Chapter 11

"War on Women"

Democrats' Interpretations of Messages Regarding Women's Health at the 2012 Democratic National Convention

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After "going blue" and voting for Barack Obama in the presidential election in 2008, the state of North Carolina (NC) was poised to appear in the political spotlight again, serving as host of the Democratic National Convention (DNC). In September 2012, it is estimated that 35,000 people attended the three day long convention in NC's largest city, Charlotte (Gordon & Kelley, 2012). While the contest for the White House would occur in all 50 states, and both Parties' conventions were merely procedural, it was becoming clear that the outcome of the election would hinge on women and women's health.

Following the 2010 midterm elections, the expression "war on women" surfaced describing what many perceived as a wide-scale effort by the Republican Party to restrict women's rights, especially their reproductive rights, through focused legislative action. State legislatures were passing laws limiting access to abortion services, narrowing the criteria for publically funded abortions, defining and categorizing rape, and dismantling laws designed to protect victims of domestic violence ("The campaign against women," 2012). Democrats and feminists (see also, Valenti, 2012b) used this phrase to characterize proponents of these laws as nothing more than trying to legislate their social views and religious beliefs. In April 2012, Senator Barbara Boxer of California wrote an op-ed appearing on Politico.com stating, "The facts are the facts. The Republicans have launched a war on women. Despite all the denials, women get it—and so do the men who care about them" (para. 17). When asked if there was a war on women, Gloria Steinem said,

> Yes, and there has been for a long time. But it wasn't always that way. The Republican Party supported the Equal Rights Amendment before the Democrats did. What's happening now is about a relatively small percentage of religious and economic extremists that have taken over the party.
>
> Reproductive freedom is a fundamental human right—to decide what happens to our own bodies is as basic as freedom of speech and freedom of assembly. But there's a backlash against it from patriarchal religions that have enshrined the idea of a male God and control of women. Religion is sometimes politics you can't—or you're not supposed to—criticize. (Hill, 2012, para 6–7)

Others said the "war on women" did not exist and argued it was nothing more than a strategy to scare and influence women voters. Republican Vice Presidential candidate Paul Ryan ridiculed the "war on women" saying, "Now it's a war on women; tomorrow it's going to be a war on left-handed Irishmen or something like that" (Sonmez, 2012b, para 2). The Chairperson of the Republican National Convention (RNC), Reince Preibus, referred to the war as "fiction," noting, "If the Democrats said we had a war on caterpillars and every mainstream media outlet talked about the fact that Republicans have a war on caterpillars, then we'd have problems with caterpillars" (Jensen, 2012, para 2). Republican Senator Lisa Murkowski of Alaska became concerned when members of her party failed to respond to legislative attacks on women's reproductive health and were silent when a prominent Republican radio host made derogatory remarks about women. Murkowski openly disagreed with many of her colleagues who denied the "war on women" saying, "If you don't think this is an attack on women go home and talk to your wife and daughters" (Johnson, 2012, para 2).

While the majority of high-ranking Republicans were downplaying the "war on women," Democrats were celebrating women. In the four years following President Obama's historic election, women and women's health issues featured prominently. In fact, the first bill Obama signed into law was the Lilly Ledbetter Fair Pay Act of 2009 (Pub.L. 111-2) to end gender pay discrimination. He also appointed 13 women to his Cabinet (matching President Clinton) and more women to judicial positions than any other president in history (Lowery, 2013). In the months leading up to the November 2012 election, women's health issues began to garner greater media attention and a larger role in the presidential and congressional elections. For example, a hearing about the Affordable Care Act's (ACA) birth control coverage requirement, which featured a male only panel, drew media attention, as well as criticism. Founder and editor of Feministing.com, Jessica Valenti (2012a), wrote:

> When a picture of Congressman Darrell Issa's all-male panel on birth control (the make-up of which prompted several Democratic women to walk out of

> the hearing) hit the Internet and mainstream media—I couldn't help but be reminded of a similar picture of George W. Bush signing the "partial birth" abortion ban, surrounded by a group of smiling clapping men. All men. (para 2)

Democratic Representative Carolyn Maloney asked during the hearing, "Where are the women" (Shine, 2012, para 2)? Then added, "We will not be forced back to that primitive era" (para 3).

Representative Todd Akin, a Republican from Missouri, declared only certain rapes "legitimate" during an interview saying, "If it's a legitimate rape, the female body has ways to try to shut that whole thing down" (Eligon & Schwitz, 2012, para 3). While Akin retracted his comment, the statement prompted additional discussion in the public sphere about how other prominent Republicans, especially vice-presidential candidate Paul Ryan, were trying to redefine rape through legislative action (Sonmez, 2012a). Still other lawmakers were passing laws requiring women seeking abortion services to undergo invasive transvaginal ultrasounds (Eckholm & Severson, 2012), and the Susan G. Komen Foundation withdrew funding from several Planned Parenthoods, a decision that resulted in lost donations and the resignation of its long-time CEO (Wallis, 2012).

A month after Komen defunded Planned Parenthood, an all-male panel of clergy convened to address contraception mandates for health insurance companies prompted by the ACA. Republican Representative Darrell Issa, who organized this meeting, did not allow a Georgetown University Law Center student, Sandra Fluke, to participate in the hearing. Two weeks later, Democratic Members of the House of Representatives assembled a panel allowing Fluke to read a prepared statement in support of the mandate. In response to Fluke's remarks, Rush Limbaugh called her a "slut" and a "prostitute" over a two-day period on his radio show (Portero, 2012). Foster Freiss, a large financial supporter of former Republican Senator and former presidential candidate Rick Santorum, suggested that women should put aspirin between their knees as a form of birth control (Frank, 2012). Rush Limbaugh said he would, "buy all the women at Georgetown University as much aspirin to put between their knees as they want" (Bassett & Bendery, 2012, para 2). Nancy Pelosi, Minority Leader of the United States House of Representatives, circulated a petition asking that Republicans in the House of Representatives disavow the comments by Freiss and Limbaugh, which she called "vicious and inappropriate" (Geiger, 2012, para 5). Many women were stunned, angry, and scared. Issues women thought they were done fighting for and long settled, such as easy access to birth control, were once again under attack by Republican lawmakers and conservative pundits.

In November 2012, incumbent Barack Obama beat Republican opponent Mitt Romney, to retain the office of the U.S. President, by a narrower margin than his victory four years earlier. Despite hosting the DNC, the state of North Carolina did not "go blue" again. Democrats maintained a lead in the Senate but could not regain the House of Representatives, leaving Congress divided. State executive branches would be led by more Republican than Democratic governors. Health and women's health issues, in particular, remained a focus of political action. Just eight months into President Obama's second term, the U.S. House of Representatives voted to repeal the ACA, also referred to as Obamacare, for the 40th time despite evidence indicating that the law was working to lower health costs (Terkel, 2013). One component of the ACA soon to be enacted, free contraception, was one of them. Conversely, according to the American Civil Liberties Union (2013), more than 300 provisions were introduced by 35 state legislatures restricting access to abortion services. Seventeen states passed abortion-related laws, and many of the legislative changes were expected to lead to the closure of clinics that provide other health services to women besides abortion, such as contraception, pap smears, and mammograms. Women's health issues remained a major focus despite the end of election season as states such as Texas, North Carolina, and North Dakota passed laws restricting abortion.

The purpose of this chapter is to explore women's health issues and, specifically, the perceptions of attendees at the DNC in Charlotte, NC, September 4–6, 2012. We conducted interviews with individuals in attendance at various convention sites open to the public using a structured interview protocol that inquired about the role of women's health during the presidential election cycle. While state and national elections were decided in November, we link participants' perceptions during the DNC with not only election outcomes, but also the political action taken at the state and local levels related to women's health.

One of our goals was to determine the presence (or absence) of the Democratic Party's platform in participants' responses. Another goal was to see how closely respondents' perceptions mirrored the media's discourse on the topic of women's issues, including health. Finally, we were interested in attendees' perceptions of what women's health issues were most relevant and should be addressed by the next President in an effort to determine if there were concerns important to the public but not reflected in political agendas or media reports. We focus on a combination of individuals' perceptions of political platforms and media reporting because as Dubriwny (2012) noted, "recognizing that [public] discourse matters is a recognition of the complex relationship between discourse and reality" (p. 3).

METHOD

The Democratic National Convention (DNC) was selected as the research site for this project because we expected that individuals in attendance would be diverse, visiting the Tarheel State from all over the country, and politically engaged; not only informed about issues but very likely to vote in November. Planners also vowed this would be the most accessible and open convention ever, beginning with a festival, public access to caucuses and the president's nomination acceptance speech (the president's speech was eventually moved indoors due to concerns about inclement weather, significantly limiting public access), affording us the opportunity to recruit a wide range of participants, including curious onlookers, protesters, and delegates.

Data Collection

After receiving Institutional Review Board approval, data was collected over the course of three days during the DNC. Since the majority of the convention was open to the general public, we were able to collect data on the street as individuals were going to and from events, as well as inside the convention center where caucus meetings, including the Democratic Party's women's caucus meetings, took place. According to Lindlof and Taylor (2002), "[i]nterviews can explore the commonsense conceptualizations, or folk theories, of communication that circulate in society" in the voice and language used by participants (p. 175). We conducted 22 total interviews (three interviews consisted of dyads and one interview was a triad) with 27 individuals inquiring about women's health issues during the presidential election cycle. Interviews, which lasted anywhere from five to 10 minutes, were audio recorded and transcribed verbatim producing 21 single-spaced pages. In order to maintain the quality of the participants' responses, we only edited data to ensure clarity. Therefore, the exemplars reported below reflect participants' authentic voices and actual language use.

Participants

Along with questions about perceptions of women's health, we asked all interviewees a series of demographic questions, such as age, race, political affiliation, and whether registered to vote and in which state (see Appendix A for interview protocol). We did not ask for names or other identifying information. Twenty-seven individuals agreed to be interviewed; 16 women and 11 men. Two-thirds of participants self-identified as White. Participants were between 25–85 years old, with a mean age of 58.6 years. Study participants came from 12 states, with the majority from North Carolina (40%). The

majority of participants ($N=23$) were registered as Democrats (Table 11.1 includes additional information about participants' demographics). In the findings section, we include limited demographic information for descriptive purposes only. Although participants' ages is an indicator of likelihood to vote (Hamel, Brodie, Morin, 2003), we also included this information because age may be a factor in which health issues are most relevant to the participant. Gender is also reported to give readers a sense of the participants' voices.

Data Analysis

Before beginning our analysis of data, we confirmed the accuracy of the transcripts, as recommended by Creswell (2002) and Maxwell (1996), by listening to each digital recording while reading the transcript and making corrections as necessary. Analysis began with a line-by-line reading of the transcripts by both authors, marking segments we found interesting and generally related to women's health. Adopting Morse's (2008) distinction between categories and themes, where categories consist of a collection of similar data and themes include an "essence" that runs through the data, we then reviewed the transcripts and identified key words that comprised categories. Next, the first author searched for these key words, engaging in a

Table 11.1 Participant Demographics

	58.63 Mean
Age, N = 22 (5 Declined to State)	*Range: 25–85*
Gender (observed)	Women, N=16
	Men, N=11
Race	White, N=18
	African American, N=7
	Asian American, N=1
State from/registered to vote in	North Carolina, N=11
	California, N=2
	Florida, N=2
	New Jersey, N=2
	Oklahoma, N=2
	South Carolina, N=2
	Texas, N=2
	Georgia, N=1
	New Mexico, N=1
	Pennsylvania, N=1
	Wisconsin, N=1
Registered to vote	All registered to vote
Party affiliation	Democrats, N=22
	Independents, N=3
	Declined to state, N=1

quantitative content analysis to further develop the categories. Data analysis procedures then followed a constant comparative method (Strauss & Corbin, 1990) and category and theme identification involved analysis between and across interviews (Silverman, 1993). Categories frequently led to broader themes found across the data.

RESULTS

The analysis of the data yielded four themes that emerged from 10 categories; both the themes and categories mirrored the topics of conversation about women's health taking place in the public sphere. These themes also represented some of the major issues that define the Democratic Party and its contemporary platform. Before reviewing exemplars that reflect the themes, we report the categories that influenced their development. A content analysis from line-by-line coding reveals 10 keyword categories (below are category names and the number of references in the transcripts in parentheses):

1. Abortion (29)
2. Decision(s)/health care decisions/decisions over body (19)
3. Cancer (18)
4. Choice/Choose (15)
5. Equality/equality (9)
6. Prevention/preventive care (11)
7. Provoking conversation/women's health being talked about (9)
8. Reproductive rights/birth control (8)
9. Freedom/sovereignty/control (6)
10. More women in public office (4)

These categories were used to inform the four themes: cancer and cancer research; equality, access, and choice; abortion; and prevention and preventative care, as well as our interpretations of them, which we will elaborate on in the discussion section. Themes not only reflected topics prevalent in media coverage of the election, but also the Democratic Party's platform and responses to the Republican Party's attacks on President Obama's primary accomplishment during his first term, the ACA, which was signed into law in March 2010. It is important to note that the ACA would assist women in several ways, requiring health insurance policies to cover contraception and routine cancer screenings, such as mammograms for women starting at age 40, the HPV vaccine for women and girls under 26, and an annual "well woman" visit, at no cost (The Kaiser Family Foundation, 2013). Insurance companies could no longer have different premium structures for women and men and

according to The Kaiser Family Foundation (2013), one million women under the age of 26 gained health care coverage because they could now remain on their parents' plans. In addition, nine months before the election, the Susan G. Komen Foundation, one of the largest breast cancer charities, made the decision to defund Planned Parenthood, an organization that provides a range of healthcare services to women, including cancer screenings. The promised benefits of the ACA and the Komen Foundation's decision were alluded to by several participants. Therefore, the first theme we discuss focuses on participants' perceptions that cancer care and cancer research are among the most important issues for the next president (Obama) to address.

Participants believed the next president should address two major issues relevant to women's health; cancer and funds to support cancer research (18). Six of those eight participants specifically mentioned breast cancer. One African American woman (declined to state age) from Atlanta, Georgia said,

> Ooooh, definitely breast cancer because it's just such a key issue and it's all races and age groups. It's not just confined to multiple people [sic], because women are in the top percent of being diagnosed for breast cancer, so I think breast cancer should be right up there at the top.

Other participants did not reference a specific disease or illness but felt equal access to (and equal cost of) healthcare, especially access to reproductive health and choice, were important issues for the next president. A 69-year-old white male from Texas said,

> I just think the overall women's health issue where women have been discriminated against for years, with a different rate structure . . . many years ago my wife's plan was like [twice] as much as mine was.

Another participant said, "I think um, reproductive rights and uh preventive care" (33-year-old, white male, from St. Petersburg, Florida).

Similar to concerns about access and choice, several participants noted that decisions over one's health and body were essential for women. Autonomy for women was foundational to equality and health of the family.

> And again it is about recognizing women as humans, equal humans to men uhh about having dignity to make your own choices and respect. Once you have that respect, it's not about, 'I love my mom,' we all love our moms [referencing the GOP Convention speech given by Ann Romney, wife of the Republican Presidential Nominee Mitt Romney], umm it's about having respect for women's choices and women's points of view and expertise, having them be equals on [sic] the table (from joint interview with two white female participants, ages 34 and 38, from Los Angeles, California and Raleigh, North Carolina).

Words and phrases like Choice/Choose (15), Freedom/sovereignty/control (6), and Decision(s) (19) appeared frequently across all the interviews, indicating that participants perceived autonomy and freedom of choice as important political issues but also where the frontlines of the war on women was taking place.

While our interview schedule did not include any questions about abortion or any other reproductive health topics, it is clear from the data that abortion was on the top of many participants' minds and referenced across all 27 interviews. One participant said this about abortion:

> First of all, the uh debate, the pro-life debate, is really about the health care decision that's private between a woman and a doctor. And women don't undertake that decision lightly. We need to find ways to work together to make abortion safe and rare (33-year-old white male from St. Petersburg, Florida).

A participant who was holding a sign opposing abortion and passing out literature said this when asked what health issue he thought was most important for the next president to address:

> I think abortion should be outlawed. But I don't consider that a women's health issue, because when you kill a baby, that's not healthcare, okay.
>
> Interviewer: Okay, so what is that? The participant continues:
>
> It's genocide (white male, declined to report any demographic information).

One participant made specific reference to Republican Representative Todd Akin of Missouri, who, prior to the Parties' conventions, commented publically that if a woman is "legitimately" raped, she could "shut down" a pregnancy (Eligon & Schwirtz, 2012):

> Well, that one guy [Rep. Todd Akin] said a thing that got blown out of the square because he said the wrong thing about rapes and abortions and hurt a lot of people, opened his mouth at the wrong time (laughter) (85-year-old white male from Thomasville, North Carolina).

Another participant referenced abortion, focusing on recent mandates in states like Virginia requiring women to undergo a transvaginal ultrasound prior to an abortion even when not medically necessary:

> When I hear them talking about abortion, and so on, it drives me crazy because none of them know what it is like to even have a period (laughter). I mean it's ridiculous—all these men—but no, I certainly hope that they are going to . . . do more to help women and you know this business of us having to have what's it called? What is this thing they want us all to have? Ultrasound?

> Interviewer: Yes, the ultrasound. The participant continues:
>
> I just think, enough of doctors who really don't understand what women go through . . . (82-year-old white female from Philadelphia, Pennsylvania).

The participant referenced above points out the irony of predominately male legislators and doctors making decisions about women's health issues when they have no embodied experience to draw upon. Feminist writers and female members of congress made similar observations about men making reproductive health decisions on behalf of women (e.g., the all-male panel convened to discuss the Affordable Care Act's birth control mandate). It is important to acknowledge, however, that there are female politicians who support such legislation. In fact, a woman in the Virginia legislature introduced the bill requiring the transvaginal ultrasound referenced by the participant above (Eckholm & Severson, 2012). Other participants made similar statements about women being better authorities over their health needs than men. An African American female from Greenville, South Carolina said, "[T]here's a certain sensitivity about health issues with women that men are not reflecting in this election. They are very insensitive."

While the lived experience of being biologically a woman may present certain limitations to understanding health matters, such as a menstrual cycle, being pregnant, or having an abortion, there is a larger argument against mandating transvaginal ultrasounds that has less to do with biological sex or gender and more to do with the site of political power and decision making, which is currently majority male and conservative. In other words, more important than embodied experience is perhaps the issue of who has agency over a women's right to choose an abortion, for example, and what that procedure entails. The following two participants illuminate this issue. One participant put it this way, "Abortion is a medical procedure, and as such it should remain in the realm of the rule of doctor-patient confidentiality, so it really is no one else's business . . ." (43-year-old white female from Charlotte, NC). A 34-year-old white female participant from Los Angeles, California said, "[I]f you are valued as an equal human being you wouldn't be treated as property, people wouldn't be making decisions for you, forcing you to do ultrasounds before you go through with an abortion and so on and so forth."

Abortion and challenges to women's right to choose an abortion may energize some voters and activists (see, Luna, 2010; Seltzer, Newman, & Leighton, 1997), yet our participants noted that prevention and preventative care, our fourth and final theme, was a concern as well. Participants' references to prevention were broadly conceived and did not relate exclusively to preventing cancer but centered on women's ability to receive screenings at little or no cost because of the ACA. An interviewee said,

> I just found out a couple of weeks ago that I'm going to be able to get a mammogram for free now and this is really important and I would really like the American people to understand how prevention can cost so much less (59-year-old white female from New Mexico).
>
> Another attendee reported: Preventive things, screenings, umm [for] different types of cancers and things like that. I think people don't think about it 'til it happens to them or somebody they know. I think we gotta be more proactive (34-year-old African American female from Greenville, South Carolina).

The four themes—cancer, equality, abortion, and prevention—point to several topics that received a great deal of media coverage in the months leading up to the election, but they also reference issues that appeared in the Democratic Party's platform, which sought to highlight President Obama's accomplishments during his first term. Moreover, these themes as a whole recognize that women's health cannot and should not focus only on abortion but should consider the comprehensive health needs of women. In the discussion section, we elaborate on the significance of the categories and themes for women's health and electoral politics.

DISCUSSION

The four themes, and the 10 categories from which they surface, are generally consistent with the President's and Democratic Party's messaging during this election cycle, which included equal pay for women, access to health care, and the right to choose, not just whether or not to have an abortion, but how to control contraception and healthcare decisions overall (see Organizing for Action, 2013). Without additional interpretation of the results, it is easy to view the majority of participants' perceptions as blindly following the Party's agenda. We will take each theme in turn, exploring first the theme of cancer and cancer research.

There is no doubt that Pink Ribbon campaigns and breast cancer walks are powerful symbols of the collective efforts to find a cure for breast cancer, while ensuring that women have easy affordable access to the screenings believed to keep mortality rates low (see King, 2008 for critiques of commercialization of Pink Ribbon campaigns). The focus on cancer, however, as one of the most important health issues for the next president shows that our participants are perhaps not fully informed about some of the realities of women's health. While the margin is narrow, according to the Centers for Disease Control and Prevention (CDC, 2013), more women die of heart disease than all cancers combined. Only one participant mentioned heart disease across all of the interviews. It is possible participants were recalling the

Susan G. Komen Foundation's decision to defund Planned Parenthood when considering what women's health issue the next president should address (Wallis, 2012). With the DNC taking place in September and Breast Cancer Awareness Month just a few weeks away in October, it is possible breast cancer was at the top of participants' minds. The Komen Foundation's persistent efforts over the last three decades may have successfully convinced the public that breast cancer is, in fact, the most pressing women's health issue and, therefore, worthy of all our attention, including the attention of the President of the United States.

Participants' thoughts about equality and access, the second theme, centered on viewing women as whole, autonomous individuals capable of making their own decisions about their bodies and their health. A perspective that is synonymous with what Dubriwny (2012) calls self-determination, the second theme of the women's health movement, which includes a women's right to control her body and make choices about health care. The majority of participants, including men, expressed frustrations with politicians who espoused limited government while attempting to control women's choices. One participant captured this feeling of hypocrisy when she said:

> My problem with Republicans is that they are all about [wanting the] government to get out of the way, they want the right to do whatever they want to do, all government, except when it comes to women making their own choices for their own healthcare. And you noticed that when Viagra hit the market, right, the Catholic church—as the lapsed Catholic that I am—would, under their health insurance, cover Viagra, but you ask them to cover diaphragm, pill, 'Oh no sorry we can't do that . . .' (43-year-old white female from Charlotte, North Carolina).

Several other participants remarked that men were the least equipped to comment on women's health issues and, therefore, a woman and her healthcare provider should make those decisions. The belief that men were less than capable of making health decisions about women and their bodies was widely felt, but it was not just a matter of female anatomy but a lack of understanding biology. As one participant observed: "Umm, the other side [GOP] doesn't believe we should have any control or say over our body, they do not understand basic biology" (59-year-old white female from New Mexico).

While some participants made clear that Republican politicians were the problem, others did not draw such a distinction and appear to perceive all men, or all conservative men, as a monolithic group working to undermine women's rights. As noted in the results section, embodied experience is of course not a prerequisite to believe that women should have autonomy over their bodies or their reproductive choices. Perhaps these perceptions, as

fallacious as some of them may be, are arguing that women's voices should at least be equal, if not dominate, in conversations about these topics.

The power of a woman's uterus and who controlled it was a major topic during the election cycle. Nearly all participants raised abortion rights (third theme) as a major issue, yet they also commented that a myopic focus on abortion as the most pressing women's health issue in the sphere of politics and governing took attention away from other illnesses and preventative care necessary for women to stay healthy and maintain control over their bodies. This mirrors Luna's (2010) description of the historical emphasis in the women's movement on reproduction and choice over other inequalities, issues relevant to women of color, or social justice. The same participant cited above added, "Our president understands women's needs and recognizes that women's health is foundational to the country." Another interviewee, when asked what she liked about how women's issues were being discussed in this election, said:

> They [speakers during the convention] have been focusing more on it [women's health] as a family issue, and an economic issue. And that it's—men are saying that it is their issue because they are sons and they are fathers. You know men [are] realizing that women, if women are in their lives, it's their issue too (43-year-old white female from Charlotte, North Carolina).

The participant quoted above and her interview partners (triad interview) expressed skepticism, agreeing that it is risky to accept the focus on women's health at face value. Both parties co-opted women's issues and women's health for political purposes. The vast majority of lawmakers are men, and whether Democrat or Republican, many are creating laws that directly impact women without their consultation or input.

As noted in the results section, abortion and reproductive rights, such as access to affordable or free birth control, appeared throughout the data. Many participants were unhappy that issues they believed were settled long ago were being contested again. One participant said, "I mean the fact, a part of me, a lot of me says the fact that we have to discuss some of these issues now when we had thought that they had been decided is a bit odd" (57-year-old, Asian American male, Sacramento, California).

Two participants from different parts of the country expressed similar concerns about having to continue a long fight to keep rights already won. "No, it's not something new, they are harboring [sic] on it more and umm women's rights now, which is okay, but we have been fighting for a lot of rights for a long time, still a lot of discrimination" (34-year-old African American woman from Rock Hill, South Carolina). Another participant said, "I've been fighting for women's health rights for 45 years or so and it's an abomination

we are fighting over and over again and I am so pleased that we have the possibility; Obamacare moves us forward" (59-year-old white female from New Mexico).

The following participant discussed concerns that some individuals might take for granted women's rights and the need to, not only protect these rights, but to educate future generations about the women's rights movement:

> I'm frustrated with young women, they think that it's always been this way and it's never going to change. I keep telling people that are my mom's age, you gotta keep telling the story so people will realize how far we have come (43-year-old African American female from Charlotte, NC).

It is clear from these participants' responses that the current political discourse is troubling and eerily familiar. While the 2012 election re-ignited discourse about a war on women, this battle is not new (see also, Valenti, 2012a). In fact, in 1991, an article appeared in *Newsweek* focusing on the status of the women's movement and journalist Susan Faludi's then recently released book about anti-feminist backlash (Shapiro et al., 1991). While the historical context was different, a look back via the *Newsweek* article suggests the war on women is likely an extension of the anti-feminist response identified in the '80s. The increased efforts, especially at the state level between 2010–2012, to undermine abortion rights is one such example of an ongoing chipping away at Roe v. Wade. Put differently, the debate about abortion did not end after the Supreme Court ruled on Roe v. Wade. In fact, this decision may have cemented a woman's right to choose while ensuring that conservative politicians and anti-choice groups would continue their efforts to undermine the law. By looking back, it is also clear that issues relevant in 1991—challenges to a woman's right to choose, access to birth control, equal pay, women's role in the state of the economy—were still relevant during the 2012 election. The data here cannot prove any causal relationship between an anti-feminist backlash and the war on women, but it does offer insight into participants' perception about the current state of women's rights, how the political parties frame those issues, and the political power of women who were perceived as losing ground. Perhaps the truth is the battle to maintain women's rights never ended. The following participant makes this observation, noting that equality for women remains an issue, speaking to the idea that the war on women is ongoing:

> I just don't like that it is still an issue . . . to still be fighting this and not fighting something else. [S]omebody said to me the other day, "Why is this still an issue? And why can't we just be talking about the economy?" This was a male that was saying this, he was saying, "Come on, let's just all get to equality so we can

> focus on other bigger issues." But if we can't even get this, we will never have equality with [sic] talking about the economy if we can't even have freedom in choosing what you are going to do for you (38-year-old white female from Raleigh, North Carolina).

This conversation between the participant and her friend points out a tension that has existed within the women's movement for decades. Until a range of inequalities are addressed (e.g., structural), all women cannot reap all of the benefits of the women's movement (Luna, 2010). Both the participant and her friend see the continual fight for equality as a barrier, but the participant concludes that gender equality is foundational to other political issues. Moreover, women will continue to strive for equality until it is achieved, and sometimes working towards equality means we cannot focus on other issues. So while the participant's friend sets up a hierarchy of issues, the participant sees gender rights as inextricably linked to other political and social issues.

The focus on reproductive health topics, yet again, was not perceived as positive. Instead of actually improving women's health, many felt as though they were fighting the war on women on two fronts. On one hand, participants felt they could not afford to ignore attacks intended to diminish the rights they fought hard to win (Kline, 2010). On the other hand, interviewees also felt it was important to continue making strides that would continue to improve access, ensure equal healthcare costs, and establish preventive care. The sense that a battle is taking place on multiple fronts is similar to some of the challenges faced by women's organizations, such as the National Organization for Women, as they try to be more inclusive and comprehensive in their mission while not losing ground on reproductive rights (Luna, 2010). Yet, this two-pronged battle made choices at the polls in November easy. As one participant observed:

> Well I think it's become a polarized issue in women's health that, you know, there's a clear divide now. Where instead of being kind of ambiguous, it's very much like a decision one way or another when you are voting (25-year-old white female from Wisconsin).

Respondents attacked the Republican Party, the party that espouses minimal government, for being hypocritical about what role government should play in personal decisions. Yet, participants volunteered that one solution is more women in public office rather than convincing the Republican Party to change. Shifting power from men to women was one solution, but until then, remaining diligent and protecting women's rights was an important course of action.

Perceptions about how women's issues were being debated in the public and political spheres illuminated a tension that both enabled and constrained women and women's health. No participants felt returning to old issues (e.g., abortion and contraception) was positive, but many also thought it was good to have women's health receiving any attention at all. Two quotes illustrate this point:

> I think it's important that it has been talked about. It's not something to be afraid to talk about. That has been the problem, most likely in the past, things like that should've been talked about more, but people who bring it up sometimes are accused of starting high-class warfare, gender warfare, and it's not bad to discuss, openly, publicly (69-year-old white male from Texas).

Another participant said:

> I do think it's important it [women's health] is being discussed, so the fact that it is even in existence is positive and I think that, um, the fact that you're getting people, you know, concerned for, the people who are like, students or who are like, not elected officials speaking and communicating with elected officials, the people that have media influence is great (25-year-old white female from Wisconsin).

While some participants believed talk about women's health issues in the public and political spheres gave these topics legitimacy, still others believed there was a need for continued dialogue. Participants agreed talk about women's health was important and positive. And there was widespread agreement that a war on women existed, but it is not clear from our data why these attacks were happening now. The role of communication technology, although never referenced by participants, could explain how these opinions were so widely held across generations, geographies, and genders. As Valenti (2012a) observed:

> Perhaps today, with the Internet moving information faster than ever before, Republican and conservative sexism doesn't go as easily unnoticed (just ask the folks at Komen). Perhaps the influx of young women and feminists into self-directed and social media activism has changed the course of the national debate. Or maybe women are just fed up with yet another legislator dictating how they should run their lives and use their bodies. (para. 9)

The data presented here does not make clear if there is a direct relationship between the use of new media technologies and feminisms, but others have noted the implications of public discourse about women's health (Dubriwny, 2012) and the consequences of media representations and third wave feminism

(Shugart, Egley Waggoner, & O'Brien Hallstein, 2001; see also Schuster, 2013). Both of these topics are worthy of more study because to summarize Dubriwny (2012), contemporary public discourse about women's health is easily aligned with a postfeminist logic, which implies feminism is no longer necessary, especially in light of the gains made during the 1960s and 1970s.

The data from interviews with individuals in attendance at the 2012 Democratic National Convention creates a complex picture of these likely voters' perceptions of communication about women's health during the presidential election. While frustrated with the attacks on women's rights and women's health, they saw opportunities in these assaults. With increased communication about issues relevant to women came a chance for more progress. Women are both vulnerable and empowered during an election season (Dubriwny, 2012).

Some participants felt the Democratic Party could move the political conversation about women's health forward by framing the discussion rather than always reacting to the Republican stance. Participants (and voters), however, could do the same. While media and political campaigns are highly influential, citizens, especially in the age of new technology, have the ability to shape the conversation as well. This echoes notions of third wave feminism in which empowerment takes place through technology, especially social media (Schuster, 2013). If the ability to control contraception is good for the health of a woman, then it is worth asserting this claim consistently rather than waiting for the opposition to undermine this position first. Democrats, then, should make more persuasive and widespread claims that legal abortion, for example, is a women's health issue, a medical procedure that occurs in consultation with and under the care of a physician. Voters need to do the same. The dichotomy of "pro-life" vs. "pro-choice" language that regularly appears in political discourse is limiting and not particularly sophisticated and, therefore, deserves reframing. Boston Globe journalist Roland Merullo (2013) captures the need for more nuanced conversation surrounding abortion well:

> It seems to me that if "pro-life" Americans truly believe abortion is murder, then, [. . .]the wisest use of their energies would be to work tirelessly to reduce the number of abortions[. . .] On the other side of the aisle, it's time for "pro-choice" people to speak out loudly—as some have—and say, "We are not pro-abortion!" (para. 2)

An excerpt from the October 11, 2012 vice presidential debate is also helpful for understanding how politicians might approach women's reproductive choice by separating policy from personal beliefs. Democratic Vice Presidential candidate and current Vice President Joe Biden argued:

> My religion defines who I am. And I've been a practicing Catholic my whole life. And it has particularly informed my social doctrine. Catholic social doctrine talks about taking care of those who—who can't take care of themselves, people who need help. With regard to abortion, I accept my church's position on abortion as a—what we call de fide doctrine. Life begins at conception. That's the Church's judgment. I accept it in my personal life. But I refuse to impose it on equally devout Christians and Muslims and Jews and—I just refuse to impose that on others, unlike my friend here, the congressman (Prager, 2012, para 2–5).

This call for more meaningful dialogue is not just about abortion but about women's health more broadly. To talk about abortion is to also talk about how we teach sex education, whether we make contraception (for women and men) affordable and accessible, both of which are more likely to limit the need for an abortion in the first place (Merullo, 2013). But a focus on controlling and delaying reproduction is only part of the story (laden with middle class values and expectations). We must also have a discussion about how to better support women who choose to have children through income equality, family leave policies, and better, more affordable childcare. Women who opt to not have children, whether abortion is involved or not, should also receive the same respect and support for their choices. Women's health is not reserved only for a special class of women of childbearing age who have the ability and means to control reproduction but for all women at all stages of life.

As communication scholars, we understand language is important and how the debate about women's health is framed can determine who wins at the ballot box and shapes legislative agendas. In 2010, National Public Radio said it would no longer use "pro-choice" or "pro-life" and instead use "people who support abortion" and "people who oppose abortion" (Shepard, 2010). We believe changes in the media have the ability to change the culture and the way people think and behave. The fact that a participant evoked a phrase used by Bill Clinton more than 20 years ago during his first presidential campaign, about keeping abortion "safe, legal, and rare," illustrates that the phrases and the rhetoric used in presidential campaigns can have a lasting impact. Although Clinton was given credit for a statement that may have been progressive for a male politician at the time, the women's movement has been arguing for legal, rare, and safe abortions well before 1992 in response to increasingly aggressive anti-abortion tactics in the 1980s (Weitz, 2010).

Much like the use of the war metaphor in cancer care, the war on women enlists women in a battle against the self and against other women, whose bodies are frequently the symbolic and actual sites of these conflicts. While this metaphor may serve to inspire some to continue to fight or enlist, we should not accept it uncritically as the only way to make sense of women's issues and women's health. In the case of this war on women, we should

recognize how the war metaphor limits the ways individuals can talk about women's health issues. In war, there are always casualties, winners and losers. War metaphors reflect both the "nature of fighting and its role in our lives" (Rossman, 2003, p. 6) as well as the way our society, in this case, treats women. According to Garrison (2007), "military metaphors reveal deeply embedded cultural values regarding body-as-property, obedience and justified violence" (n.p.). We claim that war metaphors may motivate some, but they may obscure political and organizational efforts. Indeed, individuals who do not connect with war metaphors may feel their concerns are not valid. For example, the struggles of trans* individuals and individuals of color who experience multiple levels of oppression may not receive the same consideration in this war on women (Luther, 2012). Borrowing again from Garrison (2007), if we insist on framing women's health as a war, we would need to take into consideration the "historical, cultural, and social conditions giving rise to this metaphor," such as actual military conflicts, violence, casualties, the 9/11 attacks, and hegemonic/patriarchal forms of masculinity, and in contrast, femininity (n.p.). We are calling for metaphors that encourage more expansive images of women and women's health that includes lesbians, bi-sexual, and transgender women. In fact, issues relevant to these women are largely invisible (including among participants in this study) and draw upon narrow and heteronormative definitions of femininity and masculinity—another reason the heavy reliance on reproductive health, for example, is problematic.

CONCLUSION

The interviews presented here tell a particular story of women's health during the 2012 presidential campaign. The Obama campaign made a point during the 2012 election season to highlight all of the president's efforts since he took office in 2009 to improve upon or advance women's rights. Obama had a double-digit advantage among women voters in 2008 and 2012 (Jones, 2012). Therefore, perhaps it makes political sense that the Republican Party would try to downplay or refute any existence of a war on women. Yet, Obama's lead in 2012 was one of the biggest in history; combined with hard fought gains of the women's movement, the perceived war on women may actually signal unprecedented political power.

Many participants, all likely voters, felt as though several politicians were actively working to undermine the hard fought rights of women while also preventing any progress. Not only does such a move compromise women's health but keeps women socially, economically, and politically weak. There was also a sense among participants, however, that there were reasons to feel

optimistic and empowered. Obama was viewed as a candidate for women and in the minds of many participants, this was more than a sentiment as Obama had already made strides to ensure women's respect and equality; the Affordable Care Act was an example of this promise. Women, however, could not be spectators; they would need to do more to even the playing field and that included running for and winning public office to better represent the voices and experiences of half of the population.

As health communication scholars, we take into consideration assumptions about health, illness, and disease, all of which converge to influence health behaviors. The perceptions of individuals interviewed can help focus health activism as a means of raising awareness among policymakers and the general public about women's health concerns (Zoller, 2005). In support of Zoller's (2005) call, we close this chapter with the suggestion that future work explore health activism that challenges inequitable conditions and dominant agendas, such as an overemphasis on breast cancer to the detriment of other health concerns, such as heart disease, osteoporosis, depression, and autoimmune diseases, and pushing back against structures that create and sustain inequitable conditions for all women and men (both trans* and cis) during times of political change for their transformative opportunities. We encourage others interested in exploring the role of health activism to challenge the unjust structures of health and bring about changes in healthcare policies (both in the U.S. and globally). Such activism creates openings for marginal identities and diverse voices in mainstream society. It is our hope that this analysis is one step in achieving transformative politics and improving the ways in which healthcare policies are discursively constructed, executed, and disseminated.