catholic health care," the ERDs undergo few revisions over time, in keeping with "the [Catholic] moral tradition" (Peters). For "theological reasons," in the words of associate professor of Obstetrics and Gynecology Dr. Meyer, the policies surrounding contraception in religious healthcare institutions have remained unchanged. When asked about changes in Catholic hospitals' policies that have taken place over time, Catholic lay theologian Dr. Peters explicitly denies any changes to reproductive care policies, specifying:

> Catholic health organizations don't promote or condone contraceptive practices or services that would [interfere with] reproductive ability, like direct sterilization, and... direct abortions are never permitted. Those are where the sole immediate direct effect is the termination of the pregnancy.

The role of Catholic hospitals in post-*Roe* reproductive care has thus become ambiguous, as they "weren't providing before" (Meyer) and continue not to provide.

New tensions surrounding contraception provision have since emerged in religious healthcare within the state. When asked about the specific changes providers and institutions have adopted since Dobbs, practicing family medicine physician Dr. Stulberg points to discrepancies between states. She notes that Illinois in particular has worked to protect access to reproductive care even after *Dobbs v. Jackson*:

> If anything, our state, for the past few years, has been actively working to increase access to reproductive health care across the board—contraception, postpartum care for women that have given birth, and abortion care as well.

Though religious hospitals are legally permitted to refuse the provision of reproductive care services under Illinois state law, their practices have recently begun to clash with the state. For instance, one specific issue currently being contested in religious hospitals is that of exceptions in the case of rape. Kelly Cleland, executive director of the American Society of Emergency Contraception (ASEC), observes, “In terms of public policy, we’re seeing more states requiring emergency rooms to offer EC to survivors of sexual assault.” Under Illinois state law, an amendment to the Sexual Assault Survivors Emergency Treatment Act (410 ILCS 70/2.2)—effective as of 2024—will require hospitals to provide medically and factually accurate written and oral information about emergency contraception to victims of sexual assault, in addition to a description of how and when they may be provided it. The bill is expected to conflict with the policies of some religious hospitals, which may produce tensions between legislators and providers in these settings.

Currently, state conscience clauses permit clinicians and pharmacists in religious hospitals to withhold information about and refuse the provision of EC from patients (Stein et al. 2022). In a post-*Roe* landscape, however, religious hospitals in Illinois are forced to grapple with state laws in implementing their policies regarding rape. On the topic of the different contraceptive methods used in different circumstances, Associate Professor Dr. Meyer comments on the matter:

> Most people have the consensus [and] most institutions have supported a rape victim’s right to get access to emergency contraception. The Catholic hospitals have tried to comply by creating this ‘only use it in these particular situations’ question. They have different mechanisms of use. There [are] a few different kinds of emergency contraception and then one is less likely to have its mechanism be easy to complete with abortifacients… [T]hese are religious definitions that people want to make medical and vice versa.

The particular form of EC Dr. Meyer describes would not require the subsequent use of an abortifacient. Because Catholic hospitals generally refuse to provide reproductive care, they are making minimal exceptions to accommodate for the state law; however, in only offering this particular type of emergency contraceptive, these hospitals offer victims of sexual assault little choice in the medications they can take. This particular medication may not be the most effective form of emergency contraception, and patients may not be able to turn elsewhere, given the narrow time window in which they must take EC: “If you don’t get [emergency contraception] within X many hours, it’s not effective” (Chavkin). Because rape is an emergency in which patients cannot afford to "jump through hoops” (Cleland), referrals must be meaningful, timely, and accurate. Until the amendment becomes effective in 2024, Catholic hospitals will struggle against Illinois state legislation and vice versa.

Notably, when asked about restrictions on contraceptive services, scholars and providers pointed specifically to Catholic hospitals. Though there may be hospitals of other affiliations which also limit contraceptive provision or have even stricter policies surrounding reproductive care, the restrictions Catholic hospitals impose on contraceptive care appear to affect access most greatly in Illinois specifically. This may be due to the large presence of Catholic hospitals and systems in the state. Contraceptive users may also be forced to turn to them for other reasons, such proximate traveling distances or insurance plans confining them to these hospitals. Though more research is necessary to ascertain contraceptive users’ paths to Catholic hospitals, it appears that Catholic institutions lie at the center of conscientious refusals—and the corresponding delays in care and fatal health outcomes that result from them—in the state of Illinois.

Muddled definition of conscientious objection

There exist many different affiliations of hospitals, each of which have their own policies surrounding reproductive care provision. Conscientious refusals thus pan out differently in each type of setting, with variation existing even in practices of hospitals of the same affiliation. For instance, though most commonly practiced in religious hospitals, conscientious objection is practiced among pharmacists and clinicians in secular settings as well. The motivations for these providers' refusals include their religious beliefs, political leanings, and gaps in their medical education, among others. These decisions not only become increasingly charged as the need for contraception grows more urgent, but they also pose greater barriers to reproductive care access in a post-*Roe* setting. As a result of these decisions, the definition of conscientious objection has become significantly complicated post-*Roe*. The growing ambiguity in the practice of contraceptive provision creates a greater degree of uncertainty for patients, whose ability to obtain appropriate and effective contraceptives is increasingly in quandary.

"You have to have the cooperation of a prescriber and a pharmacist in order to get it": the gatekeeping of emergency contraceptive drugs

In December 2022, six months after the *Dobbs* decision, the U.S. Food and Drug Administration (FDA) changed the labeling of the Plan B emergency contraception drug. A notable recent development, the update clarifies that Plan B has no direct effect on either implantation or fertilization based on scientific evidence (FDA 2022), and thus does not medically induce an abortion. Though the modification was meant to correct public misinformation on the mechanism of action of emergency contraceptives, Cleland notes otherwise. When asked how law and policy developments shape decisions concerning contraceptive provision, Cleland that many providers with conservative leanings or strongly held religious beliefs remain unappeased:

> I think there are there are certainly providers who genuinely don't know how these [medications] work. Because maybe they're focused on other things; there's so much to know as a doctor or nurse practitioner, [and] they have to be on top of so many different things... Maybe they don't care how it works, [or] maybe they think it doesn't matter, so they'll prescribe it no matter what. Or maybe they have already formed an idea that is not related to evidence or science. And they may not be interested in changing their practices, regardless of what the new packaging says and what the evidence says.

After the Dobbs decision, the FDA has been confronted with many decisions concerning the regulation of reproductive health services, such as emergency contraceptives and medical abortifacients. Developments such as the Plan B labeling change may better inform patients and providers who were previously unaware. Cleland notes, however, that Ella, the "prescription only" and "more effective pill version of [Plan B]," still "[requires] the cooperation of a prescriber and a pharmacist in order to [obtain]." As such, many decisions remain to be made and many avenues for expanding contraceptive access persist.

Even after such federal policies are implemented, however, some remain unwilling to revise their prior beliefs or change their practices. When conscientious refusals are motivated by political leanings or religious beliefs, the changes these policies are intended to bring about are prevented from taking effect. Emergency contraception patients are thus forced to rely on over-the-counter medications such as Plan B rather than more efficacious drugs such as Ella. The practice of conscientious objection on an individual as well as institutional level reduces the quality of the medication patients can access.

"It may be that the patients don't get the care they need": systemic disparities that arise from the practice of conscientious objection

Conscientious refusals are commonly practiced by religious hospitals, which cite theological reasons for denying reproductive care services. Additional conditions such as "whether their lease for the building where their clinic is allows them to provide contraceptive care" also impose limitations on the services provided, according to medical researcher Dr.

Daniel Grossman. Contraceptive provision outcomes also differ based on the geography and religiosity of an area, with rural and more religious areas being more restrictive. In describing the ramifications of conscientious objection, Dr. Wendy Chavkin, professor of Public Health and Obstetrics and Gynecology, proposes the following hypothetical:

> Let's say you live… someplace where there are lots of providers around. There's room for you to be an objector because someone else will do it, no problem. But if you live in a rural area where there are very few private providers around… it may be that the patients don't get the care they need.

Because patients in urban areas generally have more options, these findings are especially relevant for non-urban areas where the sole community hospital provider is Catholic. OB/GYN physician Dr. Maryam Guiahi observes instances in which these providers are “the only hospital in that region, [with] nothing closer than 30 to 60 miles”. Patients without the financial means to travel outside of this radius are barred from receiving contraceptives that require a prescription or the presence of a clinician. Dr. Chavkin notes that these patients “not only... have to travel far,” but are “not going to even know where to look necessarily,” given the meager number of contraceptive providers readily accessible. Her comments affirm the findings in the existing literature, which posit patients’ lack of awareness of available options to be a significant barrier to contraceptive access.

Even patients who manage to find a willing provider are not guaranteed to receive the medication they need. With respect to the provision of contentious reproductive care services such as contraception, medical sociologist Dr. Andréa Becker observes, “Providers’ decision-making in these cases are shaped by social inequalities, cultural notions, and personal biases.” Namely, their decisions to prescribe or not prescribe contraceptives are influenced by social prejudices they may have and ultimately reproduce disparities along the axes of race, gender, and socioeconomic status. The biases of contraceptive providers—an inequality that emerges within

the patient room— amalgamates with restrictive insurance plans to magnify the barriers which marginalized patients face.

Objection to the objection: providers' resistance to the policies of Catholic hospitals

Just as patients must grapple with the restrictions imposed by religious hospitals, providers at religious hospitals must navigate these policies to provide contraceptive care to their patients. Dr. Maryam Guiahi, who completed her OB/GYN residency at a Catholic hospital in Chicago, failed to receive training in basic reproductive care and was restricted from providing contraception to her patients. She comments, “I would say [for] many people [working] in Catholic settings, that it doesn’t mean that they are a Catholic provider, or that they follow by those values.” Dr. Guiahi is just one of many obstetrics and gynecology physicians who entered into a residency without awareness of Catholic hospitals' policies on reproductive care. Dr. Stulberg notes:

> Providers don’t know what to expect, either. When you talk to people about going to work in a religious system, they often don’t realize, “Oh, I'm not gonna be able to provide that or am I?” or what that's going to mean for their practice.

Providers and residents are often attracted to “other factors” in these religious hospitals, including the “community that they want to serve,” “the location they want to live in,” or “good surgical services” (Guiahi). Many become aware of restrictions on reproductive care only after entering practice in these settings. The findings concerning practices at religious hospitals reinforce those in the existing literature, which cite that many providers at religious institutions are forced to deny care despite not harboring objections to contraception themselves. As such, providers in religious settings also must navigate the bureaucracies of religious hospitals just as patients do.

Because of the resistance of providers to these policies, the Catholic hospital becomes a site of tension between providers and institutions. Having entered without knowledge of their restrictions, providers oppose the conscientious objection practiced by these hospitals. Dr. Stulberg describes these clinicians as objectors to the limitations imposed on their practices:

> The system's policies, the hospital policies—the directives written by the bishops—often don't reflect the moral beliefs of the people driving the care. There's actually as much conscience-drive objection to the religious policies as there is a religious justification that the policies themselves are a form of conscientious objection.

The "interplay between the system, the policy, versus the individuals working there" (Stulberg) creates pressure for each of the stakeholders involved in patient care, including the patients themselves, providers, and hospital administrators. In a post-*Roe* landscape, the contradictory stance of providers within Catholic hospitals raises questions concerning what conscientious objection entails, the extent to which it can be practiced, and the line having conscience versus denying healthcare based on religion.

Increased stress of providers in religious institutions

After the *Dobbs* decision, demand for contraception has increased all across the United States. While uncertain about changes in the usage of "regular contraception" since *Dobbs*, clinical associate professor of Clinical and Administrative Pharmacy Dr. Rebecca Stone notes, "Emergency contraception is being used a lot more now that abortion is becoming less available." The ruling has raised significant alarm surrounding the legal status of contraception in the near future, as Cleland observes, "Now… there are not a lot of legal barriers to accessing emergency contraception. That's today. In six months, the situation might look different." Access is in quandary in both abortion-illegal and abortion-legal states alike in a post-*Roe* political

climate. Since *Dobbs*, the mindset of lacking a safety net has become increasingly pervasive, according to Dr. Stone:

> "Well, if I accidentally get pregnant, you know, I don't want to, but I can get an abortion. It'll be available to me if I need it." With that sort of safety taken off the table, [women] [are] more proactive about getting emergency contraception.

Coupled with "reports about some clinical providers in [abortion-restrictive] states who have also limited or stopped providing contraception" (Grossman), it appears that contraceptives have simultaneously become more difficult yet more urgent to access. In light of its increased demand, the uncertainty of access to emergency contraception has burdened both patients and providers alike in religious hospital settings.

"It was frustrating, knowing that I had capabilities to do things that I couldn't do and that my patients needed": the stress and limited agency of providers in religious hospitals

Due to the increased use of emergency contraception, the barriers to access posed in Catholic healthcare system become of greater significance post-*Roe*. From her observations on the impacts of conscientious objection, Dr. Meyer concludes:

> I don't know that there's really a large volume of individuals who object to providing contraception. But there are a lot of hospitals, religious healthcare systems, specifically Catholic health care systems that don't allow it… My understanding is that ends up creating overflow into family planning services.

Providers like Dr. Guiahi are faced with the options of referring patients outside of the hospital or providing care through workarounds. While the referring of patients carries stigma and is unreliable, care provided through workarounds imposes considerable stress on providers. Citing "a specific quote in [the ERDs] that says institutions need to be aware of the dangers of association with abortion providers," Dr. Guiahi comments that some physicians in religious hospitals "feel that they cannot even refer a patient to another place." While Dr. Guiahi noted referring patients herself, she acknowledged her patients' limited ability to travel. Additionally,

the local cultures of different Catholic hospitals vary, leading providers in stricter settings to question the backlash they would face if they failed to abide by the ERDs. She describes her tenure at a Catholic hospital as “frustrating, knowing that I had capabilities to do things that I couldn't do [and] that my patients needed.” The restrictive nature of their reproductive care policies both limits the freedom and imposes significant pressures on providers who dissent to them.

In addition to the policies that shape practices within religious hospitals, practical barriers are also abundant. As an example, Dr. Meyer poses, “IUDs are unlikely to be available in a place that does like a Catholic hospital where they’re not stocked, because it's not allowed.” As a result, Illinois patients seeking IUDs must turn to Planned Parenthood and non-affiliated healthcare (Clayville), such as the Indiana University Chicago (IUC), the University of Chicago, Northwestern, and Rush Medical Center (Stulberg). Within religious hospitals themselves, providers experience immense pressure to provide workarounds. Many will cite non-contraceptive reasons such as heavy menstrual bleeding in order to provide birth control pills to their patients. Because contraception “[is] considered such a core service of providing women’s health care,” the necessity of contraceptives “is both harder for the church to enforce and also prompts people to do more of these workarounds” (Stulberg). The lack of availability of contraceptive services, in addition to the necessity of falsifying medical records, reduces the autonomy of providers and produces tensions in their practice of medicine.

Whether due to an inability to provide care, refer patients, or serve patients without the appropriate insurance plans, health care professionals experience distress from their inability to care for patients. As providers of essential, life-saving care, they serve a critical role in enforcing justice, bridging healthcare disparities and uplifting marginalized communities. However,

because challenges of coordinating travel and accessing broad insurance plans disproportionately affect racial minorities, lower-income individuals, and those in non-urban areas, it is marginalized patients who most struggle to access appropriate contraceptive care. Because of the restrictions imposed on reproductive care—and in turn themselves, health care professionals in religious settings become unable to fully serve these patients. *Dobbs* has stripped away the autonomy of stakeholders in reproductive care, infringing on the role of providers and endangering patients in need of care.

Greater workload of providers in secular institutions

As a result of religious hospitals' restrictions, providers in secular institutions have been forced to care for a larger volume of patients post-*Roe*. The increased travel from out of state has been another notable effect arising from *Dobbs*. Surrounded by states where abortion access is either restricted or in quandary (The New York Times 2023), secular institutions in Illinois are receiving a significant volume of patients from out of state in addition to in state. In her discussion of how *Dobbs* has changed access to reproductive care, Dr. Carole Joffe, professor of Sociology and Obstetrics, Gynecology & Reproductive Sciences, remarks:

> The fact is most people who can't get abortions are in the South or the Midwest. They're not going to travel to California. It's too expensive. They're going to drive the ten hours from Texas to either Colorado or New Mexico or Illinois. Those are the places being impacted.

Limited by distance and expenses, patients seek abortions in states located closer to them. In the first month after the ruling, abortions in the United States have decreased in abortion-illegal states and increased in abortion-legal states, with thousands crossing state boundaries to access the procedure (Norris et al. 2022). With more than 10,000 fewer legal abortions recorded in July 2022 relative to the month before, in which *Dobbs* was decided, it is evident that reproductive

care patients have been increasingly dependent on other forms of reproductive care, including abortion medications obtained through mail order and emergency contraceptives.

Because the bans and restrictions on abortion cross through state lines, patients from in-state and out-of-state alike must turn to secular institutions in Illinois for reproductive care. Though out-of-state patients seek abortions and not contraceptives, the increased workload these providers take on produces stress and delays in care, given that they must also prescribe contraceptives. Speaking on religious hospitals in abortion-illegal states, Dr. Meyer states, "[W]hat they were doing was sending people to abortion clinics… and now they cannot do that in banned states. So those people that they would normally send there are now traveling to other states." After *Dobbs*, religious and secular hospitals alike in abortion-illegal states are forced to turn away their patients to states such as Illinois.

Coupled with the in-state patients sent from religious hospitals, the immense workload secular providers must take on creates delays in reproductive care procedures for all patients. Dr. Kimport describes the situation as an "influx of patients, which in many instances has meant increase in wait times for all patients at particular facilities". As the only consistently non-objecting providers of reproductive care that have remained in a post-*Roe* landscape, secular hospitals in abortion-legal states have thus become the center of reproductive care in the United States. Even in-state patients find that their care is getting backed up, with some "getting delayed into a different kind of procedure, which might mean they need to find a different facility" (Kimport). Patients on birth control find themselves requiring emergency contraception, while patients who fail to acquire emergency contraception in a timely manner are having to seek abortions. In-state patients find themselves having to seek alternative secular facilities while providers are struggling to manage the newfound volume of patients, who come from in- and

out-of-state. The restricted abortion access in surrounding states thus creates "cascading effects on people who are in states where abortion remains legal" (Kimport). While there are no legal restrictions on contraceptive provision in Illinois, the increased workload providers face has resulted in increased wait times even for in-state patients. Secular hospitals have thus become a site of delayed reproductive care post-*Roe*.

In addition to out-of-state facilities, religious hospitals within the state have also been sending their patients to secular hospitals. The burden of these providers is thus multifold. Most contraceptive procedures mandate the presence of a clinician or a prescription, which require care to be provided in a timely manner. Dr. Kimport provides the following examples:

> While contraception has not been separated from mainstream medicine the way that abortion has, there are still kinds of methods that may or may not be readily available or may require a clinician in order to be able to use them. For example, the placement of an IUD, the placement of an implant, [and] currently, Depo Provera (a contraceptive injection) and the birth control pill all require prescription.

Because many types of contraception are not yet available over the counter, reproductive care providers in Illinois must manage both abortion care and contraceptive provision. When asked to elaborate upon the disparities she has observed, Dr. Kimport makes note of the logistic challenges rural patients face:

> Many insurances for something like the birth control pill will only allow a patient to get a few months' supply. All of these things can make it more difficult for people in rural areas who don't have as ready access to a clinician and/or a pharmacy to be able to obtain the method that they would like to use.

Distance is a significant disparity for those in non-urban areas. Coupled with the rapid depletion of stocks of contraception, the difficulty in seeking emergency contraception and abortion places rural patients in a precarious position where emergencies can quickly turn into crises in a post-*Roe* setting.

Onus of care increasingly placed on the patient

In light of an inability to obtain contraception at religious hospitals, patients must find an alternative means of seeking contraception. Some may have the time to find the appropriate care if the situation is not an emergency, but more often than not, patients of reproductive care seek emergency contraception in urgent situations. Religious hospitals fail to provide care even in these cases, which presents a significant obstacle for these patients:

> The biggest barrier in a religious hospital to getting reproductive care is that you're already in the hospital and you don't know that they're not going to provide it. And so then you're in a position where you have to find a way out of that hospital. (Clayville)

Emergency contraception, which must be taken within five days of unprotected sexual intercourse to be effective, is highly time sensitive (WHO 2021). Because religious hospitals fail to provide care even in emergency situations, the patient is put in a position where they must be responsible for their own care. When patients lack awareness of religious hospitals' policies, the conscientious refusals they face can significantly increase their risks of dangerous and undesired outcomes.

"They may not get information if they don't know how to ask about it": the requirement of social capital in obtaining contraceptives

In practice, a patient thus has to "know the local culture" and to learn to recognize that "a Catholic hospital outside of [certain cities] is probably going to be different than the Catholic hospital in Chicago... [which] may be different from a different Catholic hospital in Chicago" (Clayville). As a practicing physician whose expertise lies in women's health and medical ethics, Dr. Stulberg points to Peoria, a city with "a big Catholic system called OSF... [as] the dominant provider" and only "one other non-Catholic system," as an area in Illinois that stands out for its reproductive health restrictions. Dr. Clayville, a hospital ethics and medical school ethics education professor at the University of Illinois at Chicago, similarly notes "the Chicago campus

[to be] more liberal than the Rockford or Peoria campuses". Even in non-affiliated healthcare systems associated with universities, the degree of conscientious objectors varies from hospital to hospital. Furthermore, patients must increasingly know the relevant and appropriate questions to ask their providers. When ask to expand upon the barriers encountered by patients who lack knowledge of reproductive care restrictions, Dr. Stone phrases:

> When they don't know much about their reproductive health, they don't always ask the right questions. And sometimes they may not get information about emergency contraception or what they really need if they don'' know how to ask about it.

In order to receive the proper care post-*Roe*, patients must possess social capital in the form of knowledge on religious hospitals and reproductive health. Patients without this knowledge become further marginalized due to this barrier.

"They're asking questions about what another baby would mean": the marginalization of vulnerable patients through the exercise of personal judgment

Providers granted greater agency are also more prone to exercise their own personal judgment in the decisions they make. Aside from acts of conscientious objection, a myriad of concerns centering non-standard protocol for the provision of contraceptives has emerged. Kelly Cleland describes some pharmacists as asking younger-looking patients for identification despite the FDA having struck down the age restrictions on over-the-counter purchase of Plan B in 2013 (FDA 2022). Additionally, pharmacies in rural areas may not properly stock emergency contraception or may stock only expired emergency contraception, especially for those perceived as having aging populations (Cleland). Cleland comments, "Healthcare professionals substituting their own judgment for the judgment of the customer or the patient is something that we really are concerned about." When these judgments fail to align with patients' needs, they disenfranchise marginalized patients, as Dr. Kimport points out:

> If you actually ask the people who are experiencing… pregnancy and pregnancy decision-making... they're asking questions about, "Can I take care of this baby? What can I do? Is that something that my family can navigate? Can I emotionally financially cope with this?" They're asking questions about what another baby would mean for their existing children. They're asking questions about what it would mean to have a baby with somebody who has been violent to them, with somebody who has already for their previous children failed to be a co-partner.

The demographic of patients seeking contraception comprises of financially struggling mothers and victims of domestic violence, among other vulnerable individuals. At the hands of these providers, those who cannot receive emergency contraception in time may thus find themselves a situation where they are further financially destabilized. When providers exercise their personal judgment in deciding the care their patients receive, they may make decisions that fail to account for the needs of patients in urgent situations.

These decisions also widen the access gap for rural patients, for whom transportation impedes access to non-objecting providers. Dr. Clayville observes, "[Around] 20% of Americans… only have access to health care at a Catholic institution within a 30- to 40-minute drive." In order to seek care at alternative hospitals or pharmacies, those in rural areas must contend with extensive logistic barriers and plan in advance, which is often not feasible for time-sensitive medication such as contraceptives, as Cleland notes. She elaborates:

> You're dealing with the cost of gas, or if you don't have a car, getting transportation, figuring out a way to get there. All in a context of, this is an urgent thing that you need to do as soon as possible. If you have to go to work and you can't spend two hours driving to the other town to get your [insurance] plan ID, then that's a delay that might result in higher pregnancy risk.

In addition to the accommodations necessary to obtain the medication, patients must contend with the cost of the contraceptive itself. According to Cleland, Plan B has "consistently costed $50 since it's been on the market," with perhaps a few organizations lowering the cost to $47. Other forms of emergency contraception, such as Ella, require a prescription and are thus even

more difficult to obtain. The limited contraceptive care provided by religious hospitals and pharmacies have the greatest consequences for patients who are already most vulnerable to unplanned pregnancies, according to the existing literature. In failing to account for their circumstances and the threat which unplanned pregnancies pose to their lives, these patients become further marginalized and disenfranchised within American society.

Potential for future threats to contraceptive access

Though few restrictions to contraceptive access are currently written into law, scholars of reproductive care warn that contraceptive access may be further eroded by conscientious objectors or other judicial cases. Many of the interviewees pointed to examples of state-level bills and overreaching interpretations of *Dobbs* as evidence. Dr. Tamika Odum poses as an example:

> Right now, in Ohio, there are a couple of bills that are going around that would define first personhood as starting at fertilization. If personhood is then defined as starting at fertilization, then that would mean that we would have to reclassify emergency contraception… This is broader than just abortion.

Since *Dobbs v. Jackson* was decided, state governments have been placed in the precarious position of adapting to the ruling. The bills they pass to expand or decrease abortion and contraceptive access they make are pivotal to the future of reproductive care.

"We've already seen lawmakers trying to confuse what is abortion [and] what is contraception": state- and federal-level challenges to contraceptive provision

Thus far, the withdrawal of federal protections for abortion has already led some states to generalize restrictions on reproductive care. Though in her words, "there should be no effect of *Dobbs* on access to emergency contraception, because *Dobbs* is about abortion," Cleland observes:

> We've already seen lawmakers trying to confuse what is abortion [and] what is contraception. Particularly, there could be an effect on EC and IUDs in states trying to use their state's abortion laws to reinterpret it to include these other methods.

For instance, the Idaho Legislature lists emergency contraception as an "abortion-related activity" in their 2021 No Public Funds for Abortions Act. After *Dobbs*, public universities in Idaho, fearing felony charges, have interpreted the state law as meaning they cannot provide information on emergency contraception or even offer birth control to students (Boone 2022; Kitchener & Svrluga 2022). Similarly, a Missouri health system spanning 17 hospitals, pharmacies and urgent care clinics temporarily halted the provision of emergency contraception for fear of charges (Hawley 2022; Ballentine & Salter 2022), an incident Cleland describes as “example of a chilling effect that *Dobbs* and in turn state abortion regulations can have on the provision of EC.” The trigger laws enacted after *Dobbs* have introduced ambiguity into the practice of contraceptive care provision. These states' policies on abortion and contraception not only marginalize the most vulnerable of patients, but also affect those in abortion-legal states such as Illinois. Regardless of the protections enshrined into Illinois state law, future restrictions on contraceptive access will only serve to limit the extent to which Illinois can serve out-of-state patients.

Previous Supreme Court rulings on contraception, such as *Burwell v. Hobby Lobby Stores, Inc.* in 2014, serve as examples of federal challenges to contraceptive access. Dr. Kimport, who describes *Hobby Lobby* as having occurred in a “semi-recent past,” has observed a myriad of “challenges to the idea of legal and acceptable and accessible contraception.” While *Hobby Lobby* is concerned with private corporations, allowing owners to object to the coverage of certain contraceptives, other judicial cases may be used to challenge other aspects of

contraceptive access in the near future. Cleland predicts opponents of contraception and abortion will act strategically within the next few years to do so:

> In the next session, there's been some speculation that people who are against contraception might just wait a little bit, because people are still really mad about that. They might just wait for things to cool down, and then really come after contraception maybe next year or the year after… they also might be just on a roll and maybe want to try and make some more things happen at the state level.

In light of the pushback against *Dobbs*, it may be in the anti-abortion movement's interests to wait for the tension surrounding *Dobbs* to subside. In a few years, however, contraceptive access across the United States may change dramatically.

"I also am concerned that Dobbs empowers people who are gatekeepers": the changing decisions of health care professionals in providing contraception

In addition to harboring a looming fear of felony charges in abortion-restrictive states, providers across the country—in abortion-restrictive and abortion-protective states alike—may change their practices in response to *Dobbs*. According to Kelly Cleland, those who object to the provision of contraception may now have greater agency to deny medication:

> I also am concerned that *Dobbs* empowers people who are gatekeepers, like physicians and pharmacists… to think, "I can substitute my own judgment for the judgment of the patient. I can decide if I don't want to provide this method to somebody. I just don't have to do it." I'm concerned that we'll see, if not this year, then maybe next year or the year after, some actual public policies that support this.

The individual providers, pharmacists, and institutions allowed to refuse under Illinois state law become more strongly protected under the message Dobbs sends. In ambiguous situations especially, health care professionals may be inclined to refuse rather than provide contraceptive care to patients.

Cleland, who describes EC as a "stopgap" which ultimately "[is] not going to solve the problem" of restricted abortion access, details the necessity of increasing contraceptive access as follows:

> Contraception is never going to be enough... But for now, we're really trying to focus on advancing access to EC because in some cases it's the best chance somebody might have at preventing pregnancy when they don't have access to abortion.

Even within abortion-protective states such as Illinois, some patients rely on contraception as their only feasible option for pregnancy prevention. Though the state has worked extensively to protect reproductive care access, many obstacles still remain. An amendment to the Public Higher Education Act bill, which would have required public universities to offer emergency contraception in vending machines, failed to pass. While the amendment was eventually adopted after extensive modifications to the definition of public universities, among which were the exclusion of community colleges, the bill testifies to the resistance present even within abortion-protective states. The necessity of anticipating hindrances to reproductive care protections and potential restrictions that succeed *Dobbs* becomes evident in the context in Illinois.

Policy Recommendations

Based on the findings of this study, recommendations for broadening contraceptive access are proposed. Recommendations address contraceptive users, health care providers, and legislators, each of whom are critical stakeholders in the proper delivery of contraceptive serves. The policies proposed are intended to inform stakeholders on reproductive health care services and systems, accommodate the challenges they face in accessing care, and clarify the services to which they are entitled under the law. The recommendations outlined include: 1) the transparent dissemination of information to patients and providers, 2) increasing prescription duration and expanding telehealth programs, and 3) delineating between abortion and contraceptive services at the state level. These proposed policies are intended to account for the barriers posed by religious

institutions and bridge the racial, socioeconomic, and geographical disparities that emerge from them.

Transparent dissemination of information to patients and providers

While Illinois has made efforts to protect reproductive care access, abortions have nonetheless become an extremely difficult, if not completely infeasible, option for many. In a post-*Roe* context, the use of contraception has thus become central to pregnancy prevention, particularly for patients of marginalized status. In light of the barriers to contraceptive access in religious hospitals, as well as the other contexts in which objection occurs, it is imperative that scientifically accurate information on contraception is disseminated to patients and providers alike. Informing stakeholders involved in the delivery of the medication would broaden overall access to contraception and aid in bridging the gap between patients of varying racial, socioeconomic, and geographic demographics.

Individual providers and pharmacists alike must be better informed in order to provide accurate information to their patients and prescribe the appropriate contraceptives, if any. There are many health care professionals who refuse to prescribe or dispense contraceptives on account of personal belief, decisions protected by the law; however, many also refuse due to feeling unequipped to do so or due to lack of awareness of the mechanism of action. For this reason, medical and pharmacy school curriculums and residencies must dedicate special attention to reproductive care. By broadening the scope of topics and amount of time spent on reproductive health, medical and pharmaceutical education can better prepare their students to provide contraceptives and make informed decisions for their patients. Similarly, pharmacies and

pharmacists can more promptly stock prescription and over-the-counter contraceptives, as well as replace those which have passed their expiration dates.

Similarly, there are many lessons stakeholders can learn from the recent revision of the Plan B labeling. The significance of the modification lies in its correction of misinformation for an accessible and widely used product, an emergency contraceptive available over the counter. It clarifies Plan B's mechanism of action using up-to-date scientific evidence, allowing patients to use the medication safely without a prescription or the presence of a physician. At sites where contraception is available, information must be accurate, unambiguous, and transparent. This is especially true for emergency contraception, a medication whose time window of consumption is extremely narrow. Revisions of the labeling for similar products must similarly match updated medical research for patients to use them properly and most effectively.

Increasing prescription duration and expanding telehealth programs

The overall demand for contraception has increased after *Dobbs v. Jackson*, magnifying the barriers to access at religious hospitals and placing great burden on providers of contraceptives. Abortion patients from both in state and out of state are depending on providers in Illinois, making timely and effective procedures increasingly difficult to access. Alleviating the effects of the increased demand is thus necessary to reduce wait times for patients seeking abortions and contraceptives, in addition to decreasing the stress and workload of health care professionals providing them. These effects can be alleviated by expanding the options available for patients who seek contraceptives. As a demographic diverse in race and socioeconomic status (Kavanaugh & Pliskin 2020), as well as geographic area, contraceptive users face many disparities in access that must be accounted for. In order to serve all contraceptive users, it is

necessary to account for the unique barriers which marginalized users face, such as the inaccessibility of in-person care. Increasing the amount of prescription contraceptives patients can receive and expanding telemedicine services for contraception are two policies that can potentially bridge these disparities. In accommodating for the needs of contraceptive patients, reproductive care patients across the entirely of Illinois benefit, including out of state patients.

Due to limitations of time and cost, transportation to health care institutions can be a barrier for patients in rural areas or of lower socioeconomic status. Contraceptive users who must work long hours or take care of their children may face logistic challenges, in addition to those who must drive long hours to pharmacies or hospitals. Thus, expanding the amount of contraception received in a given visit may prove highly beneficial, especially in a post-Roe context. Such policies may permit contraceptive prescriptions to last up to 24 months from 15 months, as Illinois state law currently legislates. Outside of Illinois, states may require Medicaid to cover over-the-counter emergency contraceptives or one years' worth of oral contraceptives (Ranji et al. 2022). Policies extending the supply, breadth, and length of coverage can broaden access for contraceptive patients. Making self-administered contraceptives such as birth control pills available over the counter can mitigate the effects of religious refusals, where contraceptives may not be offered. These would alleviate the gaps in restrictive Medicaid plans and facilitate the provision of contraceptives, especially those who face barriers to transportation or are bound to religious hospitals.

Implementing telemedicine programs for reproductive care can further alleviate the tightening restrictions on reproductive care. Telemedicine, or virtual care provided to patients through technology, allows patients to receive care without the need for an in-person visit. In an abortion-protective state such as Illinois, patients in rural areas can receive access to

contraception as well as medication abortion through telemedicine. It is critical to note that telemedicine is imperfect, as it requires Internet access. This can potentially exclude racial minorities, lower-income, or child-rearing individuals; however, for those with Internet access, telemedicine can bridge the gap in contraceptive access between urban and non-urban areas. In improving contraceptive access (Song et al. 2022), telemedicine can increase patients' chances of receiving timely care alleviate the high demand for contraception. The virtual provision of abortion medication may also alleviate in-state patients' needs to seek in-person care, ultimately decreasing congestion in secular hospitals. As one of the few states in which in-state patients can receive medication abortion through telemedicine (Guttmatcher Institute 2022), Illinois has the potential to alleviate the burden on reproductive care providers through the implementation of telemedicine programs. These programs have the potential to increase contraception and abortion access across the country, in light of Illinois' status as the central location for post-*Roe* reproductive care in the Midwest.

Delineation of abortion and contraceptive services

In light of the strengthening anti-abortion movement in the U.S., threats to erode contraceptive access loom across the country. The passing of *Dobbs v. Jackson* is merely one of the many goals the movement hopes to achieve. Greater restrictions on abortion and contraceptive access will only serve to increase the risks reproductive care patients face and widen disparities in receiving quality care for marginalized patients. Though abortion procedures have been restricted and banned in many states, findings reveal that *Dobbs* has introduced ambiguity in the legality of abortion and contraception services. In religious and secular hospitals alike, the equating of birth control to emergency contraception and the confounding of

emergency contraception and medical abortifacients can results in health care providers withholding contraceptives for fear of retribution. The withholding of contraception from patients gives rise to delays, which can decrease the efficacy of the medication, increase the risks to patients' health, and increase the likelihood of needing an abortion. In order to eliminate these ambiguities, legislation on the state level must transparently specify which procedures and forms of medication they refer to. Clarifications of the state law and of any new bills introduced must be made and disseminated widely to the general public, especially to health care providers. These clarifications are necessary for the appropriate implementation of laws and the timely delivery of care in health care systems, universities, and other institutions from which patients seek contraceptives.

Conclusion

Access to contraception has been widely documented to better the economic and health outcomes of women (Beyer 2020). With the recent fall of Supreme Court rulings *Roe* and *Casey*, however, it is evident that contraceptive access is currently under attack in the United States. Since the *Dobbs v. Jackson* decision in June of 2022, which revoked the previously ruled constitutional right to abortion, contraception has become of paramount importance for managing reproductive health. The ensuing increase in demand for contraception warrants an investigation of post-*Roe* barriers to contraceptive access, especially in states with a large presence of religious hospitals. The practice of conscientious objection within religious hospitals complicates access for contraceptive users, many of whom must navigate secular and religious settings alike to seek the care they require. The obstacles they face to accessing safe and timely care are compounded by racial, socioeconomic, and geographic disparities. As Illinois has

become a pivotal site for reproductive care after the *Dobbs* decision, including for patients living outside of the state, this study sought to compare religious and secular hospitals to construct a landscape of post-*Roe* contraceptive access in Illinois.

The review of the existing literature revealed the disproportionate consequences of conscientious refusals for marginalized patients, differential policies surrounding reproductive care provision at institutions of varying affiliations, and patients' frequent lack of awareness of religious hospitals' policies and restrictions. Qualitative data collected through interviews with health care providers and scholars of various fields build upon these studies, revealing themes of conflicts between religious institutions and state legislation, increased stress in providers at religious institutions, and the onus of care increasingly being placed on the patient. These result in the muddling of the definition of conscientious objection and a greater workload placed on reproductive care providers in secular institutions, with potential threats to future contraceptive access looming.

Recommendations consider the impact of *Dobbs* on the stakeholders involved in the delivery of effective contraceptive care, including contraceptive patients, health care providers, and state legislators. In light of the findings of this study, three policy themes are proposed: transparent dissemination of information to patients and providers, the increasing of prescription duration and expansion of telehealth programs on a state level, and the delineation of abortion and contraceptive services across abortion-restrictive states. Following the findings and the recommendations that emerge, potential lines of inquiry for future research may include interactions between religious hospital practices and state laws, the moral and psychological pressures imposed onto reproductive care providers, and the biases that shape the care they provide to patients of varying demographics. More research is also necessary to ascertain the role

of hospitals of other affiliations in Illinois and the restrictions they impose on contraceptive provision, as well as the implications of the social capital increasingly being required to seek appropriate care on disparities in access. Though post-*Roe* economic and maternal and child health outcomes are yet to be unveiled, it is in anticipation of the potentially fatal consequences *Dobbs* will have on American women that research on religious healthcare, contraceptive access, and health disparities are emphasized. Propositions of expanding contraceptive access are made in the post-Roe backdrop of potential threats to future contraceptive access, and ultimately serve as a warning to legislators and religious institutions of the devastating outcomes that arise from the denial of essential care.

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Tables

Table 1

Interviewee information

Name	Affiliation	Title	Date	Length
Dr. Geoffrey R. Stone	University of Chicago Law School	Edward H. Levi Distinguished Service Professor of Law	October 28th, 2022	1 hour, 5 minutes (seminar)
Dr. Katherine Meyer (pseudonym)		Associate Professor	January 17th, 2023	40 minutes
Dr. Kristel Clayville	University of Illinois Chicago	Lecturer, Computer Science	January 18th, 2023	51 minutes
Dr. Katrina Kimport	University of California, San Francisco	Assistant Professor, Department of Obstetrics, Gynecology & Reproductive Sciences	January 19th, 2023	50 minutes
Dr. Debra Stulberg	University of Chicago Medicine	Professor of Family Medicine; Chair, Department of Family Medicine	January 27th, 2023	46 minutes
Kelly Cleland	American Society for Emergency Contraception	Executive Director	January 30th, 2023	39 minutes
Dr. Daniel Grossman	University of California, San Francisco	Professor, Department of Obstetrics, Gynecology & Reproductive Sciences; Advancing New Standards in Reproductive	February 2nd, 2023	17 minutes

		Health (ANSIRH) Director		
Dr. Rebecca Stone	University of Georgia College of Pharmacy	Clinical Associate Professor	February 6th, 2023	21 minutes
Dr. Andrea Becker	University of California, San Francisco	Postdoctoral Scholar, Department of Obstetrics, Gynecology & Reproductive Sciences	February 16th, 2023	E-mail
Dr. Madison Peters (pseudonym)		Catholic lay theologian	February 17th, 2023	37 minutes
Dr. Maryam Guiahi	Santa Barbara Cottage Hospital	Obstetrics and gynecology (OB/GYN) physician	February 17th, 2023	32 minutes
Dr. Carole Joffe, Dr. Ophra Leyser-Whalen, Dr. Tamika Odum	University of California, San Francisco; University of Texas at El Paso; University of Cincinnati	Professor; Associate Professor of Sociology; Associate Professor of Sociology	February 20th, 2023	1 hour, 17 minutes (seminar)
Dr. Wendy Chavkin	Columbia University Mailman School of Public Health	Special Lecturer/ Professor Emerita, Department of Population and Family Health and Clinical Obstetrics and Gynecology	February 22nd, 2023	33 minutes

Appendix

A. Interview guide

Questions:

1. What are the most common reasons that providers and institutions cite for refusing to prescribe or dispense contraceptives?
2. Is conscientious objection common outside of religious medical settings?
3. How do pre-existing challenges situate themselves in a post-*Roe* U.S., and if there are any new challenges, how have you seen or how do you expect access to be affected by *Dobbs v. Jackson*?
4. What effect, if any, do patients' reasons for seeking contraceptives have on providers' decisions?
5. What implications does the ruling have for racial, socioeconomic, and or geographic disparities in contraceptive access?
6. What are conscientious objectors' perceptions of emergency contraceptives as opposed to medical abortifacients? What about birth control versus other types of contraceptives?