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**THE EMPOWERMENT OF WOMEN IN REPRODUCTIVE SERVICES:
A POSTSTRUCTURAL FEMINIST CASE STUDY OF
TWO WOMEN'S HEALTH CENTERS**

A Thesis in

Human Development and Family Studies

by

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ABSTRACT

The purpose of this study was to investigate the legacy of the Women's Health Movement (WHM) in the 21st century, especially in relation to the concept of empowerment of women in the reproductive arena. An important line of research evaluating the legacy or impact of the WHM on women's (reproductive) health care involves the study of women-controlled (or feminist) health centers. Except for Simonds (1996) and Thomas (2000), the studies that assessed the WHM's legacy through feminist health centers had their primary focus on the changes in organizational structures as a result of external and internal pressures. Such accounts include discussions of feminist *care*; however the changes in care (or models of care) are not as systematically discussed as the changes in organizational structure. Furthermore, except for Thomas' (2000) study, the concept of empowerment itself is not opened up. Including Thomas' work (2000), when empowerment (or empowering care) is evaluated, it is done so from the perspectives of women's health activists and workers, not the individual women who receive the services. In order to address these needs, in the present research, I investigated the legacy of the WHM in the 21st century through studying two women-controlled agencies with a focus on how women clients define and experience empowerment and how their experiences are affected by agency (organizational), community, and societal factors. The specific research questions that guided the study were: (1) What is the current meaning and experience of empowerment for women clients of reproductive services? (2) What are the agency and societal factors that mediate women's experience of empowerment? (3) How do the two agencies differ in enabling empowerment?

In order to address the previous questions, I visited two women's health centers in the Northeast region of the United States, staying two weeks at each site. The data collected from both sites consisted of: (a) semi-structured face to face interviews with staff and clients (clients of birth control and abortion services), (b) observations of pre-abortion counseling sessions, and

gynecological visits, (c) field notes on staff-staff and staff-client interactions, on protesters, spatial arrangement of the centers, and conversations with staff, and (d) a review of agency forms and archival materials. The design of the study was a feminist case study with ethnographical components and poststructural influences. Feminism guided all the stages whereas post-structuralism guided mainly the data collection and analysis. The feminist and poststructural framework essentially led to rejecting objectivity and neutrality, and emphasizing instead personally and politically engaged, accountable research, where I claim to present only a partial (historically and temporally situated) truth about empowerment in reproductive health in two clinics.

I used the Grounded Theory Approach to qualitative analysis to analyze the data (with the help of the NUDIST software to organize the data). The theory reached was that the current generation of women experience (and define) empowerment as safe and humane care, where care is mediated by agency and community factors and by the politics of reproduction. For women receiving birth control and abortion care, safety and respectful humane care was at the core of empowerment. Safety had both physical and emotional dimensions: being safe from anti-abortion violence, and not feeling vulnerable, judged or cajoled. Humane treatment meant receiving dignified, egalitarian, individualized, and holistic care. Women's experience of empowerment (seeking safe and humane care) was affected by community, agency, and societal factors. Agency factors were the agency atmosphere (security measures and homey atmosphere), staff characteristics (age, gender, race, and childbearing status), staff beliefs and motivations, the medicalization and psychologizing of services, and the business aspects. Community factors referred mainly to the interactions between the agency and community (people, schools, churches, other providers, feminist organizations, hospitals and individual doctors) that occurred in an anti-choice climate, and reflected the isolation and integration of the centers in their respective communities. Social factors referred to the norms and institutions that influence

reproductive services, which I called the “politics of reproduction.” The findings were discussed in the light of the definitions of empowerment, empowerment models, and within the history of the Women’s Health Movement (its aims, accomplishments, and challenges).

This study contributes to revitalizing the awareness (in public and academic scholarship) of the contributions of the WHM to women's health care. The present study also provides a more current evaluation of the WHM, its present challenges and the strategies applied by women-controlled centers in navigating these challenges, contributing to the growing research on social movements and movement organizations. Although not a full ethnography (due mainly to the limited time spent at the sites), the present study is a case study with ethnographical components taking its place alongside of Simonds and Morgen's feminist ethnographies with in-depth, multimethod and multilevel investigation of empowering care. Finally, as different from Morgen's and Simonds' ethnographies, the present study is the first feminist ethnographical research of clinics from a post-structural framework.

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CHAPTER 1

INTRODUCTION

*I came back to research on the women's health movement in the early 1990s when I saw how little attention was being paid to the role of grassroots activities in the dramatic changes in women's health care over the two previous decades. I noticed (how could I not?) that the heroic and innovative campaigns against AIDS and breast cancer were presented as if they were spontaneous and unprecedented, as if they had no connection with and owed none of their successes to the women's health movement. I heard countless debates about the health care reform that rarely, and then barely, mentioned the work of activists from the women's and community's health and civil right movements, who had fought for change for many years. I drove past office buildings that advertised women's health care, but the names on all signs had M.D. after them. I saw bookstore shelves literally overflowing with books about women's health, books that themselves provided evidence of enormous changes in the amount and kind of information available to women about our bodies, and that often failed to acknowledge the role of women's health movement as catalyst to that flood of information. I have taught scores of courses on women's health, political activism, and feminist theory to bright, energetic students of women's studies, anthropology, and sociology over the years. They may have heard of, and some may have read, *Our Bodies Ourselves*. Otherwise they know very little about the women's health movement, even though many consider themselves feminists.*

Morgen, 2002, p. xi

The college women I interviewed seemed largely unaware of the [women's health] movement and its basic premises. At the end of each of my interviews when I asked the women if they had any questions for me, many wanted to know exactly what I was researching. When I noted my interest in the women's health movement and briefly explained some of its values and goals, many of my interviewees became enthusiastically interested, as people often do when hearing an idea for the first time and realizing that it makes a lot of sense in terms of who they are and how they experience things.

Griffith, 1997, p. 407

Purpose and significance of the study

I was not born in this country (the United States) where the Women's Health Movement took place. However, in all my years living in the U.S., I did not learn about the history and accomplishments of the Women's Health Movement until I took a course (with my co-chair

Phyllis Mansfield) in women's studies on reproductive issues. Throughout this research, my friends, colleagues, and the clients of the two agencies I visited asked me (just like they asked Griffith) "what exactly I was studying." Many had not heard of the Women's Health Movement either. A few weeks ago, I listened to a doctor on a public radio show who started a doctors' movement to fight pharmaceutical companies in propagating information about drugs and drug-related research. Talking about the mistrust of drug companies and doctors who prescribe the drugs without reading the research, and patients who comply with their doctors unquestioningly, he did not mention once the Women's Health Movement's critique of capitalist medicine or its accomplishments in increasing safety of contraceptive drugs and devices. These confirm Morgen's and Griffith's observations, that despite the fact that it provided one of the first radical and comprehensive critiques of Western medicine and led to major changes in women's health care, today little is known about and attributed to the Women's Health Movement.

Considered a "megamovement" (Weisman, 1998) dating back to the popular health movement of the 1830s and 1840s (Zimmerman & Hill, 2000), the Women's Health Movement was launched in the United States in the late 1960s and early 1970s as a grassroots organization of women for abortion rights, reproductive freedom, and dignified and affordable care (Morgen, 1995). Working individually (as individual activists) or in national organizations, local women clinics and self-help groups, the Women's Health Movement advocates formulated an extensive critique of women's health care in the areas of doctor-patient relationship, contraceptive safety and access, sterilization uses and abuses, medicalization of childbirth, and excessive and unnecessary use of gynecological and breast surgery (Gordon, 1990; Ruzek, 1978). This critique of women's health care was embedded in a larger critique of medicine. Feminists found that the problems they detected were due to the larger social and historical forces such as the medicalization of normal female reproductive events, the ascendance of males in (and systematic exclusion of females from) medicine and gynecology, the biomedical model of health,

androcentric bias in medical education and medical research, and the growing relationship between capitalism, medicine, and patriarchy.

In the 1800s, women in the U.S. functioned autonomously as midwives and general healers. With the enactment of medical licensing laws in the nineteenth and early twentieth century that established the trained doctors as the only legal practitioners of medicine and medical schools (which excluded women) as the only places to obtain this training, medicine became a scientific and elite profession that excluded females from practicing (as lay healers) and learning the new scientific medicine (Ehrenreich and English, 1972). Women's exclusion from scientific medicine was further reinforced in the 19th century by the emergence of an industrial economy whose patriarchal ideology of separate spheres (separation of home and economic production) relegated women to the home (Cott, 1977; Morantz-Sanchez, 1985; Weltner, 1983).

The ascendance of scientific medicine, especially in the 20th century, led to the "medicalization" of daily life, where labels such as "healthy" and "ill" were made relevant to an ever increasing part of human existence (Zola, 1978). Modern medicine also adopted a "biomedical model" of health and health care, with a primary (and narrow) focus on disease and pathology, which ignored the social contexts of health and illness, and privileged intervention over prevention (Lorber, 1997; Zimmerman & Hill, 2000). Women's Health Movement advocates drew attention to the role of gender in their critique of medicalization and the biomedical model of health. They pointed out that although many of the women's contacts with the health care system occurred when they are "well" rather than "sick" (when they are pregnant, seeking contraception or giving birth, etc), due to increased medicalization of these normal life events and the pathologizing view of medicine, women's health care was organized around assumptions of acute illness. In such a system, healthy women were assigned the "sick" role and the physicians were assigned the role of the "expert" whose authority -to make decisions for women- was justified and who acted in the best interest of the patient (Ruzek, 1978). Feminists

further criticized the biomedical approach for its ignorance of the social contexts of women's health and illness -how health is connected to the unequal distribution of resources based on gender (as well as race/ethnicity and class). They offered instead a sociomedical model of health (Zimmerman & Hill, 2000).

Women's Health Movement (WHM) advocates also criticized medicine for its androcentric (male centric) bias in medical research and education. The androcentric bias in medicine in particular affects scientific inquiry in the (1) choice and definitions of problems for study, (2) the exclusion of females as experimental subjects, (3) bias in the methodology to collect and interpret data, and (4) bias in theories and conclusions drawn from data (Rosser, 1994).

Women health advocates realized that gaining self-determination in the health care system was problematic, because American medicine is not only patriarchal but capitalistic as well (Ruzek, 1978). Feminist health activists showed that the American health care industry is an exploitative business, where women are exploited both as users of services and workers in the services. Women's Health Movement advocates criticized this gendered division of labor, where women faced systematic opposition in their efforts to become physicians. Even when they did become physicians, women were clustered in low-paying, low-status positions.

The main aim of the WHM underlying the critique of medicine (and related critique of women's health care) was to *empower* women in the areas of reproduction and sexuality. This coincided with the empowerment of women as consumers of health services in general and reproductive services in particular. Empowerment is a construct found in numerous fields of study including education, psychology, sociology, anthropology, feminist research, theology, nursing, public health, prevention, and social work/human services (Robertson & Minkler, 1994; Shields, 1995). Despite its status as an important concept emerging in various fields, empowerment is a multi-faceted, elusive phenomenon that is hard to define. Freire (1970) states

that it is usually the absence of empowerment in people's lives that is most readily recognized. In her study of the ways in which feminist women's health centers translate an ideology of empowerment into health care, Thomas (2000) also has difficulty defining "empowerment." She confesses "while I felt I would somehow "know" empowerment if I saw it in the data, defining and operationalizing the concept proved somewhat difficult" (p. 143).

The purpose of this study is to investigate the legacy of the Women's Health Movement in the 21st century, especially in relation to the concept of empowerment of women in the reproductive arena. An important line of research evaluating the legacy or impact of the WHM on women's (reproductive) health care involves the study of women-controlled (or feminist) health centers (Morgen, 2002; Simonds, 1996; Simmons, Kay, and Regan, 1984; Thomas, 1999, 2000). Ferree and Martin (1995) define feminist organizations as "the places in which and through which the work of the women's movement is done" (p. 13). In the same vein, established on the eve of or immediately after *Roe v. Wade*, feminist health centers were the "vanguard organizations" that translated the principles of the Women's Health Movement into practice (Morgen, 2002).

Except for Simonds (1996) and Thomas (2000), the studies that assessed the WHM's legacy through feminist health centers had their primary focus on the changes in organizational structures (e.g. division of labor, decision making, funding) as a result of external and internal pressures. Such accounts include discussions of feminist *care*; however the changes in care (or models of care) are not as systematically discussed as the changes in organizational structure. Discussions of feminist care comprise empowerment strategies, but except for Thomas (2000), the concept of empowerment itself is not opened up (as Thomas quotes above, how do we "know" empowerment when we see it). Including Thomas' work (2000), when empowerment (or empowering care) is evaluated, it is done so from the perspectives of women's health activists and workers, not the individual women who receive the services. In order to address these needs, the present research investigates the legacy of the WHM in the 21st century through studying two

women-controlled agencies with a focus on how women clients define and experience empowerment and how their experiences are affected by agency (organizational) and societal factors.

The specific research questions that guided the study are:

- (1) What is the current meaning and experience of empowerment for women clients of reproductive services?
- (2) What are the agency and societal factors that mediate women's experience of empowerment?
- (3) How do the two agencies differ in enabling empowerment?

This study contributes to increasing the awareness (in public and academic scholarship) on the contributions of the WHM to women's health care, an awareness that, as the beginning of this chapter shows, seems to be fading. The evaluations of the WHM's legacy through the work of clinics cover the historical period up to the early 1990s. In addition to remembering the contributions of the WHM, the present study also aims to provide a more current evaluation of the WHM, its present challenges and the strategies applied by women-controlled centers in navigating these challenges. In this vein, the study contributes to the growing research (as mentioned above) on social movements (women's movement) and movement organizations (women-controlled organizations) (Ferree and Martin, 1995; Morgen, 2002; Ruzek, 1978; Simonds, 1996; Simmons, Kay, and Regan, 1984; Thomas, 1999, 2000).

Within the research on movement organizations, only Simonds and Morgen (her work between 1977 and 1979 in a feminist clinic) conducted ethnographical research, which provided an in-depth view of feminist work (and care) and contributed methodologically to feminist ethnographical research. Although not a full ethnography (due mainly to the limited time spent at the sites), the present study is a case study with ethnographical components taking its place

alongside of Simonds and Morgen's feminist ethnographies with in-depth, multimethod and multilevel investigation of empowering care obtained through staff and client interviews; observations of staff interactions, space, gynecological exams, counseling sessions, and abortion procedures; and review of agency materials (such as newspaper clippings, meeting notes, brochures, forms, newsletters, etc.). As different from Morgen's and Simonds' ethnographies, the present study is the first feminist ethnographical research of clinics with a post-structural framework. The post-structural theory guided the study through data collection and analysis stages. While experimental forms of writing were applied in the results section (such as dramatization and poem), the main style of the results and discussion sections is still very traditional or positivist with the writer's authority left unchallenged. In the following section, I discuss the conceptual framework of the study that will shed light on the meanings of feminist and post-structural methodologies.

Conceptual framework

Feminist epistemologies (feminist ways of knowing)

The central piece of the feminist critique of traditional social sciences is the notion of objectivity and its related dichotomies. Feminist epistemology has revealed that in a desire to imitate natural sciences, social sciences negate the self and subjectivity in research, and present knowledge as something "discovered" by neutral -value free- means, or as knowledge that exists apart from those who construct it (Pritchard Hughes, 1995). Feminists have challenged this notion of objectivity or the "Enlightenment idea of an Archimedean point where a universal knower can stand and see the world without perspective" (Lennon & Whitford, 1994, p. 3). Except for feminist empiricists who work within the paradigm of objectivity, feminist epistemologists have argued that such a notion of objectivity is neither possible nor desirable

(undesirability being due to the intricate relationship between such knowledge claims and power). Objectivity is seen as impossible because all knowledge is socially constructed and bears the marks of its producers who are "spatio/temporally, historically/culturally/socially" situated (Lennon & Whitford, 1994). Objectivity is further seen as undesirable because in denying to acknowledge the subjectivity of researchers and of research (especially with its embedded sexist values), objectivity creates false dichotomies and defines as legitimate knowledge that which is associated with the 'masculine'. Dale Spender (1978) has argued that:

few, it appears, have questioned our polarisation of reason/emotion, objectivity/subjectivity, reality/phantasy, hard data/soft data, and examined them for links with our polarisation of male/female. Yet within the dogma of science it would seem that reason, objectivity, reality -and male- occupy high status positions (p. 4).

Spender (1978) states that these artificial divisions are the products of a sexist positivist science. She argues that feminists should challenge both objectivity and these dichotomies, and reject knowledge about females being 'tagged on to' existing sexist knowledge to create new criteria for what counts as "knowledge". Affected by feminist political consciousness and this desire to create new criteria for knowledge, feminist methods of knowing have challenged dichotomies between theory and praxis, researcher and researched, and stressed theory built from women's lived experience (Richardson, 1997), and research guided by feminist consciousness (Stanley and Wise, 1983).

Starting theorizing from women's experiences is most evident in the school of feminist thought called standpoint theories. Standpoint theories argue that, in societies stratified by any politics shaping the social structure, such as race, gender, class, and sexuality, starting off thought and research from the activities and perspectives of those at the bottom-end of these hierarchies provide less partial accounts and generate more critical questioning about the whole social order (Harding, 1993). Feminists who utilize this theory believe that starting off thought and research

from women's lives and experiences will "provide less partial and distorted accounts not only of women's lives, but also of men's lives and of the whole social order" (Harding, 1993, p. 56).

Postmodernism and poststructuralism

In contrast to feminism's "anchoring knowledge in the 'subjectivity of the oppressed'" (in this case in the female subjectivities) (Lennon & Whitford, 1994, p. 3), postmodern or poststructural theorists question the possibility of any authentic knowledge (Pritchard Hughes, 1995). Instead of conceiving of knowledge as dominant or subjugated, where subjugated ones can be released through 'education' of some kind (such as feminist consciousness), postmodernists and poststructuralists posit a model of an individual (subject) who is, at all times, embedded in and negotiates her way through multiple 'regimes of truth' (Foucault, 1972 as cited in Pritchard Hughes, 1995). As Richardson (1994) states:

The core of postmodernism is the *doubt* that any method or theory, discourse or genre, tradition or novelty, has a universal and general claim as the "right" or privileged form of authoritative knowledge. Postmodernism suspects all truth claims of masking and serving particular interests in local, cultural, and political struggles. (p. 517)

Postmodernism and poststructuralism argue that all methods of knowing and telling are partial accounts, and emphasize partial, local, and historical knowledge over the "God-trick" or universal, atemporal knowledge claims. A difference between postmodernism and poststructuralism is the emphasis the latter puts on language or discourse used in the social sciences. Poststructuralism links language, subjectivity, social organization, and power (Richardson, 1994) and brings out the recognition that all our interactions with reality are mediated by conceptual frameworks or discourses, which are also historically and socially situated (Lennon & Whitford, 1994). Thus, not only there is a questioning of any universal truth to be reached, but there is the further claim that any such attempt is mediated by language (where the discourse of the scholars itself should be scrutinized). Poststructuralists argue that language

does not neutrally "reflect" reality, but creates social reality. Within this social reality are subjectivities (our sense of selves) and social science (what we know and how we know). Poststructuralism points to "continual co-creation of self -subjectivities- and social science" where knowing about the "self" and knowing about the subject are "intertwined, partial, historical, local knowledges" (Richardson, 1997, p. 89).

With their critique of universal truth claims, and poststructuralists' analysis of language, postmodernists and poststructuralists bring out concerns over author(ity) in social science research and writing and direct us to reflect on how we, by the language/discourses we use in representing others in research, contribute to the reproduction of systems of domination. How do what we do and write reproduce or challenge power systems? For whom do we speak, with what voice, to what end? (Richardson, 1997). As Richardson (1994) states, these questions force social scientists to understand (and present) ourselves "reflexively as persons writing from particular positions at specific times" and deconstruct our own writings (p. 518).

Poststructural feminism

Poststructural feminists work toward/within a reconfigured social science, or as Lather (2000) states, a "less comfortable social science" which is "accountable to complexity" of research (p. 284-285). Poststructuralists share with feminists the critique of universal claims of androcentric humanist science. However, feminists refused to let go of 'quasi-metanarratives' (or grand theories) embedded in theories of ideology, macrostructures, interaction, hermeneutics, and even created some 'quasi-metanarratives' of their own (as in the works of Nancy Chodorow and Carol Gilligan) (Richardson, 1997). Postmodernism and poststructuralism brought to feminism the need to question *all* grand narratives, accepting all of their claims only as partial and historically situated truths. They further emphasized how feminist narratives essentialized the category of "woman" (universalized women's experience) and pointed to both the differences

among women and to a more dynamic notion of power as shifting rather than an immutable fact based on one's gender, race, etc. Poststructural feminists do not give up the critique and transforming of that which is oppressive to women, but speak of plurality and diversity as much as solidarity, "the kind of speaking that is required for overcoming the oppression of women in its endless variety and monotonous similarity" (Rubin, 1976 as cited in Richardson, 1997, p. 56).

Another important contribution of poststructuralism to feminism has been the questioning of the researcher's author(ity) in research (research and writing). Even though feminist researchers like Ann Oakley have questioned the power relations between the researcher and the subject in feminist research, feminists have not given up the impulse to "give voice" to those who have been silenced, to speak for others, especially through the writing of the research (Richardson, 1997). Poststructuralist critiques of authority have led feminists to question this impulse to give voice, to become more self-reflexive (recognizing and deconstructing their authority as researchers), and to work towards research as vulnerable and accountable researchers. Poststructural critiques also led to research texts that are multi-voiced, complex, reflect the messiness of research including different, at times contradictory voices. For example, in their ethnographic study on poor and working class people and social policies, Lois Weis and Michelle Fine (2000) discuss how, "following a poststructuralist emphasis on contradiction, heterogeneity, and multiplicity," they produced a "quilt of stories and a cacophony of voices speaking to each other in dispute, dissonance, support, dialogue, and contradiction" (p. 52). Weis and Fine state that once the participants' subjectivities are "considered and sought after *as if* multiple, varied, conflicting, and contradictory, then the 'data elicited' are self-consciously dependent upon the social locations of participants and the epistemological assumptions of the methods" (p. 52).

Viewing and (re)presenting the data in multi-voiced, contradictory, complex stories acknowledges and honors the (multiple) subjectivities of the research participants as bound by

time, place, gender, race, class, their life stage, and conscious and unconscious desires regarding the topic and the research situation (interview or observation) itself. Doing (and writing) messy research also involves acknowledgement of the researcher's subjectivities or writing ourselves back into research, with our vulnerabilities as well as accountabilities, our own conscious and unconscious desires and beliefs about the topic, feelings and thoughts during research (and how they change over time).

In traditional – positivist – ethnographies, as Ruth Behar (1993) states, "We ask for revelations from others, but we reveal little or nothing of ourselves; we make others vulnerable, but we ourselves remain invulnerable" (p. 273). The report then is written in a way where our informants are "left to carry the burden of representations, as we hide behind the alleged cloak of neutrality" (Weis and Fine, 2000, p. 34). Behar (1996), as other poststructural feminists do, insists on practicing an "anthropology that breaks the heart - one that requires that our own revelations and vulnerabilities be exposed just as we expose those of the women we come to know in our field sites" (as cited in Villenas, 2000, p. 76).

In removing the "cloak of neutrality" and situating the researcher back into the research process, Weis and Fine (2000) further discuss the importance of accountability. Accountability involves addressing our power and privilege as researchers, telling the good as well as the bad stories -or rough spots- in our research (that goes against our beliefs, expectations, and that could be used by right wing activists), and address (and be aware of) possible uses of our research to inform social policies, social movements, or daily community life.

The adoption of a feminist and poststructural framework in this study essentially means rejecting objectivity and neutrality, and emphasizing instead personally and politically engaged, accountable research, where I claim to present only a partial (historically and temporally situated) truth about empowerment in reproductive health in two clinics.

CHAPTER 2

LITERATURE REVIEW

PART ONE: THE WOMEN'S HEALTH MOVEMENT

The origins

According to Gordon (1990), the Women's Health Movement in the United States emerged in the late 1960s out of the "reproductive rights" stage of the birth control movement, and grew within the contexts of the women's liberation and community health movements in the 1960s and 70s. More recent analyses, such as Weisman's (1998), view the Women's Health Movement as a "megamovement" with multiple "waves" dating back to the popular health movement of the 1830s and 1840s (Zimmerman & Hill, 2000). Examining women's health activism in the 1830s, the late nineteenth century and the progressive era, the 1960s, the 1970s, and 1990s, Weisman (1998) suggests that "the recurring episodes of multi-issue women's health activism could be viewed as waves in a women's health 'megamovement' (p. 29). In each movement wave, Weisman (1998) states, "women's health and body concerns emerged into public discourse and evoked collective action by successive generations of activists intent on changing some aspect of women's health care or policy" (p. 29). Even though the origins can be traced to the 19th century, the rise of the Women's Health Movement is generally attributed to the mid- to late 1960s, when a broader and more extensive critique of medicine and women's health care was launched.

Gordon (1990) recounts the Boston Women's Health Book Collective, author of the famous *Our Bodies, Ourselves*, the National Women's Health Network (NWHN), and the National Black Women's Health Project (NBWHP) as "emblematic of the women's health

movement." Morgen (2002), in turn, lists the Boston Women's Health Book Collective, Jane organization, Carol Downer, Lorraine Rothman, the Los Angeles Feminist Women's Health Center, Barbara Seaman, and Belita Cowen as "conceiving" the history of the movement. As in both Gordon and Morgen's accounts, the most well known foundational story of the movement is the formation of the Boston's Women's Health Book Collective.

The origins of the Boston Women's Health Book Collective date back to the spring of 1969, to a women's liberation conference in Boston, where a group of women found themselves in a discussion group focused on "women and their bodies." Discovering that they all had frustrating and humiliating experiences with physicians and the health system, the women decided to learn more about their own bodies in order to be able to do something about the condescending, paternalistic, judgmental and noninformative behavior of the physicians (Ruzek, 1978). The following summer, these Boston women researched and wrote papers on anatomy, physiology, sexuality, venereal disease, birth control, abortion, pregnancy, childbirth, as well as on medical institutions and the health care system in the context of capitalist society. These papers were used in organizing health courses in day schools, nursery schools, churches, and women's homes. The mimeographed notes and papers were bound together into the first printed edition of the famous *Our Bodies, Ourselves* (Ruzek, 1978). The authors differentiated *Our Bodies, Ourselves* from other medical information by its goal of presenting information in a way that would empower or liberate the women (Morgen, 2002). In the past thirty years, multiple editions of *Our Bodies Ourselves*, sold in millions in the United States and globally (Morgen, 2002), making the book an important resource for women and health care providers alike.

Women's Health Movement's critique of health care

Problem areas

With the help of the movement organizations and individual activists listed by Morgen (2002) and Gordon (1990), and hundreds of local women clinics and self-help groups, the Women's Health Movement advocates formulated their critique of women's health care in the areas of doctor-patient relationship, contraceptive safety and access, sterilization uses and abuses, medicalization of childbirth, and excessive and unnecessary use of gynecological and breast surgery.

Feminist critiques of the doctor-patient relationship centered on (male) physicians' treatment of women as children or persons to be sheltered from unpleasant information and relieved of the responsibility of decision making. Besides being treated like children, health activists were also angered at how the physicians controlled information women needed to make competent decisions for themselves, talking to them in technical language, withholding information from them, and not providing any health education materials in the waiting rooms to help patients understand their bodies and communicate better with the doctor. In the examining room, women felt demeaned when addressing physicians as "Doctor X" and being called by their first names or by "honey" or "dear". Women also complained of how the structure of the exam - being draped, stripped, and lying on their back with feet in stirrups- made it difficult to see what was happening and to interact with the physician, ask him questions, etc. (Ruzek, 1978).

Women's basic complaints reflected their disagreements over the appropriate style of patient-physician interaction, the assertion of their right for full access to information, and the right to fully participate in decision making in health matters. Women's demand to participate in decision-making in health issues started with routine matters such as which contraceptive to use,

or which drugs or anesthesia to accept during childbirth, but then spread to issues regarding abortion, sterilization, and major surgery (especially breast surgery) (Ruzek, 1978).

In terms of contraceptive access and safety, Women's Health Movement advocates exposed the dangers of oral contraceptives (forcing on the transition to lower dosage pills and inclusion of inserts to explain possible side effects), the effects of DES (diethylstilbestrol) used to prevent miscarriage and tested as the "morning after pill", and deaths and infertility caused by IUDs (especially the Dalkon Shield) (Gordon, 1990; Ruzek, 1978). Feminist papers like *Her-Self*, *Off Our Backs*, *The Monthly Extract*, and *The Spokeswoman* publicized other potential problems "including the FDA approval of Depo-Provera as a contraceptive after only limited testing, dangerous levels of mercury discovered in Koromex contraceptive jelly, side effects of vaginal sprays, powerful prostagladins used as contraceptives, and carcinogenic properties of Flagyl (routinely prescribed for a common type of vaginal infection) and Tinidazole (a new rival to Flagyl)" (Ruzek, 1978, p. 42).

Within their critique of contraceptive access and safety, Women's Health Movement advocates also drew attention to the way disadvantaged women were used as guinea pigs in medical research. At the initial trial, the pill was given to unsuspecting Puerto Rican women, several of whom died of the high-dosage pills. Later in 1971, Joseph Goldzieher, a gynecologist at the Southwest Foundation for Research and Education in San Antonio, presented his research at a meeting, describing a double-blind study he conducted on the effects of the pill (headache, nervousness, nausea, vomiting, depression, and breast tenderness) on poor Mexican-American women who took the pill as opposed to a placebo. While the medical community ignored the experiment, the Third World Women's Caucus attempted to bring legal action against him (Ruzek, 1978).

In addition to the right to safe contraception, women's health activists also began pressing for the right to sterilization (an irreversible type of contraception) on demand regardless

of the age and parity criteria imposed on women by physicians. However, while (white middle class) feminists were demanding the right to be sterilized voluntarily, black women in the South were concerned over what was called the "Mississippi appendectomies", where their fallopian tubes were tied or their uteri were removed without their knowledge or consent (Ruzek, 1978). Similar procedures were done on poor black, women who did not speak English, and on Native American women. After the publicization of the case of two black girls aged 12 and 14 being sterilized in Alabama without their mother's informed consent, the Department of Health, Education, and Welfare began developing guidelines for sterilization procedures paid for by federal funds. These guidelines assured informed consent and prohibited sterilization of women younger than twenty-one (Gordon, 1990). Despite the new guidelines, Gordon (1990) states that, the studies conducted by the women's organizations, public interests groups, and federal agencies found little hospital compliance with the new guidelines.

Out of the struggle to enforce federal guidelines, came a more complex analysis of sterilization abuse and a new type of feminist reproduction-control group; a national coalition made up of CARASA -The Committee for Abortion Rights and Against Sterilization Abuse, R2N2 -The Reproductive Rights Network, Committee To End Sterilization Abuse, the Mexican-American Women's National Association, the Center for Constitutional Rights, and the Chicana Nurses Association. This national coalition united not only abortion rights and sterilization issue, but also had demands for better maternity and infant care after birth (Gordon, 1990). The coalition also helped change the feminist movement's identification with white, heterosexual, middle class women.

The last two areas of criticism were on medicalization of childbirth and excessive use of gynecological and breast surgeries. Ostrum (as cited in Ruzek, 1978) points out that, in 1949, Margaret Mead described American birth procedures as designed primarily for the benefit of the obstetricians. In 1972, Doris Haire, the co-president of the International Childbirth Education

Association (ICEA), published "The Cultural Warping of Childbirth." Having visited maternity care facilities in North and South America, Western Europe, Russia, Asia, Oceania, and Africa, Haire discovered that "many commonly accepted or enforced American childbirth practices, which often disregard human physiological and psychological needs, are not supported by scientific research but are rooted in hospital and medical tradition" (Ruzek, 1978, p. 48). Haire pointed out that American hospital practices inhibited spontaneous births and increased the need for all types of medical intervention.

In relation to excessive use of surgeries, Seaman (1972) reported that twice as many hysterectomies and breast operations (especially mastectomy) were applied in a year in U.S. than in Britain or Wales. Reports of excessive and unnecessary pelvic surgery and cesarean sections being performed on American women started appearing in medical and feminist literature. Especially disturbing were Seaman's reports on audits performed in New York by the Columbia School of Public Health in the late 1950s and 60s for the Teamsters Union. The investigators noted that of the hysterectomy cases audited, one-third of the women were operated on unnecessarily, while another 10% of the operations were of dubious necessity (Ruzek, 1978). Frankfort (1972) raised issues against radical mastectomies. She argued that most American women with breast malignancy undergo extensive surgery, even though numerous studies showed simple surgery followed by radiation treatment to be as effective as radical surgery. Frankfort argued that women had at least to be informed that there were no clear advantages in choosing radical over simple surgery. Feminists saw the cause of these excessive procedures to lie in the disregard of the female body in medical texts and in the regard of physicians for profit.

Women's Health Movement's critique of the doctor-patient relationship, contraceptive safety and access, sterilization uses and abuses, medicalization of childbirth, and excessive and unnecessary use of gynecological and breast surgery were embedded in a larger critique of medicine. Feminists found that the problems they detected in the areas discussed were due to the

larger social and historical forces such as the medicalization of normal female reproductive events, the ascendance of males in (and pushing out of females from) medicine and gynecology, biomedical model of health, androcentric bias in medical education and medical research, and the growing relationship between capitalism, medicine, and patriarchy.

Feminist critique of medicine

The beginnings of western medicine in U.S are similar to that of Europe, where women were excluded from the faculty and student body of the first medical schools set up in medieval and early modern Europe in church-run universities (Lorber, 1997). Ehrenreich and English (1972) wrote that, in the 1800s, due to the existence of few restrictions on practice, medicine was open to anyone who demonstrated healing skills. At this time in U.S., women functioned autonomously as midwives and general healers, practicing frequently with their husbands, and entering the trade after an apprenticeship with an established healer (Ehrenreich and English, 1972). However, the medical licensing laws enacted in the nineteenth and early twentieth century established the trained doctors as the only legal practitioners of medicine (Ehrenreich and English, 1972), and medical schools as the only places to obtain this training. With these laws that privileged university-educated doctors (who were men) over lay healers (most of whom were women), and of medical schools over the apprenticeship model, medicine became an elite profession that systemically excluded women, and set quotas for all women, and African-American, Jewish, and Catholic men (Lorber, 1997). Women's exclusion from scientific medicine was further reinforced (in the 19th century) by the emergence of an industrial economy whose patriarchal ideology of separate spheres (separation of home and economic production) relegated women to the home (Cott, 1977; Morantz-Sanchez, 1985; Weltner, 1983). Medical education and practice, as informed by this ideology, defined healthy femininity as "passivity and a desire for marriage and motherhood" (Cooksey & Brown, 1998). Physicians preached about the

negative effects of nervous stimulation (by involvement in social, educational, and political affairs) on women's reproductive functions, and subjected women to unnecessary gynecological surgeries (e.g., clitoridectomy, female circumcision, and ovariectomy) (Ruzek, 1978).

The ascendancy of scientific medicine, especially in the 20th century, led to "medicalization" of more and more domains of daily life, where labels such as "healthy" and "ill" were made relevant to an ever-increasing part of human existence (Zola, 1978). Modern medicine also adopted a "biomedical model" of health and health care, with a primary (and narrow) focus on disease and pathology, which ignored the social contexts of health and illness, and privileged intervention over prevention (Lorber, 1997; Zimmerman & Hill, 2000). Women's Health Movement advocates drew attention to the role of gender in their critique of medicalization and the biomedical model of health. They pointed out that although many of the women's contacts with the health care system occurred when they were "well" rather than "sick" (when they were pregnant, seeking contraception or giving birth, etc), due to increased medicalization of these normal life events and the pathologizing view of medicine, women's health care was organized around assumptions of acute illness¹. In such a system, healthy women were assigned the "sick" role and the physicians were assigned the role of the "expert" whose authority -to make decisions for women- was justified and who acted in the best interest of the patient (Ruzek, 1978). However, as feminists showed, physicians were not acting in the best interests of women. They were, instead, patronizing or "talking down" to women, overtreating some with unnecessary radical mastectomies and hysterectomies, carcinogenic hormone therapy, psychosurgery, spirit-killing psychiatry and other forms of psychotherapy (Foster, 1995). Doctors were also dismissing the symptoms as "psychosomatic" and failing to treat others who suffered from problems related

¹ Women's Health Movement advocates also criticized the organization of women's health care around gynecology and obstetrics (called "gynecological imperialism"), which, they said, reinforced the ideology of women as sex objects by forcing the women to enter health care through their reproductive organs and be recognized mainly for their reproductive capacity (Ruzek, 1978).

to pregnancy, contraceptive use, and childbirth, even cancer and brain tumors (Miles, 1991; Ruzek, 1978).

Feminists criticized the biomedical approach further for its ignorance of the social contexts of women's health and illness -how health is connected to the unequal distribution of resources based on gender (as well as race/ethnicity and class). They offered instead a sociomedical model of health (Zimmerman & Hill, 2000). Susan Sherwin (1996) applies this critique to medical ethics. She criticizes the individualistic concept of patient "autonomy" in biomedical ethics that assumes patients (and physicians) are agents independent of larger socioeconomic contexts. This model, she argues, obscures the fact that by the time the particular decisions have to be made, the range of options available to both parties have been narrowed significantly by political and policy decisions taken within the larger institutions of health care. The treatments available to patients are a product of earlier decisions made in setting research agendas, the allocation and accessibility of economic and health care resources, and the power of the dominant medical tradition. Sherwin (1998) proposes a "relational" or socially situated definition of autonomy that goes beyond acknowledging and protecting competent patients' authority to accept or refuse treatment recommended by the health care provider (informed choice), and takes into account the impact of social and political structures, sexism and other forms of oppression, on the lives of individuals. The main implication of this new ethics for reproductive rights and reproductive health care is that increasing women's autonomy as clients is not just a matter of increasing their power relative to the physician, but of increasing patients' social power more broadly and restructuring the health care system to ensure its responsiveness to a range of women's needs by removing discriminatory attitudes and barriers (Sherwin, 1998).

The biomedical approach of medicine also assumed an androcentric (malecentric) view of patients and bodies. Women's Health Movement advocates also criticized medicine for its androcentric bias in medical research and education. The androcentric bias in science in general

and in medicine in particular affects scientific inquiry in the (1) choice and definitions of problems for study, (2) the exclusion of females as experimental subjects, (3) bias in the methodology to collect and interpret data, and (4) bias in theories and conclusions drawn from data (Rosser, 1994). As a result of this, in medical research, hypotheses were not formulated to take gender differences into account (e.g. heart disease and AIDS that affect both sexes are designated as "male diseases") and research on conditions specific to females was accorded low priority. In terms of the androcentric bias in choice and definition of problems for study, feminists also criticized the lack of funding for male contraceptives, and growing funding on new reproductive technologies (like amniocentesis, and in vitro fertilization), which reinforce women's role as reproductive objects, and put pressure on women to reproduce "perfect" children while placing control in the hands of the male establishment. Women are also not included in existing experimental research mainly due to "interference" from estrous or menstrual cycles, fear of inducing fetal deformities to pregnant subjects, and higher incidence of some diseases in men (Rosser, 1994). As a result, reproductive (and general) drugs and devices have been marketed before being adequately tested for implications for women.

The last realm in the Women's Health Movement critique of medicine is the relationship between medicine and capitalism. Women health advocates realized that gaining self-determination in the health care system was problematic, because American medicine is not only patriarchal but capitalistic as well (Ruzek, 1978). Feminist health activists showed that the American health care industry is an exploitative business, where women are exploited both as users of services and workers in the services. In terms of health workers, as mentioned before, the emergence of the industrial economy reinforced the exclusion of women from medical education and practice. Women's Health Movement advocates criticized this gendered division of labor, where women faced systematic opposition in their efforts to become physicians. Even when they did become physicians, women were clustered in low-paying, low-status positions.

Feminists also criticized women's exploitation as users of health care. As Zimmerman and Hill (2000) state, "as a commodity, health care was available to those who could pay for it" (p. 774). They continue that, when in the late 1930s, labor unions negotiated for employment-based health insurance systems, it only intensified the gendering of health care because most women (who did not work outside of the home) were excluded from these benefits, or could have care access -as dependents- only through marriage. Capitalistic health care systems of the U.S. were also built on the patriarchal assumption that women's unpaid labor as caregivers for friends and family would be freely available (Glazer, 1988).

In later critiques, women's health advocates pointed to the increasing relationship between capitalistic medicine and the pharmaceutical industry, with an aim towards profit maximization. Yanoshik and Norsigian (1989) stated that in the United States and in much of the world, the contraceptive market was dominated by large corporations, and that this dominance meant that:

production and distribution of contraceptives....is driven by the goal of profit maximization and not a concern for reproductive health. Selling contraceptives to the largest number of people, despite health risks, cultural suitability or the user's needs, is the primary goal of the contraceptive industry (LaCheen, 1986, p. 105).

Premenstrual Syndrome and menopause provide other sites of the partnership between the medical establishment and pharmaceutical companies. During 1990, over 2000 articles dealt with hormone replacement therapy, and estrogen sales were estimated at \$460 million (Lock as cited in Sargent and Brettell, 1996). In contrast, those studies showing little difference between women and men in menopausal phenomenon were buried at the back pages of the newspaper, rather than featured on the front page (Fausto-Sterling and Bleiler as cited in Sargent and Brettell, 1996).

As a result of this socioeconomic critique of medicine, within the women's health movement, some feminists emphasized the need for a socialist state, while others worked for immediate major reforms within the medical system.

Strategies for change applied by the Women's Health Movement

Concerned over the quality of health care in conventional settings that is revealed by the preceding discussion, Women's Health Movement activists developed a wide range of strategies for restructuring care at the societal, institutional, and interpersonal levels. The strategies used to restructure health care were also actions to deinstitutionalize medical authority and transform the relationships between patients and practitioners. When Ruzek (1978) wrote her analysis of the Women's Health Movement, she listed five main strategies women's health activists used to restructure health care and deinstitutionalize medical authority. These were: (1) reducing the knowledge differential between patient and practitioner, (2) challenging the license and mandate of physicians to provide certain services, (3) reducing professionals' control and monopoly over related goods and services, (4) altering the size of the profession relative to clientele, and (5) transforming the clientele from an aggregate into a collectivity. With the maturing of the movement and new internal (within the movement) and external (e.g. The New Right) pressures, these strategies were revised and new strategies were added. However, I will discuss these here, because they constitute the core strategies on which movement organizations were based.

Reducing the knowledge differential between patient and practitioner

Women's lack of knowledge about their bodies and the health care system, and professionals' reluctance to make that information accessible to the women were seen as creating barriers to obtaining quality care and helping to institutionalize (and legitimize) professional

authority. To reduce this power difference between professionals and women clients, women's health activists employed strategies like educating patients, practitioners, and law-makers, selective utilization of practitioners, and self-help activities (Ruzek, 1978).

Education

Women's health activists provided education to women thorough organizing health discussion groups and body courses, and by providing women with health literature including books, pamphlets, and films often produced from research, self-examination, and looking at other feminist groups' writings. Health and body courses emphasized discussion and reading as well as instructions in cervical self-examinations. In the courses, women would learn about basic female anatomy, symptoms of vaginal infections, early pregnancy, contraceptive methods, abortion, childbearing, and menopause (Ruzek, 1978). All such groups aimed to shake women's acceptance of conventional medicine and to emphasize women's right and responsibility to make decisions about her own health care. Personal health problems (like contraceptive failure, botched abortions, and "unnatural birth") were defined as shared problems derived from the medical system rather than individual weakness or failure (Ruzek, 1978).

Women's health activists also directed educational efforts towards medical personnel in both conventional and alternative settings (conventional settings are the ones with the traditional professional-client role). The National Women's Health Coalition organized a series of conferences for physicians and allied professionals in 1973, introducing them to atraumatic abortion techniques and raising questions involving psychological, legal, and social problems surrounding abortion (Ruzek, 1978). Other efforts towards educating physicians included workshops, physician-training programs (in early vacuum aspiration abortion in woman-controlled settings), demonstrations of self-examination in nursing and medical schools, and

requiring medical schools to buy and distribute packets of materials, including a copy of *Our Bodies, Ourselves*, to medical students.

Selective utilization

Selective utilization of physicians and medical facilities is another strategy that helped increase patients' knowledge, as well as ensure better care at lower cost in the short-run, and encourage physicians to improve quality of care over time (Ruzek, 1978). The improvement in quality of care over time would be achieved by feminists' channeling of patients to approved physicians while cutting the supply to those offering inferior or overly expensive services. Feminist newspapers published health directories and community guides informing women where abortions, contraceptives, maternity care, and health referral were available, what the fees were, whether the service provider accepted public or private insurance, and some evaluation of the services (Ruzek, 1978). Some directories also included the physicians' gender and willingness to treat "counterculture" women.

Self-help gynecology

Ruzek (1978) states that promoting self-help groups was the core strategy the women's health movement used to redefine boundaries of medical authority. Self-help gynecology was born on April 7, 1971, at the Everywoman's Bookstore in Los Angeles, where after exhausting book learning on abortion and health issues, feminists, urged by Carol Downer, started doing self-cervical-examinations (Ruzek, 1978). Self-examination and self-help gynecology were revolutionary concepts that gave women the power to reclaim a part of themselves controlled by male professionals. The most controversial practice was menstrual extraction, a technology that made extraction of menstrual blood and contents of the uterus (thus early abortion) possible. By the ease of its use, menstrual extraction method challenged both clinical practice and the role of

the professional. In addition to cervical examinations and menstrual extraction, self-help included training in breast examination, and knowledge of the risks of different birth control methods (Morgen, 2002).

Challenging the license and mandate of physicians and reducing professionals' control and monopoly over related goods and services

Two other closely related strategies used by feminists to restructure health care and deinstitutionalize medical authority were to challenge license and mandate of physicians and to reduce the physicians' control and monopoly over related goods and services. By its very existence, the Women's Health Movement challenged the medical profession's mandate in obstetrics and gynecology. More specifically, self-help practices and home birth challenged professionals' mandate and license as well as their control over goods and services, by showing that lay persons can quite competently perform many tasks that were previously restricted to the medical profession (Ruzek, 1978).

Alternative institutions that utilized paraprofessionals and lay women also challenged professional mandate and license. Ruzek (1978) states that two types of feminist clinics emerged out of the self-help gynecology. In *traditional-feminist* clinics, female paraprofessionals provided much of actual care, reducing the opportunities for physician dominance by minimizing patients' interaction with physicians and by reducing the patient-provider status differential. Closeness and communication between the patient and the professional were also facilitated by having an all-female staff. The second type of clinics was the *radical-feminist* settings, where patients were encouraged to assume major responsibility for their own care (with the assistance of experienced laywomen). Physicians, when present, were relegated to technician status, and hired only to do things restricted by law. Laywomen with paraprofessional training provided most of the routine

care and the relationship between the patient and the provider was one of "mutual participation" or "consultant-client" role (Ruzek, 1978).

In terms of its potential to redefine medical authority, feminists were divided on whether providing alternative institutions of health care for women challenged the existing medical system or helped "siphon off" discontent, allowing conventional institutions to ignore women's needs and/or dump "problem patients" to clinics (Ruzek, 1978). Regarding the role of the professional, self-help proponents recognized the need for technical skills that physicians, nurses, and other professionals possess. However, the problem was how to get the needed skills without the "elitist, self-interested trappings of professionalism" (Ruzek, 1978, p. 174).

Another strategy used by the Women's Health Movement to reduce physicians' control over goods and services was the use of legal and judicial systems to give non-physicians the rights to prescribe and certify for insurance. The efforts to certify outpatient clinics, community health centers, and in-home providers as legitimate recipients of public funds helped dilute physicians' authority. Ruzek (1978) states that physicians' control was most dramatically reduced by the feminists' definition of female life-events as "normal" rather than "sick" states. This redefinition negates both the need and efficacy of many goods and services (e.g. anesthesia in childbirth, prescription contraceptives, and estrogen replacement therapy) and physicians' role as gatekeepers of these goods and services.

Other strategies to reduce physicians' license and control over goods involved enforcing the conditions of license such as those taken by direct pressure groups to force professionals to fulfill their mandate to protect the public welfare (e.g. petitions by the Coalition for the Medical Rights of Women for regulating the IUD, and laboratory procedures of Pap smears). Other direct pressure measures used by the Women's Health Movement included patient advocates, blacklisting, picketing, demonstrating, investigating and monitoring agencies, and invoking the power of the state sometimes in unconventional ways (Ruzek, 1978).

Altering the size of the profession relative to clientele

One of the factors that reinforces physicians' mandate and monopoly over goods and services is the profession's size relative to its clientele. By having a restricted size, the medical profession keeps professionals services in short supply, which in turn leads to expensive services received by clients who accept these services without questioning. Improving the practitioner-patient ratio is thus a necessary condition for altering authority relationships. By increasing the number and visibility of women physicians and opening practice to nurses and paraprofessionals, the Women's Health Movement altered the size of this ratio. This change was also attempted through legislative and judicial measures to admit more women to medical school, and to expand nurse practice (Ruzek, 1978).

Transforming the clientele from an aggregate into a collectivity

In addition to claiming a mandate to protect the public's health, keeping control over the medical goods, services and knowledge, and restricting the size of the professionals, medical authority was also buttressed by having clienteles that remained aggregates rather than collectivities (Ruzek, 1978). In contrast to the unaffiliated clientele, the medical professional belongs to an occupational association that provides him/her with certain privileges. Ainsworth-Vaughn (1995) found that one of the strategies that doctors used to construct power in the doctor-patient relationship was to invoke structural affiliations or referring to doctors affiliations with other providers.

Related to, yet more important than a lack of affiliation, aggregate clientele are also disconnected from one another, unable to "compare notes" or press complaints, except as individuals, which enabled the dismissal of those problems as isolated events or random errors (Ruzek, 1978). In contrast, an organized clientele, with collective awareness of its subordinate situation and common values or expectations used to evaluate services, was seen as a serious

threat to institutionalized authority. Ruzek (1978) states that the growth of the entire Women's Health Movement indicated that women can transform themselves from an aggregate to collective clientele, who are able to influence the health care system through lobbying, educating the public, taking legal action against professionals and demanding that certain aspects of health care be placed under women's control.

A major problem appeared when the transformation into a collective was defined mainly from the point of view of consumer rights. When the reproductive rights argument is made subordinate to that of consumer rights and thus becomes entrapped in the profit-oriented system, it neglects the possibility that women consumers, being taxpayers or insurance premium payers themselves, might resist the changes and refuse to absorb the cost of an increased quality care that comes with increased patient time. Ruzek (1978) predicted that without reallocation of societal resources or a major shift to group care, the capitalist health economy would remain a barrier to the renegotiation of medical authority.

Feminists clinics as movement organizations

In their edited work "Feminist organizations: Harvest of the new women's movement," Ferree and Martin (1995) argue that despite scholarship on the women's movement (as a social movement) and on feminist organizations (as organizational research), there has been little work on the intersections of both. Defining feminist organizations as "the places in which and the means through which the work of the women's movement is done", Ferree and Martin (1995) draw attention to this intersection of feminism as a social movement with organizations that "mobilize and coordinate collective action" (p. 13). They state that the women's movement exists because feminists founded and staffed thousands of organizations (e.g. rape crisis centers,

women's health clinics, women's bookstores, theater groups) to do the work of the movement.

The sheer number of feminist groups shows the success of the women's movement.

Ferree and Martin (1995) argue that the relationship between feminist organizations and the women's movement is dynamic and reciprocal. The movement gives the organizations "their broad purpose, and specific agenda, and supply of activists," while it draws from them "a set of practices, political and material resources, and a supportive context within which activists can carry on their lives while struggling for change" (p. 7). Ferree and Martin attempt to find out how the movement defines the organizations while the organizations continue to redefine and transform the movement, its agenda, surrounding cultures, and the lives of the activist women of the movement and individual women on whose behalf they work.

Ruzek (1978) states that feminist health organizations proliferated since 1969, when the first body courses were organized. By one estimate, by 1974, there were at least one thousand organizations directly involving women in various health activism, and tens of thousands of individuals who considered themselves to be active participants of the Women's Health Movement (Ruzek, 1978). These were clinics, groups providing illegal abortions (e.g. Jane), counseling centers, rape control organizations, and national associations (Ruzek, 1978). Morgen (2002) claims that, among the feminist health organizations, the women-controlled health clinics, which were established either on the eve of or immediately after *Roe v. Wade*, were "the vanguard organizations that were fertile soil for many of the movement's innovations" (p. 71). Through providing women with an alternative health service (alternative to mainstream medical system), these clinics were testing the tenets of feminist theory and the core political values of the Women's Health Movement and formulating new practices.

According to Morgen (2002), what made these clinics "feminist" and movement organizations were:

- (1) Concept of control by women: to fight against the male physicians' monopoly of reproductive knowledge, in these clinics women -who were not medical professionals- owned, operated, and made decisions. Women-controlled also meant use of female providers, nonphysician or nonprofessional health providers -ranging from lay health workers to nurses and nurse practitioners (medical fields filled with women).
- (2) Emphasis on self-help: Providing information to women about their bodies, providing training on cervical-exams, breast exams, birth control methods.
- (3) Value placed on the egalitarian relationship: Adoption of a collective structure with consensus decision making as a way to decrease the medical authority of -male- doctor over client and over other professional and nonprofessional workers (many of which are women).
- (4) Value attached to providing low-cost care as a response to the critique of capitalist health care that put profits of doctors, hospitals, and pharmaceutical and insurance companies above women's need for and the right to access to services.
- (5) Feminist care as a politicized issue: Incorporation of the WHM's analyses of sexism, racism, and class issues into community health and education programs, staff training, and mission statement and goals. Some examples of these in service were abandoning the practice of draping a woman during a pelvic exam (so that the woman can see what the physician is doing), showing a woman her cervix, use of home remedies to treat gynecological problems, prescription of lower dose oral contraceptives and encouragement of barrier methods of contraception over oral contraceptives and IUDs, emphasis on preventive (rather than curative-based) care,

providing women with extensive information on birth control and abortion in a non-judgmental and non-directive way, use of patient advocates during abortion, reorganization of provider-client relationships to include greater mutuality and respect, including calling doctors by first names, presenting information to allow a patient to take a role in decision-making, and explaining each step of a procedure. Feminist definitions of care also included political advocacy (around reproductive rights, health care access, and women's health issues) and community organizing. The main goal of feminist health care was to empower women.

- (6) Feminist workplaces: In contrast to mainstream, capitalistic and impersonal bureaucratic organizations, feminist clinics were established as collectives, with an aim to empower staff, where the boundaries between public and private lives of staff (and personal and political) were blurred, and working toward common values created solidarity among staff, for whom working in a feminist clinic was more than just a job.

Most of the post-Roe vs. Wade clinics provided abortions. Those that did not, offered pregnancy testing and abortion counseling and referral as a primary activity or in addition to well-woman gynecological and/or family planning services. In addition to abortion, contraceptive services, and abortion care, some clinics also included lesbian health care, prenatal and natural birthing classes, counseling, massage, psychotherapy, and lay-controlled artificial insemination services (Morgen, 2002). Clinics addressed the needs of the women in their communities, structuring health care around the concerns of working class, ethically and racially diverse or lesbian women. In addressing the issues around race, class, and sexual identity among their staff and in their population, these clinics also contributed to debates in the WHM, redefining the movement's agenda on the intersections of feminism and race and sexuality.

Organizational changes in feminist clinics from 1970s-1990s

Morgen (2002) states that, in the mid-70s when she first began her research on and participation in the Women's Health Movement, the movement was "fully alive: encountering opposition but blossoming" (p. 110). The feminist organizations -including health clinics- were in their formative years and full of hope to empower women in women-controlled settings that embodied feminist tenets and egalitarian relations (to replace hierarchy and bureaucracy). However, starting from early on and intensifying in 1980s, with internal and external pressures, feminist clinics changed their organizational structures and revised their strategies in fighting for WHM's goals to decrease medical authority and restructure women's health care. In Ferree and Martin's (1995) term, feminist clinics (along with other feminist movement organizations) became "hybrid" organizations incorporating alternative and mainstream principles/practices. Ferree and Martin (1995) define feminist organizations as a "blend of institutionalized and social movement practices" that change over time in response to their own needs, the needs of the women they serve, and the demands of the environment (p. 7). They state that a movement organization is by definition in tension; "always a compromise between the ideals by which it judges itself and the realities of its daily practices" (p. 8). Ferree and Martin are more interested in studying what compromises are made, at whose expense, by which groups of women, and how the day-to-day negotiations are carried out and what effect they have.

Long before Ferree and Martin, Jane Mansbridge (1973) and Jo Freeman (1972) identified the issues that participatory democratic and collective feminist structures faced. These were the increased length of time required for decision making (under the consensus system), emotional intensity of interactions among members, and the persistent inequalities despite democratic ideals and structures. In terms of the structural changes in and hybridization of feminist *health* organizations, there exist three important studies on the Women's Health Movement (referred from hereon as WHM) organizations. These were conducted by Simmons,

Kay, and Regan's (1984) in the early eighties, Morgen (2002) in 1990, and Thomas (1999) in 1992-1993, covering together the changes from the 1970s to the 1990s.

Simmons, Kay, and Regan (1984) studied 28 WHM groups that were women controlled, provided women's health services, espoused the alternative view of health, and adopted a collectivist structure. Ranking the groups from the most to the least collective, they found that organizations with more collectivist organizations had higher task sharing and rotation, a stronger sense of community, higher regard for shared values in recruitment, lower salary differentials, and smaller size. Simmons, Kay, and Regan (1984) also report -in the early 80s- a change in collectivist structures towards increased hierarchies and changed perceptions of the consensus model (seen now as time consuming and inefficient). Both of these changes were attributed to the financial pressures and the pressures of trying to survive in a hostile larger political and economic environment.

Morgen (2002), with the assistance of a graduate student (Alice Julier), initiated an investigation of the organizational change in the WHM from 1970s to 1990s. Morgen and Julier surveyed fifty organizations about the changes they experienced since their founding. About three-quarter of the agencies surveyed defined themselves as women-controlled, with two-thirds espousing an explicitly feminist ideology. In terms of their composition in 1989 (as compared to 1979), the organizations had remained predominantly white, with most of the staff in their thirties (where teenagers were under represented), and served larger number of clients than before. The absolute size of the budgets had dramatically increased between 1979 and 1989. However, the financial difficulties caused by the increasing health care costs (especially for insurance premium -for malpractice and facility coverage, medical supplies and physician services), decreasing government funds, and costs incurred by the antiabortion assaults, had put serious strain to all organizations' budgets. Fifteen percent of the agencies reported that budget cuts meant

"significant changes in their goals and services." Two-thirds were forced to reduce advocacy and outreach activities, and almost as many laid off staff (Morgen, 2002).

In terms of the changes in their organizational structures, between 1979 and 1989, there was increased "job specialization, hierarchy, and time spent on clerical and administrative work," where the majority of the organizations linked salaries to job titles and responsibilities (71%) or compensated for seniority (50%), did not apply periodical job rotation, and had boards of directors (69%) or directors (75%) (Morgen, 2002, p. 114). In the areas of politics, activities, and priorities, the outreach activities of the organizations had increased and resulted in growth in services to women of color and low-income women. Nearly half of the agencies also reported increases in community involvement, community organizing, and advocacy activities. On the down side, although most respondents described their affiliation with the WHM as unchanged, 25% of the respondents described it as weaker. Both self-help and consciousness raising activities were on the decline, and the contacts with other -national or local- feminist organizations were either unchanged (50%) or reduced (25%) (Morgen, 2002).

When Morgen (2002) asked respondents about the external pressures they experienced (pressures caused by forces outside the WHM) and their effects on the agencies' goals and ideology, she found that the biggest pressure came from the New Right -especially the antiabortion movement. Twenty-seven organizations had direct contact with Operation Rescue, while others experienced considerable pressure from it. Large majority of the respondents reported that the antiabortion movement had actually increased their determination in providing their services.

The other external pressures were from the state and the health care establishment. The state pressured the agencies through applications for or receipt of state grants/contracts, as well as state regulation of facilities. Fifty-one percent reported "some pressure" and twenty-five percent reported "considerable pressure" from the state. The majority of the respondents, again, perceived

these state and federal pressures as having little impact on or as reinforcing their goals and activities. Sixty one percent of the organizations felt "some pressure" from the health care establishment, where one fifth described the pressure powerful enough to undermine their goals and ideology. In terms of positive external influences, the respondents cited other feminist groups and local community organizations as exerting "some" to "considerable" influence that reinforced their goals and agenda. (Morgen, 2002).

The third major study on the organizational changes of feminist clinics between 1970s and 1990s is Thomas' (1999) work in 1992-1993. Thomas studied the role of feminist ideology in long-term structural changes through conducting surveys, interviews, and site visits in 14 free standing, women owned and operated feminist health centers that were established in 1970s, and espoused "the feminist philosophy of self-help, education, and empowerment." Thomas states that most studies of structural change in women's movement organizations focus either on external (e.g. state, counter-movements) *or* internal forces (e.g. staff conflict, leadership). Even when they focused on both, the studies failed to develop the relationships among internal forces, external forces and ideology. She, in contrast, argues that it is the ideology (feminist ideology) that mediates the effect of external and internal pressures on organizational change.

Thomas (1999) states that all 14 feminist centers began with collective structures, where all full-time members rotated on the jobs (to equalize knowledge, decrease boredom on tedious jobs, and provide easy replacement for absent members), members were paid equal wages (except for seniority), consensus was utilized for decision making, and the method of "constructive criticism and strokes" was adopted for dealing with staff conflict.

Within a few years of opening, though, most clinics developed a "two-tiered system of power," where some members were paid more (due to position, responsibilities, or needs), and in some clinics, specialists who did not belong to the collective were hired. In an effort to deal with the lengthy staff meetings and feelings of inefficiency, and to expand their services, most

collectives established committee structures, yet several moved from giving responsibility to committees to specific individuals (who would then gain more power and money). Leadership roles emerged in some agencies. Other agencies adopted a type of central committee with representatives from various committees to set or propose policies, which then would go to a collective vote. Thus, Thomas (1999) notes, in the early to mid-80s, all the centers that began as collectives had shifted toward some type of hierarchical structure.

When she studied the 14 organizations in the 1990s, Thomas (1999) found that they could be grouped under three ideal types: feminist bureaucracy, participatory bureaucracy, and collectivist democratic. What differentiated agencies along these types was how they negotiated their feminist ideologies around the three issues of: (1) maintaining a system of dispersed vs. concentrated power distribution, (2) perceived importance of organizational growth vs. autonomy, and (3) the importance of feminism as an organizational outcome vs. internal process. Feminist bureaucracies had hierarchical structures (with high division of labor and less distribution of power), a desire for growth, and emphasis on feminist outcomes. Shifts to centralized power -and specialization- were done to increase efficiency and growth (expansion of services and clients). Participatory bureaucracies had minimal division of labor (less than four levels of stratification), where the ultimate authority rested with individuals (individual directors), yet there existed mechanisms to ensure staff input in critical decisions. Participatory bureaucracies also expressed a desire for growth. However, in contrast to feminist bureaucracies' focus on budget, new services, and satellites, growth in the participatory centers meant internal issues of expansion and efficiency. Feminism was defined as process and outcomes. Collectivist democracies were committed to low division of labor where the ultimate decision-making rested in the group as a whole. Collectivist democracies did not see growth as a priority (but a goal toward diversification of services to meet client needs better), and defined process as central to a feminist organization.

Changes in the Women's Health Movement between 1970 and 1990s

As mentioned before by Morgen (2002), the three biggest external influences that led to structural changes in feminist clinics are the New Right (with the anti-abortion movement), the state, and the medical establishment. Believing that feminist clinics are movement organizations that both contribute to and provide measures for the success of the Women's Health Movement, Morgen (2002) tracks the changes in the movement through the histories of feminist clinics, in the ways they negotiated these three external pressures from the capitalist state, the New Right, and the capitalist medical establishment, and their intersections (e.g. the state and medicine supporting the anti-abortion movement). With the same belief, I will discuss in this section, the changes in the WHM between 1970s and 1990s, through focusing on how medicine, the state, and the New Right changed (and were in some cases changed by) the work of the feminist clinics.

Medicine

Petchesky (1990) states that, although some doctors strongly advocated abortion rights, and others performed abortions or helped women get safer abortions before *Roe vs. Wade*, organized medicine operated as a conservative, self-interested political force. The American Medical Association (AMA) supported the *Roe vs. Wade* decision within a framework where abortion was defined as a woman's right to privacy in the medical choices she makes *in consultation with her doctor*, who thus retains power (Morgen, 2002, p. 127). In addition to fighting for abortion rights and access to low-cost outpatient abortion services, the WHM also challenged medicine through the use, in feminist clinics, of self-help, non-professional (lay) providers, emphasis on alternative (non-prescription) remedies, demystification of health information and providers, and clinic administration and control by nonprofessional women (Morgen, 2002). Organized medicine resisted these challenges through the use of medical

licensing laws, reimbursement policies of insurance companies and public agencies, and regulatory practices.

Medical licensure laws were used to regulate the practices of the clinics through criminalizing self-help gynecology (an example of which was the arrest and acquittal of Carol Downer and Colleen Wilson of Los Angeles Feminist Women's Health Center in 1972 for practicing medicine without license), and requiring physician licensing for gynecological and abortion services.

Despite their ideological commitment to overturning professional (and male) control of health care, feminist clinics had to work closely with doctors, often under the license of a physician -and the physician was typically a white male- if they sought to provide abortions, family planning, or many other gynecological services legally and in a way that could be reimbursed by private and third-party payers.

Morgen, 2002, p. 127.

Morgen (2002) adds that even though physicians had power in feminist clinics associated with their licenses, their relationships with the lay staff and their power to dictate policies varied. The physicians' relationships with the lay staff varied depending on their values and beliefs about the role of nonprofessionals in health care, self-help, and the attitudes of clinic staff about how they wanted the physicians to function within their organization. In some clinics, doctors had to agree with the clinic's philosophy of health care that included self-help, use of lay workers who recorded "her story," inserted the speculum, and performed gonorrhea culture and Pap smears, and emphasizing the lowest dose oral contraceptives possible and barrier methods of birth control.

Morgen (2002) states that it was not so much the licensing laws but the reimbursement policies of private and public health insurance plans that led to a decrease in the use of lay workers. Physicians had tremendous effect on the development of the third-party payer policies according to which the insurance plans would only cover services that were provided by a

physician. Physicians were also well represented in health regulatory and oversight committees, leading to organized medicine's control through regulatory practices. An example of this is the two investigations and the denying of funds to the Los Angeles Feminist Health Center by the Los Angeles Regional Family Planning Council, due to its members' disapproval of "participatory clinics that emphasized self-help and peer and paraprofessional counseling." (Morgen, 2002, p. 130)

Feminist health activists responded to these restrictions of organized medicine by using both guerilla tactics (such as unannounced inspections of the obstetrical units of hospitals for unsafe childbirth practices), and more cooperative techniques such as "pelvic teaching programs" that included feminists' sharing with medical students how to perform pelvic exams in a respectful and interactive way. Both of these strategies however, had mixed results (Morgen, 2002).

As hinted to at the beginning of this section, organized medicine was also responsible for the criminalization of abortion before Roe, and the marginalization of abortion and abortion providers after Roe. Joffe (1991) states that the most important force in the campaign to criminalize abortion in the 19th century was organized medicine. The American Medical Association, founded in 1847, defined abortion as "immoral" and "a medically dangerous" act. This, Joffe (1991) states, was part of medicine's larger attempt to attain "professional" control over "irregular" medical practitioners, such as healers, homeopaths, and midwives. Organized medicine controlled the terms of "legal" abortions (called "therapeutic abortions") before Roe. After Roe, it contributed to the marginalization and stigmatization of abortion through the physicians' unwillingness to learn or perform the procedure and shunning of providers who provided them (Joffe, 1995). The doctors Joffe (1991) studied testify that, in spite of legalization, abortion has never been fully accepted by mainstream medicine, particularly by obstetrics/gynecology. Those who provided them paid a price, such as the silent treatment or

insults from colleagues, withheld promotions or honors, and the cold reception of abortion-related research by editors of important journals. The growing anti-abortion movement of the New Right in the 1980s (Morgen, 2002), and the free standing abortion clinics which isolated providers from mainstream medicine (Joffe, 1995) contributed to this marginalization.

Even though medicine as an organized force resisted (and later co-opted) the attempts of Women's Health Movement activists, there have always been individual physicians who worked in the movement and, like the "doctors of conscience" Joffe (1991, 1995) studied, performed abortions in a safe, low-cost, and respectful environment before and after *Roe vs. Wade*. Female physicians active in the WHM learned about alternative care through working in feminist clinics. Dr. Terry Brock (a pseudonym) who served as a medical director at a feminist clinic in California states that she learned:

certain ways of dealing with patients that were...valuable in terms of treating them as equals, or...sharing information with them, the kind of thing that is not particularly the way we are taught in medical school...I learned a lot more about contraception and minor GYN problems than I learned in medical school.

Morgen, 2002, p. 136

Female physicians active in the WHM also acted as translators between the feminists and mainstream physicians, and challenged medicine from inside through entering (and surviving) medical school, establishing committees (such as Committee to End Sterilization Abuse), rejuvenating American Medical Women's Association, founding the Society for the Advancement of Women's Health Research and its journal *Journal of Women's Health*, and disseminating the model of alternative care through their work outside the clinics. Morgen (2002) also mentions the role of feminist clinics in increasing the number of female physicians with feminist consciousness. This was accomplished when many lay workers who were frustrated over the limitations on nonlicensed practitioners entered medical school.

Working in feminist clinics did also provide a challenge to these female physicians. One of these challenges was the initial feeling of threat by the lack of a rigid medical hierarchy and an atmosphere where their judgments could be freely questioned. In the experiences of two physicians Morgen (2002) interviewed, this threat eventually subsided with the realization of a genuine concern for the patient by all staff members in the clinic, respect for the increasing level of medical information held by all staff members, and the physician's right to make a final decision in medical matters. Other challenges were not knowing the qualifications of other staff members (due to the abolishment of job titles in collective structures) and problems in communication due to the differences in physiology, anatomy, or pharmacology backgrounds of physicians and lay workers. In addition to these challenges, female physicians were also offended at the continuing anti-doctor attitude of women's health activists, especially when it led to the viewing of all doctors (including females who played a key part in feminism and endured ridicule and hostility from male doctors) as a "conservative group with little sympathy for feminist causes" (Morgen, 2002, p. 142).

In terms of the physicians who worked in concordance with the WHM, in addition to female physicians in the movement, there were also male and female physicians who performed abortions before and after *Roe vs. Wade*. Challenging the "back alley butchers" symbol used by pro-choice activists to remind the pre-Roe era, Joffe (1991, 1995) studied physicians who performed abortions (or acted as facilitators to providers) in the pre-Roe era at the risks of imprisonment and loss of medical license. She calls them "doctors of conscience" because they were motivated not by financial reasons, but reasons of conscience, a deeply held belief that women should be able to end unwanted pregnancies. Their beliefs were the results of observing women's determination to seek abortions, the devastating consequences of incompetently performed abortions, colleagues' hypocrisy in denying women abortions while asking for one for their daughters or wives, and exposure to cultures where abortion was more commonplace. Some

were also motivated by personal histories as a holocaust survivor (that instilled the need to confront government authority), religious beliefs (of serving God), or immersion in political activism in civil rights, anti-war (Vietnam), and feminist movements. These physicians contributed to medicine and WHM through training residents in abortion procedures, writing textbooks on abortion, working in pain management and counseling in the abortion process, and being involved in the activities of NAF (National Abortion Federation). However, as previously mentioned, they did continue to suffer marginalization, stigmatization (and violence) due to their lack of acceptance by mainstream medicine and the rise of the New Right with its anti-abortion attacks (Joffe, 1991).

Many aspects of organized medicine were changed by the work of the WHM activists and these individual physicians. Some of these changes were providing women with adequate information, informed consent procedures, establishing non-medical environments in hospitals and other women centers. While being changed, medicine also co-opted many attempts of WHM. These changes and cooptations will be discussed further in the following section of "accomplishments and co-optations".

The state

From the 70s through 90s, the state (defined by Morgen as all levels of government, the law, the judicial system, and public social welfare and health bureaucracies) had direct and indirect effects on the WHM and feminist clinics, through regulatory practices, laws restricting abortion access, and funding of feminist clinics. Whenever clinics sought medical licensure, they exposed themselves to the oversight, regulation, and power of the state. As the workers of the Women's Community Health Center (WCHC), a women-controlled collective in Cambridge, Massachusetts that provided well-woman gynecology and abortion services state:

Women's health centers all around the country are working toward ending medical monopoly of health care and taking back our control over our bodies. Restrictive zoning ordinances, selective enforcement of health department regulations, and enactment of legislation requiring woman-owned facilities to comply with economically discriminating building codes, are all ways that feminist health centers are being harassed.

WCHC, 1979, as cited in Morgen, 2002, p. 157

In the case of the WCHC, after operating for a year under the licenses of the physicians, WCHC applied for a state licensure as an abortion and well-woman clinic, to be able to secure funds from a larger variety of sources including insurances, and attract referrals from other community agencies. Securing the license involved two years of fighting with hostile bureaucracy and red tape in regulatory policies and practices (in zoning, building codes, and health regulations), behind which were anti-abortion forces. The two years of struggle led to considerable debt forcing the agency to close in 1981. WCHC's staff saw the center as "a victim of the New Right and depression economics" (Morgen, 2002, p. 161).

The New Right that took root in the 1970s started gaining political power in the late 1970s. The ascendance to power came in the 1980s with the election of Ronald Reagan (Morgen, 2002). During this time, the anti-abortion forces within the New Right won many legislative victories such as the Hyde Amendment (1977) (that prohibited the use of federal Medicaid funds for abortion or abortion-related services) and laws passed by many states limiting abortion rights and access (such as requiring parental consent for minors and spousal consent or notification for all women, waiting periods, and restrictions on the use of the state's portion of Medicaid to pay for abortion). Some states also passed laws to require all women's counseling and referral centers to obtain clinic licenses from the state department of public health. To qualify for a license, centers had to restrict the procedures performed by lay workers, name a physician as medical director, and conform to costly building codes that made it difficult to be in a low-income neighborhood (Morgen, 2002).

After Clinton's election in 1992, there were important changes in federal policies on abortion. Some of these were the lifting of the gag rule (a statute that prohibited any health facility from mentioning abortion as an option for pregnant women), and overturning the bans on fetal tissue research and RU-486, the abortion pill (Morgen, 2002).

In addition to regulatory policies and laws restricting abortion access, the state influenced feminist clinics also through the channeling or cutting off of funds. In the political climate of 1960s and 1970s with expanding funds for social services, many feminist clinics sought and received state money in the form of grants and/or contracts from federal, state, or local agencies, and state funded private agencies (Morgen, 2002). While helping relieve business pressures and increasing their services to more women, these state monies also coopted the clinics, transforming these clinics (and the WHM) so much that their challenge to the dominant power relationships were significantly reduced.

Women's Health Services (WHS), a feminist clinic founded in the 1970s as a health information and referral service, experienced this cooptation, yet was later able to revitalize its feminist ideology and structure. The state money that WHS received initially through a small subcontract with a local agency, and later through the CETA grant (Comprehensive Employment and Training Act) from the U.S. Department of Labor, coopted the organization of the agency through selective funding of activities, fostering bureaucratic structure, and creating a sense of financial insecurity. State's selective funding of activities, which involved channeling of support toward direct service provision and away from community projects, led to an increase in direct services (such as counseling, family planning, etc.), and a decrease in the political outreach activities of WHS. Within direct services, the one-on-one model provider-client model of services, which was favored by the state funds, became more pervasive in theory and practice. Self-help was replaced by paraprofessionalism. This was also evident in the discourse of the clinic where "women helping women" became "paraprofessionals serving clients", and "staff rap

groups" (where counselors shared feelings and concerns about their work) became "counseling supervision". WHS's feminist model of care that included group care, cervical self-examination, staff rap group, and advocacy disappeared over the years.

Cooptive pressures were also felt in the organizational changes towards a bureaucratic structure. Increased needs for periodic billing and documentation (tasks which can be difficult to rotate among staff) and administrative work led in WHS to increased task specialization and specialization of service provision and administrative duties. This separation of administrative and service work was against the feminist structure of WHS where task rotation and a commitment to equal distribution of knowledge were seen as critical for the functioning of the collective. The specialization with unequal distribution of labor and knowledge led to hierarchies between the director and staff, between regular and CETA workers, between part-time and full-time staff, and between paid staff and volunteers (Morgen, 2002).

State funds also created a sense of financial insecurity and dependency that eroded WHS's autonomy and oppositional practices. Not knowing when they would receive the payment and with increased dependency on external agencies (which it did not want to offend), the agency became reluctant to join a protest to challenge the local hospital's closing of prenatal and gynecology outpatient clinics and to challenge a local agency for its treatment of women clients. The organization's orientation had changed from social change to social service. Staff were more likely to attend "in-service training sessions" offered by other local social service agencies than feminist health conferences and workshops (Morgen, 2002).

The CETA grant, which resulted in these cooptations, ironically, also led to the renewal of the agency's commitment to feminist and collective values. This happened when the staff hired through the CETA grant, who were mainly African-American and from working class backgrounds, challenged the racist and class-based structure of the agency.

Through expanding funds for social services, the political climate of the 1960s and the 1970s brought funds to feminist clinics. The climate of the 1980s brought funding cuts. Reagan's passage in 1981 of the Omnibus Budget Reconciliation Act and other neoconservative and neoliberal policies implemented during 1980s led to cutting of federal funds for social programs. These policies also led to the consolidation of many categorical programs into block grants, where some service areas (such as family planning, day care) lost more than others (adoption services, child abuse programs), depending on political appeal (Morgen, 2002).

Among the fifty health clinics and advocacy organizations agencies Morgen (2002) surveyed, 25% endured "serious" budget cuts during the 1980s, where two-thirds were forced to lay off staff, and reduce non-revenue generating activities such as education, outreach, or advocacy. Forty-three percent of these agencies cut services, more than one third reduced staff benefits and one-third cut staff benefits. Morgen (2002) states that while most agencies survived the Reagan years, others closed down or stayed open only by allowing themselves to be managed by mainstream health groups (e.g. health departments) or be bought out by physician-owned partnerships.

The anti-abortion movement and violence

Since the late 1970s antiabortion forces made use of a range of terrorist tactics against the clients, staff, and property of abortion providing clinics, in the forms of arson, bombings, vandalism, stalking and intimidation of staff and clients, physical assault, and blockades (Morgen, 2002). Morgen (2002) states that an arson attack that destroyed a Planned Parenthood clinic in St. Paul, Minnesota in 1977 is one of the first recorded acts of violence by antiabortion groups. Violence against abortion clinics peaked in the mid-1980s, with the national toll in 1984 involving eighteen bombings, six cases of attempted bombing or arson, twenty-three death threats, and nearly seventy clinic invasions involving acts of vandalism (Ms, 1995 as cited in

Morgen, 2002). In 1988, Joseph Scheidler of the Pro-Life Action League and Randall Terry, the head of Operation Rescue, developed a new technique, the clinic blockade. In addition to these intense acts of violence, by the early 1980s, right-to-life groups increased their efforts in front of abortion clinics, which now included shouting at clients, calling them baby killers and shoving pictures of fetuses and bloody parts in the clients' faces (Morgen, 2002).

The antiabortion violence peaked again in the mid-1990s with the murdering of physicians who provided abortions. In March 1993, Dr. David Gunn was shot to death outside of a Pensacola, Florida clinic where he performed abortions. This was followed (in five months) by the killing in Alabama of Dr. Wayne Patterson, an abortion provider who worked with him. Dr. George Tiller was wounded outside of a clinic in Wichita, Kansas. In July 1994, Paul Hill shot and killed Dr. James Bayard Britton and James Barrett, a clinic escort at another Pensacola clinic. In December 1994, John Salvi murdered Shannon Lowney and Leanne Nichols at two clinics in Brookline, Massachusetts and in 1998, Dr. Barnett Slepian was shot to death at his home in Rochester, New York. These assassinations helped the passage of the Freedom of Access to Clinic Entrances (FACE) Act in May 1994, which prohibited the use of force, threats, or physical obstruction to interfere with a person trying to enter or leave an abortion clinic (Morgen, 2002).

Antiabortion violence affected feminist clinics, Planned Parenthood, non-profit and for-profit clinics that provided abortions. Morgen (2002) states that what set feminist clinics apart from these other targets of violence are the fewer financial resources and fewer connections with police forces and representatives of local court systems that feminist clinics had. Morgen's (2002) survey of clinics (on their operation between 1979 and 1989) showed that the New Right and the antiabortion forces in it exerted a powerful negative influence on the Women's Health Movement and the operation of feminist clinics. Morgen (2002) found that about forty percent of her respondents acknowledged that they felt considerable pressure from the antiabortion movement, with more than half of the sample having direct contact with Operation Rescue.

Antiabortion violence affected the finances of the clinics. Clinics who were targets of bombings and arson attacks paid tremendous amounts of money to establish and maintain high security measures. Because they were considered "high risk enterprises", they also had to pay higher liability insurance and workers compensation premiums (or had lost them). Some clinics also had difficulty renewing leases or finding new rental space, due to the landlords who were concerned about potential property damage and inconvenience to other tenants (Morgen, 2002). In addition to finances, violence also affected the recruitment and retaining of workers. Due to constant harassment, staff of some of these clinics felt like their workplace was the "center of a combat zone" and that they were trapped in an endless war (Morgen, 2002, p. 198).

In response to these attacks, feminist clinics and the WHM developed various grassroots and legal strategies such as establishing escort services to protect clients from blockades, and verbal and physical harassment, bringing charges against antiabortion groups, renting places with private parking lots (that prevented trespassing), and publicizing (through their newsletters, media or posters) the dates, locations of arson and bombings in their region and soliciting information about the criminals (Morgen, 2002). Morgen (2002) states that although these acts of violence had considerable financial, political, and emotional effects on feminist clinics, they also reenergized clinic staff's political commitments and reinforced their determination to provide abortion services.

The Women's Health Movement in the 1990s: Accomplishments, cooptations, and challenges

Zimmerman and Hill (2000) state that the Women's Health Movement constitutes the first significant and broad-based critique of modern medicine and serves as the first major consumer voice in health care since the rise of modern medicine. As discussed in the beginning of this chapter, the Women's Health Movement critique of modern medicine revolved around the medicalization of normal reproductive events, the male monopoly in medical education and practice (especially gynecology and obstetrics), a biomedical model of health, androcentric bias in medical education and research, and the growing relationship between capitalism, medicine, and patriarchy. Women's Health Movement activists fought for:

- Increased control for women in decision and actions affecting their bodies and health.
- The de-medicalization of women's life events and problems (defining health care issues so as to release women's experiences from needless medical ownership and excessive therapeutic control).
- An emphasis on information (around women's health issues), prevention and less invasive treatment.
- An atmosphere of interpersonal respect between physicians and patients, regardless of gender, class, and race.
- The centrality of a sociomedical as opposed to a biomedical model of health.
- Increased number of female providers (including physicians and paraprofessionals).
- Increased research on women's health research (including allocation of more funds to women's health research).
- A commitment to health care as a right, including legislative efforts to ensure women's reproductive right and guaranteeing access to physicians and hospitals regardless of financial or insurance status.

(Thomas, 2000; Zimmerman, 2000; Zimmerman and Hill, 2000, p. 773)

This section involves a discussion of how these aims were accomplished and coopted when the movement reached the 1990s. The major accomplishments of the Women's Health Movement by the 1990s were in the areas of raising consciousness in women and in the general public on reproductive rights, scoring important gains in health policy and keeping abortion legal, leading to the attitudinal changes in some physicians, and contributing to the rise of information on women's health (Gordon, 1990; Morgen, 2002; Norsigian, 1996).

Morgen (2002) states that "women today can receive more information about their bodies and reproductive health care, and in some settings they are encouraged to participate actively in their own health care by questioning their providers and asserting their own preferences and opinions" (p. 149). In terms of health policies, WHM was effective in the adoption of informed consent procedures for procedures ranging from sterilization to breast biopsies to Cesarean section, where the regulations about what constitutes informed consent protect women from sterilization abuse, medical experimentation, and unnecessary medical procedures (Morgen, 2002). The WHM also played a crucial role in extending women's right to know through FDA requirements for package inserts that provide information about the side effects and contraindications of prescription drugs, including oral contraceptives and hormone replacement therapy (Norsigian, 1996).

Other areas of success for WHM were those concerning women and medicine. These were the increasing the number of women (including women of color) in medical education and practice, increased federal money to women's health research, the establishment (by NIH) of the Office of Research on Women's Health, and the NIH-mandated inclusion of women in all research grants (Morgen, 2002).

Despite these accomplishments, WHM did not lead to a major change in the medical establishment (medical education, training, and practice). The movement did not fully succeed in de-medicalizing reproductive events, the provision of alternative services did not threaten or

change established medical institutions (Gordon, 1990; Norsigian, 1996), and the "control of women's health care still remains in the province of physicians and other health professionals, who, although they manage patient care differently than before, still manage it nevertheless" (Morgen, 2002, p. 149). Although the movement led to an increase of women in medicine, as will be discussed below, women in medicine are concentrated in low-paying, low-status jobs and medical education and practice is still fraught with gender inequities (Zimmerman, 2000). Lastly, affordable, accessible respectful health care (especially for poor and uninsured women) is still an ongoing challenge.

In the previous section I discussed how medicine, state, and the antiabortion forces thwarted the efforts of WHM. Another major force many scholars of the movement cite as being responsible for coopting the movement is the capitalist and patriarchal context of U.S. medicine. As Zimmerman and Hill (2000) document, since its beginnings in the 19th century, U.S. medicine has developed in the context of capitalism and patriarchy. However, the influence of capitalism in medicine increased significantly in 1980s and 1990s, with the rise in health care costs since 1960s, coupled with the reversing of federal funds for health care (after the 1980 election of Reagan). These political-economic changes reinforced the competitive market model of medical system and led to the growing influence of "managed care" in women's health care.

Zimmerman and Hill (2000) investigate the effects of this market model of care on the WHM, focusing especially on the effects of Health Management Organizations (HMOs) that implement managed care principles. In terms of the WHM activists' aim to control women's control over their bodies and health, Zimmerman and Hill found that the "consumer choice" of physicians and "self-care" principles of managed care implemented by HMOs led to a decrease in women's control in health decisions and actions. They state that while women need multiple providers, multiple providers are not consistent with the "efficiency" concept of managed care. Even when HMO plans allowed women to self-refer to an obstetrician-gynecologist other than

their primary care providers (and 70% as of 1994 did), half of the plans limit visits to one visit per year. The principle of "self-care" on the other hand, Zimmerman and Hill (2000) state, represents the cooptation of the WHM's principle of "personal responsibility" or "agency". They show how "self-care" is used to deny health benefits to women who are perceived as "causing" or "contributing" their own illnesses. Zimmerman and Hill (2000) report Ezzard's survey where half of the 16 large insurers studied used domestic violence as a risk criterion for denying health, life, or homeowners' insurance to women. Zimmerman and Hill (2000) also emphasize the individualistic focus of "self-care" that does not take into consideration socioeconomic factors surrounding women, such as exposure to health risks linked to conditions of poverty, one's workplace, or one's neighborhood.

On the de-medicalization of women's life events, Zimmerman and Hill (2000) conclude that health care reforms in the U.S. served to increase rather than decrease medicalization. The de-medicalization of childbirth is very limited (involving some decrease in the use of Cesarean section, and ongoing management of pregnancy and childbirth by physicians), while new areas of women's lives are medicalized. These include the medicalization of appearance (through weight control, fitness, dieting, and cosmetic surgery) and fertility, where women are the primary clients and vulnerable to fraud and overtreatment by medicine.

Regarding the WHM's emphasis on information, prevention and less invasive treatment, Zimmerman and Hill (2000) found that managed care arrangements did involve more prevention and early intervention services such as clinical breast examinations, mammography, pelvic examinations, and Pap smear tests. HMOs were also more likely to cover all types of reversible contraception than other forms of health insurance. However, related to increased medicalization, HMO plans also involved more invasive techniques of treatment.

While HMOs do provide more prevention services, Zimmerman and Hill (2000) note the increasing number of women without insurance. Judy Norsigian (1994) observes this paradox the health care industry created for women:

Women are at greater risk for overtreatment when we have insurance...and are under greater risk of undertreatment when we have no form of medical coverage. Access to appropriate care remains an unattained goal for many women regardless of their insurance status.

Norsigian, 1994 as cited in Morgen, 2002, p. 235

Norsigian (1994) is touching upon a major principle of WHM: health care as a right. In addition to the paradox mentioned above, this aim is further complicated by the problems associated with Medicaid and Medicare and the inconsistent coverage by private insurance plans of maternity leave, birth control and abortion services. Zimmerman and Hill (2000) attribute these problems to gender inequity in the health care system. Gender inequity is seen in the linking of health to employment. Making health care contingent on employment disadvantages many women, since women are more likely to be in part-time jobs or working at home. Many women also move in and out of jobs during childbirth, and lose their services in between. Inequity also exists in the organization of health care where the needs of men are met better than those of women. This is created by an orientation towards acute than chronic conditions, higher coverage of impotency than of oral contraceptives, and inadequate services for old age that is overpopulated by women.

In terms of the WHM's aim of establishing interpersonal respect between provider and patient, regardless of gender, race or class, Zimmerman and Hill (2000) report that women patients are still treated less aggressively or less effectively than men in the areas of AIDS diagnosis and heart disease. They add that there is also evidence that providers do not take women's subjective reports seriously and dismiss them as "psychosomatic", as in the case of chronic fatigue syndrome. Lastly, Zimmerman and Hill (2000) report that American medicine

still operates from a biomedical perspective, where social contexts of health and illness, such as the patriarchal nature of the society, and the unequal distribution of resources on the basis of gender, class, race and ethnicity are ignored. Women's social circumstances that contribute to their health and illness (and the differences in these between women of different classes, races, and ethnicities) are crucial for a sociomedical model of health.

Zimmerman and Hill (2000) discuss mainly the effect of health care reforms, especially the efforts that fall under "managed care" on the WHM's aims. Other factors within the market economy of health care that affected the WHM in the 1980s and 1990s were the women's health centers with their cooptations of the feminist model of care, and the competition caused by Planned Parenthood organizations.

Morgen (2002) states that, with the reversal of federal spending on health care that reinforced the competitive market model for the medical system, many hospitals and physician-owned groups developed women's health centers to provide primary care for women. The demand for these centers was inspired by the WHM and thus their emergence and proliferation partially reflects the effect of WHM on mainstream medicine. However, the major driving force in their creation (and operation) was profit making and their main effect was "commodification of women's health". These centers emphasized aspects of the feminist health care model that were most amenable to mainstream medicine. Their rhetoric included empowerment, wellness and prevention, providing women with information, etc. A recent study found that almost all the new centers had the same goal: "provision of services in a caring, sensitive manner that empowers women to take control of their health care and involves shared decision-making between provider and client" (Weisman et al., 1995, p. 113). The new centers also aimed at a de-medicalized appearance for their facilities.

Despite their rhetoric and looks, these centers are not alternative health care providers because they are not owned and controlled by lay women, but operate under professional control

where their policies are dictated by hospital boards or administrators or by the physician. The centers provided women with information. However, the information was from the mainstream medical model, emphasizing for example the benefits of estrogen replacement therapy, mental health counseling, mammography and other such revenue promoting services. As different from feminist (or women-controlled) centers, these centers also did not have any information or activities aimed at political activism on women's reproductive rights (e.g. helping women understand the effects of cuts in social programs such as WIC, food stamps, and welfare on women's health, and mobilize women to fight against such cuts). Lastly, the client base of these new women's centers were women covered by insurance, mainly affluent women. This is also different from feminist centers, who ensured that their practices did not exclude low income women, women of color, lesbians, and others who encountered discrimination in mainstream medical facilities (Morgen, 2002).

The cumulative effect of these new women's centers was coopting the efforts of WHM to empower women, de-medicalize their lives, and provide affordable health care that focuses on less invasive techniques. As Morgen (2002) comments, the language of "empowered consumers," which was "very much part of the neoliberal agenda, contributes to a depoliticization of health care advocacy and translates discourse about power into the language of the marketplace" (p. 235).

Women-controlled clinics competed with both these new centers and Planned Parenthood Federation of America, another non-feminist organization. Planned Parenthood organizations chose to open abortion clinics in communities served by small feminist clinics. Gail Sands of the Emma Goldman Clinic in Iowa state that "instead of going into 'underserved areas', Planned Parenthood targets markets that have already been set up for them by the blood, sweat, and tears of feminist clinics" (Morgen, 2002, p. 150). This led to competition for clients and loss of services in some clinics due to diverting of federal funds to Planned Parenthoods.

Zimmerman and Hill (2000) and Morgen (2002) discuss mainly the effects of the capitalist context of U.S. medicine. As mentioned previously, since its beginnings in the 19th century, U.S. modern medicine has been not only capitalist but also patriarchal. WHM activists believed that the key to decreasing the male monopoly in medicine (including the androcentric bias in medical education and research that reflected biased and inadequate research into women's health issues) was to increase the number of women in medicine. It was soon recognized though, that adding more women to medicine without changing the content and process of medical education and practice would not lead to major changes in the gendered structure of medicine (Zimmerman, 2000).

Zimmerman (2000) had conducted one of the most recent evaluations of the current status of gender bias in medical education, through looking at three areas: (1) the presence and participation of women as medical students and faculty, (2) the problem of gender bias in the content of medical curricula and training programs, and (3) the friendliness for both men and women of the climate and environment of medical education. In terms of the presence and participation of women as medical students, Zimmerman (2000) found that, compared to 1970, the number of women in medical education in 1990s has increased threefold. In 1970, 10% of entering students and 9 % of graduating students were women, whereas in the 1998-1999 academic year, 44.4 % of entering students and 42.6% of graduates were women. The number of minorities (especially minority women) in medical education has also increased, though not in proportion to their representation in the American society. While the number of women in medical education increased, there were fewer women doing residency after medical school, and those who were doing it were highly concentrated in the fields of family practice, internal medicine, obstetrics/gynecology, pediatrics and psychiatry. There were very few women in general surgery (21% of residents were women), orthopaedic surgery (7%) and thoracic surgery (6%).

As faculty in medical school, Zimmerman (2000) notes how women physicians experience a "glass ceiling" within medical schools, moving into positions of authority less often and more slowly than men. Zimmerman cites Bickel's (1995) suggestion that this is mainly a result of the process of "cumulative disadvantage" that includes sexist practices (e.g. collegial exclusion and harassment under the guise of joking), the inflexibility of the organizational structures to provide support to women in balancing work and family (through interpersonal sensitivity and adequate policies regarding insurance, maternity leave, child care, and flex-time arrangements), and the lack of mentoring.

These dimensions of cumulative disadvantage relate to the climate of medical education, which is the second area Zimmerman (2000) assessed. She concludes that the atmosphere of medical schools in U.S. is less friendly to women than men, and includes sexual harassment, belittling, and patronizing of women medical students and residents, and the lack of institutional support for women faculty. These factors, Zimmerman (2000) suggests, both create barriers for women in professional advancement and might lead to self-selection into fields that are less populated by men (thus less hostile to women) and have less demanding requirements (e.g. choosing internal medicine than general surgery).

On the third area of gender bias in the content of medical curricula and training programs, Zimmerman (2000) notes the existing deficiencies in medical curricula reflected by the inadequacy of medical research on women, gaps in the incorporation of research findings on women into medical curricula, and in the existing use of the male body as the model. In addition to the deficiencies, Zimmerman emphasizes the outdated preoccupation with women's reproductive systems, which prevents the reaching of a comprehensive approach on women's health. Lastly, she discusses the instruction in standard medical curricula in the doctor-patient communication, especially in treating women with respect. She concludes that although the instruction is useful, it needs to be complemented by changes in the teachers who model doctor-

patient interaction for the students (since most clinical teaching is done on an apprenticeship model) and by an increased understanding by the physicians of the sociocultural and economic factors (poverty, violence, economic dependence, etc.) associated with gender.

Zimmerman (2000) found that it is not only the content but also the structure of the medical curriculum that affects gender bias or fairness. The major problem in the structure of medical curricula derives from the fragmentation of women's health where "routine care for women's common health problems is divided in the organization of medical education and practice between gynecological/obstetrical and other health services" with a focus on specialization and turf interests rather than women's health care needs (Zimmerman, 2000, p. 129). While there is a general consensus about the incorporation of women's health into medical curricula, there are differences of opinion over the way it should be done. The questions raised are who should provide routine health care for women and who should be trained to do so?

Zimmerman (2000) cites the differences between gynecology/obstetrics, internal medicine, and family practice on the knowledge on women's health. She states that it is only recently that the education in Ob/Gyn has incorporated training on non-reproductive aspects of women's health, such as common conditions women face (e.g. diabetes and hypertension) and a greater focus on basic primary care including psychosocial issues. Internal medicine, in contrast, maintains a generic male model for all bodily systems and functions, except for the reproductive area. They usually refer women to ob/gyn physicians for reproductive issues, and receive little training in social and behavioral issues of concern to women, such as depression, poverty, economic dependence, violence, and substance abuse. Family practice is the specialty that provides the broadest education and training in psychological and social perspectives in women's care, yet as Zimmerman (2000) notes, is again based largely on the male model. This fragmentation in education and training has significant consequences for women's health care, where the existence of multiple practitioners for routine care creates problems particularly for

uninsured and underinsured women, leads to gaps or duplication in care, and coordination and continuity of care for women (Zimmerman, 2000).

PART TWO: THE CONCEPT OF EMPOWERMENT

In the first part of this chapter, I discussed the Women's Health Movement, with its origins, critique, and its history or rather "her story" of accomplishments and cooptations. The main aim of the Women's Health Movement was to *empower* women in the areas of reproduction and sexuality. This coincided with the empowerment of women as consumers of health services in general and reproductive services in particular. In order to understand how empowerment in the women's health context occurs, we need an operational definition of empowerment. In the second part of this chapter, I will discuss the definitions of empowerment, empowerment models borrowed from the fields of reproductive health care and health care ethics, and their implications for research.

Definitions of empowerment

Empowerment is a construct found in numerous fields of study including education, psychology, sociology, anthropology, feminist research, theology, nursing, public health, prevention, and social work/human services (Robertson & Minkler, 1994; Shields, 1995). However, despite its status as an important concept emerging in various fields, empowerment is a multi-faceted, elusive phenomenon that is very hard to define. As Freire (1970) states, it is usually the absence of empowerment in people's lives that is most readily recognized.

Julian Rappaport defined empowerment in mental health/community psychology broadly as a process by which people, organizations, and communities gain mastery over their own lives.

She laid out the two requirements of an empowerment ideology. An empowerment ideology requires us first to "look at many diverse settings where people are already handling their own problems in living, in order to learn more about how they do it" and then to find ways to take what we learn from these settings and solutions and make them public (Rappaport, 1981, p. 15). This process involves adopting the viewpoint of professionals as collaborators (as opposed to the professionals as experts view of prevention and advocacy), assumption of already existing or potential competencies in people, and the acceptance of the possibility of multiple locally rather than centrally controlled solutions (different solutions necessitated by different settings).

Empowerment as defined by Rappaport (1981) had major influences in the health field. Robertson and Minkler (1994) state that it is "well documented that health is significantly affected by the extent to which one feels control or mastery over one's life, in other words, by the amount of power or powerlessness one feels." When conceptualized in such a way (in terms of control and as embedded in social, political contexts), empowerment becomes a crucial strategy for health promotion. Health promotion defined in empowerment terms is the "process of enabling people to increase control over, and improve their health" (WHO, 1986).

Robertson and Minkler (1994) state that, borrowing from feminist conceptualizations of power, the new health promotion movement attempts to frame empowerment as "power with" instead of "power over" or "power to." They state that many new health promotion practitioners see their new professional role as empowering or *giving power to* individuals and communities. However, this would mean no change in the old provider/client relationship. Instead of giving *power to* the people, Robertson and Minkler (1994) argue that the professionals should share *power with* the people. They reiterate Rappaport's (1985) point that empowerment occurs not when power is given but when power is taken by individuals and communities to enable themselves to set and achieve their own agendas. Rappaport (1985) states that "what those who

have power and want to share it can do is to provide *the conditions and the language and beliefs* that make it possible to be taken by those who are in need of it" (p. 18, italics added).

Other similar conceptualizations of empowerment can be found in nursing, medicine, and the human services. In nursing Gibson (1991) defines empowerment as a social process of recognizing, promoting, and enhancing client's abilities to meet their own needs, solve their own problems, and mobilize the necessary resources in order to feel in control of their own lives.

All preceding definitions of empowerment refer to individuals from both sexes and the definitions are derived mainly from theory. Shields (1995) states that, even though women have used the term to articulate experiences in their lives, women and gender issues have not been adequately addressed in empowerment research. In an aim to counter the theory-driven and gender-neutral conceptualizations of empowerment, Shields (1995) conducted an exploratory study that focused on women's perception of the meaning of empowerment in their lives. Fifteen women aged 21-71 who self-identified with the concept of empowerment participated in in-depth interviews with a follow-up opportunity for group participation. Qualitative analysis of the results indicated that women experienced empowerment as a multi-faceted process with three central themes: the development of an internal self, the ability to take action based on their internal sense of self, and a theme of connectedness. The emergence of an internal sense of self involved four components: claiming pieces of one's identity (as related to gender, sexuality, femininity, and sex role), development of self-value, development of self-acceptance, and the development of trust in terms of self-knowledge. Within the second element of empowerment, the movement to action, choice and control, women mentioned the importance of having voice, the ability to take positive risks based on a sense of internal self, development of a competence including special skills and abilities, and the emergence of refined thinking and learning patterns. Lastly, a theme of connectedness was present in each of the 15 interviews and occurred at two levels: intrapersonal connectedness (connection and integration between all components of the internal sense of self

and the ability to take congruent action; revealed in words like wholeness, balance, groundedness, or centeredness) and interpersonal connectedness (commitment to other people and to the community). Shield's (1995) results show that empowerment as perceived by women share similar characteristics with conceptualizations derived from theory such as the centrality of a sense of control and of language (having a voice and developing communication skills).

The preceding discussion of the definitions of empowerment shows that the essential components of empowerment are having control over one's life and decisions, having choice, "having a voice", and holding self-efficacy beliefs (beliefs that one can make a change). Within the context of human services, these translate into the view of clients as resources (instead of needy individuals, objects, or passive recipients of services), listening to and learning from the people, and view of professionals as collaborators or partners instead of experts. Most of these components are crucial for understanding empowerment models.

Empowerment models

As can be seen from the preceding discussion, empowerment is a multi-faceted process that involves intrapersonal, interpersonal, organizational and societal levels. This section comprises a discussion of empowerment models at organizational and systemic levels. Organizational models of empowerment focus mainly on the institutional (and interpersonal) factors impacting empowerment. In contrast, the systemic approaches to empowerment situate and analyze power and empowerment as a multilevel concept with interpersonal, institutional, and societal influences.

Organizational models

Ideal types of health care worlds of Ruzek

Ruzek (1978) states that practitioners' and patients' beliefs about the responsibility and autonomy appropriate to each are a crucial factor limiting or encouraging women's decision-making opportunities (their autonomy) in health care. Using these beliefs (that range from expecting physicians to assume all responsibility and authority to expecting women to assume most responsibility of routine care), and utilizing field observations, interviews, and literature, Ruzek (1978) constructed four ideal types of routine obstetrical and gynecological health care settings. These are traditional-authoritarian, traditional-egalitarian, traditional-feminist, and radical-feminist worlds, where feminist settings assigned more responsibility and authority to the clients. How authority and responsibility were negotiated in each place depended on six dimensions: (1) dominant role relationships between the service provider and the women client, (2) social distribution of medical knowledge, (3) division of labor, (4) access to curatives, (5) management of time and space, and (6) assignment of risk.

Dominant role relationships between the service provider and the women clients. Within this dimension, at one end of the continuum are traditional-authoritarian health care worlds that are dominated by physicians who believe that all authority and decision making should remain in their hands. These settings employ the "activity-passivity" model of physician-patient relationships. Some interaction with high-status patients may also conform to the "guidance-cooperation" model. Emerson (as cited in Ruzek, 1978) argues that women are expected to be "passive and self-effacing, show a willingness to relinquish control to the doctor, refrain from speaking at length, or from making inquiries requiring long explanations, and to keep from projecting profusely (p. 105). This lack of participation is guaranteed through the attitudes of

physicians that inhibit discussion, the use of unnecessary anesthesia in childbirth, and scare tactics designed to force women to submit to radical mastectomies (Ruzek, 1978).

In traditional-egalitarian worlds, professionals assume responsibility for and authority over care, while patients are expected to be somewhat informed and involved. However, although patients are encouraged to make choices and decisions, they do so within the parameters defined by the physician. Role relationships follow the "guidance-cooperation" or "mutual-participation" models of Szasz and Hollander (1956).

Traditional-feminist and radical-feminist settings that emanated from the Women's Health Movement, altered the role relationships on authority and responsibility in significant ways. In traditional-feminist clinics, female paraprofessionals provide most of the actual care, which reduce opportunities for physician dominance over women clients. In many clinics, physicians diagnose, offer advice, or perform medical procedures, only after other workers have seen the patient. Closeness and communication between provider and client are also facilitated by the existence of an all-female paraprofessional staff (Ruzek, 1978). The interaction between the patients and paraprofessionals followed the "mutual-participation" model of Szasz and Hollander (1956), where women are expected to be interested and involved in their own care.

At the other end of the continuum of beliefs and role relationships concerning authority and responsibility of health care are the radical-feminist worlds, where patients are encouraged to assume major responsibility for their own care (with the assistance of trained laywomen). Whenever present, physicians are delegated to technician status, hired only to do the jobs restricted by law (e.g. writing prescription, inserting IUDs, perform abortions, etc.), and are allowed to do so only after lay persons have defined what needs to be done (Ruzek, 1978). The basic difference from the traditional-feminist settings is that women in radical-feminist settings learned to perform basic health services for themselves.

Social distribution of medical knowledge. The second dimension of authority and responsibility defining ideal types of health care settings is the assumptions about the social distribution of medical knowledge. Ruzek (1978) states that, in traditional-authoritarian settings, physicians believe themselves to be the only reliable source of medical information. The physician's desire to maintain a monopoly over medical knowledge might involve unwillingness to provide adequate information to women about the side effects and risks of oral contraceptives, refusing to reveal diagnoses, not only for fatal diseases but also for common disorders, and resenting the reproductive information that was in women's hands (Ruzek, 1978).

In contrast to traditional-authoritarian settings, physicians in traditional-egalitarian settings believe that only by receiving adequate information can the women better manage pregnancy and delivery, report symptoms more accurately, and make truly informed decisions about their own care -even surgery (Ruzek, 1978). However, even in this setting, women are expected to increase their knowledge only through the physicians, and not by themselves. A major goal of the Women's Health Movement was to change this social distribution of medical knowledge from the exclusive property of licensed experts to women themselves. Thus, in both traditional- and radical-feminist settings, women are expected to increase their knowledge about their bodies and their health through encounters with physicians, nurses, lay health workers, and family and friends, and participation in health discussion groups and self-care clinics (Ruzek, 1978). Participants in feminist settings believed that, with adequate information, women themselves are the most competent ones to make decisions on contraceptives, sterilization, childbirth, and gynecological and breast surgeries.

The division of labor. Ruzek (1978) states that the division of labor in health care settings is both determined by and helps to solidify the distribution of medical knowledge. In both traditional-authoritarian and traditional-egalitarian settings, there exists a rigid division of labor

between workers and patients based on formal training and certification. For example, receptionists perform clerical services, nurses perform some clerical but mostly "nursing services" (e.g. dispensing medication, taking temperatures, assisting in pelvic examinations, etc.), and physicians reserve all medical tasks for themselves, including the rights to delegate undesirable tasks to lower-status physicians or to nurses (Ruzek, 1978). The division of labor in conventional settings also creates distance between clients and practitioners, restricting patients' access to medical information.

In traditional-feminist and radical-feminist settings, the division of labor is less hierarchical, and physicians actions and responsibilities are observed and evaluated by lay women (Ruzek, 1978). These settings minimize specialization, certification, and hierarchical relationships as much as possible through job rotation between staff. Ruzek (1978) states that while this pattern works in small groups, clinics move towards increased specialization as they expand their services. Riger (1984) also found that the collective orientation and anti-leadership stance of feminist organizations led to their gradual demise. A collectivistic structure brought the dilemmas of time, emotion and inequality (the slowness of decision-making procedures, emotional intensity of interactions, inequitable influence within groups that value equality, and difficulty in holding members accountable).

Despite the attempts at minimizing specialization, in traditional-feminist settings, the division of labor between physicians and non-physicians was similar to those in conventional settings, with the non-professionals' performance of services relieving physicians from the tedious tasks without challenging their authority. In contrast, the radical-feminist settings altered the division of labor through self-help strategies.

According to Ruzek (1978), the three last dimensions of health care are access to curatives, management of time and space, and assignment of risk. Regarding access to curatives, the main difference between conventional and feminist settings is the respective desirability and

access to prescription drugs and devices vs. more natural or less-technological methods (such as barrier methods of contraception, home birth, etc.). Ruzek argues that in traditional-authoritarian worlds, physicians maintain secrecy about their curatives, pushing oral contraceptives as superior to other methods, despite the evidence that combination of diaphragms with jelly or foam with condoms are equally as effective as the pill or IUDs.

In terms of territorial arrangements, Ruzek (1978) argues that in physician-controlled conventional settings space is subdivided between workers, patients, and persons waiting for patients. In gynecological exams, space is further divided by stirrups and drapes, "marking off the women's pelvis as practitioners territory" (Ruzek, 1978, p. 128). In traditional-egalitarian settings women may be allowed to observe pelvic examinations directly or with a mirror. In contrast, feminist settings try to arrange space to minimize distinctions between patients and practitioners, operating through home-like environments and arranging self-help meetings in various places (churches, colleges, homes, etc.). Regarding time, although there might not be a difference between conventional and feminist settings in the waiting time to see the professional (except for self-help delivery model), the feminist settings try to use the waiting time for education and forming personal rapport with clients. Feminist settings also try to have longer visiting time than those patients would have in conventional settings (Ruzek, 1978). Assignment of risk dimension deals with the definitions of risk and safety in conventional and feminist settings and the related willingness to intervene.

A more recent example of an organizational approach to empowerment, which provides additional support for Ruzek's (1978) dimensions, comes from Jan Thomas' (2000) study of 14 feminist health centers.

Thomas' model of empowering care

Thomas' (2000) study focused on how feminist health clinics defined and translated empowerment into care. Using the mission statements, she found that the centers conceptualized empowerment as a process "that takes place over time through the mutual sharing of information, knowledge, and skills" and "culminates in a woman's active control of her health care" (Thomas, 2000, p. 144). She states that hospital-based women's health centers adopt a similar discourse of empowerment that emphasizes the sharing of information with women. However, these discourses do not include the shift in the locus of control from provider to patient. This focus on women's control over their health care is equivalent to the concepts of responsibility and autonomy on which Ruzek (1978) based her ideal health care worlds.

Thomas (2000) found that feminist women's health centers used three main strategies to empower women towards taking control over their health care. These were: (1) Education and information to increase knowledge and demystify medicine, (2) Breaking down institutional barriers, and (3) Dignity and Respect.

Providing information. Thomas (2000) found that one of the most basic ways feminist centers empowered their clients was by providing them with education and information in a nonjudgmental, peer-oriented manner, where the information (such as in pamphlets) included both mainstream medical information and self-help and alternative treatments. The information was also provided in an interactive manner, where women were told step by step what was being done and why during an exam or a procedure. Women were encouraged to participate in their gynecological care, e.g., weighing themselves, inserting a speculum to see the cervix, taking their blood pressure and temperatures. Thomas (2000) also observed that most centers used lay health workers to provide services such as birth control counseling, blood pressure checks, prenatal care,

and assisting in abortions. Lay workers were used to reinforce the belief that women can learn about their health care from each other.

Breaking down institutional barriers. A second strategy feminist health centers used to empower women was breaking down institutional barriers such as uneasy access to the center, impersonal and alienating atmosphere of medical settings, limited appointment time, massiveness of bureaucracies and medical facilities, and the provider attitude to privilege efficiency over the patient. Feminist centers attempted to break these barriers down through choosing easily accessible locations, using older renovated homes or small office buildings for their personal non-medical environments, reducing the social distance between staff and clients by referring to the staff (including physicians) by their first names and having staff who did not wear lab coats, spending the needed time with each client, having specialized care for special populations (lesbians, women with special needs, etc.) and through community outreach programs.

Dignity and respect. The last strategy used by feminist health centers to empower women was treating all women with dignity and respect. This included having providers treat women as though they can make choices that are right for them, and having women clients realize that they *deserve* to have their needs met in a health care interaction. Providing colorful patient gowns and mittens on stirrups, and allowing clients to be dressed when first meeting the provider also helped restore respect and dignity in gynecological settings.

The first two strategies discussed by Thomas (2000) parallel Ruzek's (1978) dimensions of "social distribution of medical knowledge" (providing information), "division of labor" (use of lay workers), "dominant role relationship between provider and client" (interactive service, reducing social distance between staff and clients), and "management of time and space" (personal non-medical settings, spending needed time with each client). To Ruzek's dimensions,

Thomas adds the importance of dignity and respect, which is an ethical dimension. Ethics of health care will be discussed in depth in the following section.

Systemic approaches to empowerment

Systemic approaches to empowerment situate and analyze power as a multilevel concept with interpersonal, institutional, and societal influences. In this section, I will discuss systemic approaches from the quality of care perspective and from the ethical perspective. Both perspectives emphasize the effect of larger, sociopolitical forces on the individual experience of an empowering care. The major difference, though, is that in the ethical perspectives these influences are seen within a framework of justice, as defined in relational terms (as "relational autonomy").

Quality of care perspective

In their "strategic approach" to contraceptive introduction, Simmons et al. (1997) state that in the field of reproductive services the introduction of new contraceptive technologies has not expanded contraceptive choice. This is because the relationship between technology and choice have been considered in a social and institutional vacuum, and the fit of the new method with the delivery capacities of the institutions, with the existing methods as well as with beliefs in a culture has been ignored. Due to the lack of success of this technology-driven paradigm, experts from the World Health Organization and other institutions defined a new paradigm of contraceptive introduction called the "strategic approach".

Simmons et al. (1997) have conceptualized the strategic model as a triangle with the "users" at the apex (reproductive health needs and rights, user perspectives, medical profile, sociocultural and gender influences) being influenced by and influencing "service" (policies and

program management, availability and accessibility and quality of care) and "technology" (method-mix characteristics, efficiency, side effects, reversibility, etc.). Users, service, and technology are further embedded in the larger contexts of polity, society, and economy (see Appendix A).

Questions suggested by the user-service interface are the following: Do users find the health center accessible in terms of distance and cost? Are waiting times acceptable? Are users rights to adequate information and voluntarism in contraceptive use and method choice respected? Are people are treated respectfully and with adequate care by the staff? Are women with incomplete abortions provided with adequate care? Are contraceptive methods affordable? (Simmons et al., 1997). The institutional factors regarding service-delivery capacity deal with whether the service delivery system has the necessary managerial capacity in terms of human resources development, planning, logistics and monitoring, whether technical capacity allows application of new methods with quality of care, and whether the institutional policies support voluntarism and choice in contraceptive use.

A similar model that emphasizes program capacity as well as the users' perspective in family planning services is Bruce's (1990) framework for assessing quality of care in these services. In an attempt to redefine quality of care in family planning services, which has always been treated to be synonymous with the availability and/or access to contraceptive services, Bruce (1990) lists six salient dimensions. These are choice of methods, information given to users, technical competence, interpersonal relations, follow-up or continuity mechanisms, and appropriate constellation of services.

Choice of methods refers to both the number of contraceptive methods offered on a reliable basis and their intrinsic variability across different subgroups defined by gender, age, contraceptive intention, health profile, race, income, etc. Information given to clients includes information about the range of methods available, their contraindications, advantages,

disadvantages, and providing details on how to use the method selected. Technical competence involves competence of technique of providers, observance of protocols, etc. Interpersonal relations are relations between service providers and clients as influenced by a program's mission and ideology, management style, resource allocation, ratio of providers to clients, and supervisory structure. Mechanisms to encourage continuity can involve relying on community media, or on specific mechanisms such as home visits by workers. Appropriate constellation of services refers to situating family planning services so that they are convenient and acceptable to clients, responding to their natural health concepts, and meeting their pressing health needs (Bruce, 1990).

Ethical approaches to empowerment

Ethics in general, and health-care ethics in particular, are disciplines concerned with identifying criteria by which to judge the moral legitimacy of practices or to identify the considerations that are morally relevant in determining the acceptability and justification of health practices (Sherwin, 1996). Kols et al. (1999) discuss a model of client-centered care in family planning based on the four principles of biomedical ethics: autonomy, justice, beneficence, and nonmaleficence. Respect for autonomy recognizes that clients have the right and the ability to make decisions about their health care. Principle of informed consent, which is at the heart of autonomy, requires providers not only to respect clients' right to take actions based on their values and beliefs, but also to encourage and enable clients to make such decisions by helping them understand their options (Kols et al., 1999).

Justice demands that both risks and benefits be distributed equitably throughout society, that everyone have access to services. Beneficence obliges providers to act in the client's best interests either by preventing harm or by doing good. Nonmaleficence requires providers not to inflict harm, which requires family planning providers to have an up-to-date and in-depth

knowledge of contraceptives, and to follow guidelines and protocols to ensure client safety (Kols et al., 1999).

After defining the four principles, Kols et al. (1999) discuss how these ethical guiding principles map on to client concerns and how these concerns may be met. Respect for autonomy represents clients concerns over acquiring full and correct information from providers on different contraceptive options and being treated with respect in their ability to make decisions. Being treated with respect involves courtesy, confidentiality, and privacy. The principle of justice reflects client's access to services, which are affordable, reliable, and without barriers. Beneficence reflect client worries over whether the providers have the technical competence required to give those services and whether they will make an effort to understand their particular situations and needs. Lastly, the principle of nonmaleficence represents clients' worries over safety issues. Kols et al. (1999) argue that putting these ethical principles into practice to meet clients needs requires changing providers' attitudes from paternalistic to client centered ones, assessment of client satisfaction, raising client expectations about care, and meeting the needs of the staff through training, supervision, and supplies, etc.

Sherwin (1998) states that, although ethicists and biomedical ethicists focus on such criteria as protection of human rights, the well-being of patients, and justice in the distribution of scarce resources when evaluating the ethics of practices in health care, they have been quite insensitive to the roles that health-care practices play in the perpetuation of oppressive systems. She says that feminist ethics requires that oppression, which is a moral matter, should be included in any evaluation of ethics of particular practices in health care.

Aside from excluding oppression as an ethical criterion, Sherwin (1998) criticizes biomedical ethics also for its subject matter being conceptualized "as a contest between two opposed models of patient care." These models are paternalism and autonomy. Sherwin (1998) argues that conceptualizing ethics of health care in this way focuses on the issue of control of

medical decision making at the moment of the treatment. This in turn assumes that medical decision making is simply an individual matter between patients and providers carried out at the precise moment of individual treatment. In reality, the range of options available to both parties at the time of treatment have been reduced significantly by prior decisions on setting research agendas, allocation and accessibility of health care resources, and by the power of the dominant medical tradition. Feminist ethics requires that these prior layers of decision-making be exposed and evaluated and concepts of "justice" and "autonomy" be redefined in socially situated (instead of individualistic) terms (Sherwin, 1996). In Sherwin's (1998) reconceptualization, "relational autonomy" becomes more than informed choice (or the presence or absence of being offered a choice), but also requires that the person have the opportunity to develop the skills necessary for making the type of choice in question, the experience of being respected in her decision, and encouragement to reflect on her own values. Besides change at this individual level, relational autonomy demands attention to ways in which choices of those belonging to oppressed groups can be modified to include nonoppressive options (as when women choose cosmetic surgery or hormone replacement therapy as a result of seeing her options being oppressively constructed to leave her little choice but to pursue beauty for sense of self and social acceptance) (Sherwin, 1998).

The relational interpretation of client autonomy has various crucial implications for health care. In terms of health care research, the relational autonomy approach requires going beyond the criterion of informed consent, and asking questions about who is invited to participate in research, who is not, and how the particular research questions were selected. In health care practices it demands looking at the doctor-patient relationship in the wider context through analyzing how service providers participate in reinforcing social understandings of women, and how women patients resist physician power through noncompliance or demands for change in service. The relational approach also requires the questioning of health care orientations that view

health-related services simply as consumer options, to be made available to whoever chooses them. Policy choices on what procedures are developed and what services health professionals are trained to provide should be subject to public debate (Sherwin, 1998). As a final implication, Sherwin adds that health care providers become sensitive to their own biases and assumptions about patients. All of these represent empowerment strategies at different levels of health care.

Implications of empowerment definitions and models

As defined by Rappaport (1985), Robertson and Minkler (1994), Gibson (1991), Shields (1995) and Thomas (2000), empowerment involves having a sense of control, a voice, self-efficacy beliefs, and choices. In the health care context, it is defined as the client's having control over her health care. The empowerment models provide a more in-depth analysis of how empowerment (control over one's care) occurs, how we can operationalize and measure it.

Thomas (2000), Bruce (1990), and Simmons et al. (1997) emphasize the importance of distance, cost, and time (waiting time and time in services). I call this the dimension of *access to services*. Questions under this dimension of empowerment are whether the health center(s) are easily accessible for the women, have affordable care (and is it affordable to all women?), and have acceptable waiting times. Ruzek (1978) adds to these the "management of time", which brings the questions of how much time is spent with providers and how the waiting time is used. She states that in feminist centers the waiting time is utilized to educate and build rapport with women and that the providers spend more time with women than providers do in traditional settings.

The second dimension of empowerment that emerges from Ruzek's (1978), Thomas' (2000), Bruce (1990), and Simmons et al. (1997) models involves what I call the *service delivery characteristics* in an agency that influence empowerment. All models discuss the importance of

providing correct and adequate information to women on reproductive methods and procedures that include advantages, disadvantages, and side effects. Thomas (2000) and Ruzek (1978) add to these the inclusion of information on alternative treatments and encouragement of self-help. They also emphasize the importance of the way the information is presented, where interactive, nonjudgmental, peer-oriented styles used by feminist clinics are expected to lead to empowerment. Bruce (1990) mentions the choice of methods offered on a reliable basis and their variability across subgroups of women as defined by age, contraceptive intention, health profile, race, income, etc. Ruzek (1978) focuses on the preferences for barrier methods over hormonal ones. Other aspects of service delivery characteristics are the dominant relationship between provider and client (Ruzek and Thomas), the division of labor in the agency (Ruzek and Thomas), follow-up mechanisms (Bruce), management of space (Ruzek and Thomas), assignment of risk, and staff training and support (Bruce and Simmons et al.).

The ethical perspectives to empowerment bring out a third dimension of empowerment, *ethics of care*. Within this dimension of empowerment certain aspects of the previous two dimensions (of access and service delivery characteristics) are interpreted as ethical issues. For example, Kols et al. (1999) states that the principle of justice demands that risks and benefits be equally distributed in a society and that everyone has access to services. Translated into women's health care this means that clients' access to services that are affordable, reliable, and without barriers is a matter of justice. Thomas (1990) also refers this under "dignity and respect," where she describes feminist centers' mission of serving all women regardless of their income status.

Both Kols et al. (1999) and Sherwin (1998) also interpret providing of information as an ethical issue. Kols et al. states that "respect for autonomy" requires that a client be provided full and correct information and be respected in her decision making ability and her decisions. Being treated with respect also included courtesy, confidentiality, and privacy. Sherwin adds to these the

need to provide the opportunities for the client to develop the skills that are necessary for making informed decisions, and the importance of providing women with non-oppressive options.

The last aspect of ethics is Sherwin's (1998) emphasis on exposing the prior layers of decisions making (e.g. reproductive policies, dominant medical paradigm, research agendas) which limit women's (and providers') autonomy in reproductive health care.

These three dimensions of empowerment, *access*, *service delivery characteristics*, and *ethics of care*, were used in this study as "sensitizing concepts" to guide data collection and analysis.

To the extent that our lives are tied to our disciplines, our ability to construct ourselves in other stories will depend upon how the discipline can be deconstructed.

Laurel Richardson, 2000, p. 154

CHAPTER 3

METHODS

The design of the present study is a feminist case study with ethnographical components and poststructural influences. In what follows I discuss the phases of my research, the data collection, analysis, writing, and the research issues of reliability/validity as guided by the ideas of feminism or post-structural feminism. Feminism guided all the stages whereas post-structuralism guided mainly the data collection and analysis. The feminist and poststructural framework essentially led to rejecting objectivity and neutrality, and emphasizing instead personally and politically engaged, accountable research, where I claim to present only a partial (historically and temporally situated) truth about empowerment in reproductive health in two clinics.

In my research, the stages that I present below in a logically ordered fashion (from collection to writing) in reality overlapped. Data analysis began with data collection, and even before that in the search for sites, when my access to agencies was complicated by the bureaucracies and staff shortages in Planned Parenthoods, financial struggle of a feminist organization, and perceived threat by the District of Health Centers. Data analysis during transcription of interviews or review of field notes, and agency documents also guided further data collection in revising the interview questions, asking more questions to staff on the operation of the agency, and in making decisions on what to focus in future observations. This circular feedback relationship between data analysis and collection is commonly mentioned in

ethnographic research and in the Grounded Theory method (Strauss, 1995); however the reporting is still done in a traditional way in the sense that research is 'reconstructed' as a linear and unmessy (hygienic) process. In each section below, I will attempt to interrupt the traditional description of steps with weaving in research experiences that exemplify the concepts of subjectivity, researcher's authority, vulnerabilities, and accountability as discussed in Chapter 1.

As a primary intervention, I would like the readers to imagine what the research would be like if it was conducted by a male researcher, a woman researcher of a different age/color/sexual orientation, or simply by themselves. Very different data and interpretations would be elicited, which would still reveal partial yet other sides of the same phenomena. I conducted this research as a white, heterosexual, international, single woman in her early thirties, as a feminist woman who is situated in a doctoral program with a more positivist/objectivist approach to social science. Through the research process, I also moved from a feminist to a poststructural feminist position, which puts me in an even more vulnerable academic position. My being in early thirties (vs. twenties or forties) on the other hand, led to specific -more peer like- relations to staff and clients, and to a complex look on the abortion decision itself.

As I will further address in the reliability/validity section, I believe that situating myself in the research process and taking a self-reflexive position to unmask the research process and reveal complexities of research strengthens the research report.

Data Collection

I started this journey looking for three sites that offered birth control services to women. These would be a feminist health center, a Planned Parenthood, and a hospital-run clinic or a women's center run by the department of health. With my doctoral committee's suggestion, I decreased the sample to two sites: a feminist and a non-feminist site. For the non-feminist site,

preference was given to either a Planned Parenthood or a public health center which, based on their mission, funding, private/public status, were expected to reveal diverse data on the empowering processes.

In my search for the sites, I contacted many academicians and service providers (between September 2000 and May 2001) in the field of human services, public health and women's health who provided me with contact information for possible sites. I also searched the internet. I then contacted a total of eight agencies, introduced myself, asked for their services and populations they served, and if interested in the research, presented them with letters explaining my research on empowerment of women in reproductive services, which I defined as women's participation in their services. Most of these conversations with agency personnel were held over the phone, through e-mail, and fax, except for the two cases where I visited the agencies. In the letter presented, I asked the agencies if I could interview a sample of their staff and clients, observe a few of the sessions between health care providers and women clients receiving birth control counseling, and review materials such as their pamphlets, agency policies and guidelines and any evaluations conducted by previous researchers. I attached to the letter a copy of a consent form to be signed by agency directors. (Please see Appendix B for a copy of a letter and the director consent form where the name of the agency and the person's identity are excluded for confidentiality purposes).

Six of the eight agencies I contacted refused to participate in my research. The six agencies that refused participation were district health centers, a for-profit feminist health center, a community reproductive health center, and three different Planned Parenthood agencies. The reasons given for not participating were staff shortage and limited resources to accommodate the researcher, worries over overburdening the clientele who were exposed to the agencies' own surveys, and in the district of health centers, a concern over the topic of my research (empowerment), which I sensed posed a threat to their centers for it seemed as an evaluation of

their staff. It is also interesting to note that the feminist agency requested compensation money for accommodating me for two weeks in their agency.

Two centers that did agree to participate were a feminist health center and a women's health center in two different, mid-size cities in the northeast United States. To protect their identity, I will call these centers with the pseudonyms Feminist Health Center (FHC) and Women's Health Center (WHC). I made two trips to FHC in July and September of 2001, and three trips to WHC in March, April, and September of 2002. Both centers are progressive and thus not as contrasting as a Planned Parenthood or a public health center might have been. However, there are enough differences such as for profit vs. non-profit status, running as a collective vs. a hierarchical structure, and having a medical vs. less medical approach to providing services, which provided diversity in empowerment processes. The existing similarities such as the progressive -a woman centered- approach, being a small community clinic, and located in (and serving) a mid-size city with a predominantly white population on the other hand, made the data compatible and meaningful to compare. Initially my focus was on empowerment in *birth control* services. However, due to the fact that both agencies also provided abortion services and being an abortion provider constituted (historically and presently) an important part of their identity, I decided instead to focus on both abortion and birth control services and recruit clients who used one or both of these services of these agencies.

In each agency, I had key informants (the Education and Outreach Coordinator of FHC and the Executive Director and Head Counselor in WHC) who helped me schedule the trips, introduced the research to the staff, and were my main contacts in initial recruitment of staff and ongoing recruitment of clients. In FHC, the interview clients were recruited mainly through the help of the receptionist (where receptionist was one of the positions staff performed on a rotating basis). The receptionist presented my research flier to the women with the intake form, explain the research very briefly, and request them to decide on participation. If I was there, I also

introduced myself to the women. Clients made their decision to participate and returned the flier with their intake form to the receptionist. I also recruited clients for interviews with the help of the physician's assistant. Recruitment for counseling and gynecological, and abortion follow-up observations was done with the help of the health care workers counseling the women before abortions, and the physician's assistant. Both the counselors and the physician's assistant introduced me and asked for women's consent for observation, after which I further explained the study and obtained their signed consent. Some of these women also agreed to participate in an interview to be scheduled on another day.

In WHC, the initial recruitment strategy was similar to the one in FHC, where the receptionist included my flier with the intake forms (though without any verbal explanations of it). Due to lack of success with that strategy, after talking with the Head Counselor, we switched to including the flier with the intake forms and having counselors ask the women about their research participation in observation only or observation plus an interview conducted at a day and time suitable for them. Noticing that it was still difficult to recruit women especially for interviews, I discussed with the Executive Director and the Head Counselor the possibility of recruiting women at the follow-up visit (when the women had completed the abortion and thus were more relieved) where the nurse practitioners introduced the research to the women. This proved to be a much more successful strategy to recruit abortion clients to interview. The nurse practitioners also helped me to recruit women for gynecological observations and interviews. (Please see Appendix C for copies of fliers for the two agencies). Despite the difficulty of recruitment of clients for my research, I felt very welcome in both places and am indebted to the women working in both agencies for opening what they called their homes to me. These difficulties also provided me with an important research experience in ethnographic research, especially on the need to be flexible and to adapt research strategies to the needs of the settings.

The data collected from both sites consisted of: (a) semi-structured face to face interviews with staff and clients (clients of birth control and abortion services), (b) observations of pre-abortion counseling sessions, and gynecological visits (including regular gyn check-up, birth control renewal, and post-abortion follow-up visits), (c) field notes on staff-staff and staff-client interactions, on protesters, spatial arrangement of the centers, and conversations I held with staff during the time I waited for recruitment of clients, and (d) a review of agency forms (such as consent forms, and intake forms, educational pamphlets (and posters) that were displayed throughout the centers and the pamphlets that were given to the women by health care workers, counselors, physician's assistant or nurse practitioners) and archival materials (such as agency albums).

The pamphlets and handouts given to women included information on birth control methods, emergency contraception, abortion procedures (medical or surgical abortion), after-care instructions (including the 24-hr number of the agency), and how to cope with abortion. The pamphlets (and posters) throughout both agencies (at the entrance, in the waiting rooms, counseling rooms, exam rooms, bathrooms) included other topics of women's health such as domestic violence, how to talk to your partner/parent/daughter about abortion, reproductive rights advocacy, and hormone replacement therapy. Both centers had Spanish versions of certain pamphlets. Both centers also had pamphlets targeting different populations such as teenagers or parents of teenagers (e.g. WHC's "My Parents Would Kill Me" or "Your Daughter Wants to Talk"), men (both WHC and FHC had a pamphlet on "men and abortion". FHC also had a pamphlet called "Men and Birth Control"), and Catholic women (both WHC and FHC had the pamphlet called "You are not alone: Information for Catholic women about the abortion decision" published by Catholics for a Free Choice").

In addition to the pamphlets, I also reviewed issues (between 1978 and 1994) of a newsletter published by FHC and an agency album consisting of local newspaper clippings on

WHC's history (the album also had a few documents on agency reports of violence and press releases by the agency). The review of these archival materials provided historical information about the birth and the evolution of both agencies, their ties to the community and the Women's Health Movement. They also provided information about the violence and other challenges -e.g. zoning problems- the agencies faced in providing abortion care for women.

All the staff interviews were conducted at the agencies (except for my interview with Duncan, the medical director of FHC, which was conducted at his home). The interviews with the clients from both agencies were conducted either in rooms at the centers, at their homes, or at a restaurant close to WHC. The staff and client interviews ranged from forty minutes to an hour and half. All interviews were audiotaped. All staff and client names used in the study are pseudonyms that the participants chose to adopt.

Observations took place in the counseling rooms, gyn exam rooms, and in the "procedure room" of FHC (for the only abortion I observed). During the abortion, abortion follow-up, and gynecological observations, which involved the women using the stirrups, due to privacy and respect, I stood by the head of the client. And in all observations, except for requesting demographic information from the women and recording the beginning time, I decided not to take any notes until after the observation. When the session was over, I thanked the women, left the room, and filled out the observation form and wrote a more detailed summary of my observation in my notebook. (Please see Appendix D for copies of staff and client interview and observation forms for both agencies).

I took field notes on my informal conversations with the staff, on my observations of interactions among the staff, between the staff and clients, protesters, spatial arrangement of the centers, postings on boards for clients and staff, and in WHC the entries to the staff communication notebook. Field notes also included theoretical and empirical questions and interpretations, as well as a record of my personal journey throughout research, including

transcription and data analysis stages (where the field notes became "transcription notes" and "memos" respectively). Field notes during data collection were taken in the down-times (away from recruitment, observations, and conversations with staff) in an office or an unused counseling room provided for my use for that day, as well as after leaving the center for the day. For the latter, I took short notes during the day to remember the sequence of the events and which events needed more elaboration. The examples of different type of field notes taken during data collection could be found below in "research as an embodied experience" section. Field notes provided information that supplemented the other types of data, especially the interview data, and enriched my understanding of the dynamics of the agency, which was better captured in becoming a participant observer and going through the daily operation of the agency with the agency workers.

(Inter)ruption: Lessons from the field or the unsaid of research

Research as an embodied experience

Wanda Pillow (2000) states that, in her ethnographic research on teenage pregnancy programs she "entered the field settings filled with critical, postmodern, feminist, and qualitative research theories and practices" yet found herself "unprepared for the utter *physicality*" of her research experience (p. 200). During the research, she spent day after day in classrooms where the young women's bodies were continually changing -"swelling, stretching, widening, lactating" (p. 200). As she tried to write stories of these girls, Pillow states returning again and again to the body -her body and bodies of the girls- representing different yet shared experiences of "their reproductive capacities, and the interests in such by the state" (p. 200).

During my research, I also found myself faced with the physicality or what I will call as "embodiedness" of the research on reproductive services. There were my experiences as an observer, interviewer, and as data analyst and those of the women participants experiences,

especially on abortion. As Willow (2000) did, I also entered the field with feminist and qualitative theories, yet did not expect to be affected by the bodily experience of research, hearing women's stories and pain during the interviews and pre-abortion counseling sessions, and observing an abortion session and its aftermath (the washing and examining of the fetal tissue after the vacuum procedure), talking with staff over their passions and frustrations regarding their work, feeling angry at the violations of women's bodies by medicine, driving past protesters with bloody fetus signs to get to the WHC clinic, etc. Here are some examples from my field notes during data collection and transcription.

My abortion observation was very interesting. I will never forget the way the girl looked at me while leaving the room after the abortion. Like a sheep that was slaughtered. During the abortion, I was a little uncomfortable with the conversation going on among Dr. Duncan, Hazel (tech person), and Iris (patient support/advocate). The conversation was on one hand normalizing the procedure, yet on the other hand seemed like it decreased the attention on the girl lying there, as if not recognizing her experience, anxiety and pain. Hazel took the jar filled with the vacuumed blood, and brought it to the sink that was behind a screen separator, paying attention to hide the jar from the girl's view. To examine the fetal tissue, to see if all were there. She called me to her side and showed me the thing which would be the fetus. Since it was six or seven weeks of pregnancy, only as big as a quarter coin, it did not look like anything. A white thing. Its being white differentiated it from the blood. She showed me the nerve-like things around it and said those were where the fetus implanted to the uterus. I did not have an upset stomach or anything, but it was still a weird experience. I myself was scared during the pre-abortion counseling sessions, grew afraid hearing about the procedure. As I tried to visualize what was going to happen, I found it more and more humiliating, more violating.

Field notes on attending an abortion of an 18 year old girl, on my first data collection day in FHC, July 3, 2001.

After Shery's consultations (initial counseling sessions) -which were emotionally hard on me I think, she and I went to Lynn to see if I can observe some of the abortion counselings and then there were some misunderstandings...

Field note, WHC, March 19, 2002

Hurts me to transcribe the part about women feeling violated and arching their back, tightening their thighs, trying to avoid the puncturing of the instruments

Transcription note, Roxanne -a health worker in FHC- was talking about how some women tense their bodies during abortion. December 25, 2001

I'm transcribing my interview with Veronica, a client of the Women's Health Center. She's talking about being lasered. Says "I'm lasered".. then, somewhere I ask her "how long was it from the abortion to the burning?" burning.. she was burnt.. and she says right before, the lasering was more bothersome than the abortion, which she says was her choice.. I am pained, overly sensitized maybe? But still moved and pained by these things in the interviews.. we are talking about lasering, being burnt in your cunt. It's not anywhere in your body, which is sensitive enough too, but your genitals.. it's being scarred. You're scarred. I wonder if the doctors, the nurses, the health workers realize the pain and the vivid images that go with this.. they'll say "what do you want us to do? She had cancer, we are doing our best fighting the cancer? We are saving her life for god's sake?" Yes. But maybe I just want them to stop and think and feel for a second, how it would feel if they had to be lasered in their penises, balls, or cunts.. and then just feel for the client and understand the meaning of the thing for her as a whole. That's all I would ask them to do.

Notes on transcribing an interview with Veronica, May 26, 2002

I arrived at the city at 5:00 pm. Really tired and with the beginnings of a flu. I slept about 7 hrs yet I woke up not very rested. I came to the center at 8:30 am in the morning. As I was turning into the street of the center, I saw a police car or two and a cop was pulling a protester with a poster of a bloody fetus. As I was driving, I just took quick glances at the poster. The fetus could have been a new born baby with blood on it, yet I suspect it was a dismembered fetus. Couldn't tell.

Field notes on protesters and violence, WHC, April 10, 2002.

My thoughts also went to what if *I'm* pregnant, why I oppose hormonal methods now but would use them if I became pregnant once. So, wanna shift the blame, not wanna make the full decision over my body? I was thinking why women called it a mistake, when talking about their unintended pregnancies. Same discourse with teenagers I talked to in the AERS Project, about abstinence. They said it was a mistake, sex was a mistake. That would not happen again.. Saying it's a mistake may be the best suitable way (although some women also say they were irresponsible, so take on the responsibility of the pregnancy) better than saying I did not intentionally use birth control or I avoided my responsibility. So, it might be about responsibility but we -women- never see it as our "right" to make these decisions on sex, on birth control. So, can we have responsibilities without rights?

Field notes taken while waiting in a nearby restaurant for an interview with a WHC client, April 10, 2002.

This concept of embodied knowledge and research has gained increasing importance in feminist, postmodern, and poststructural theories where body becomes a "place from which to theorize, analyze, practice, and critically reconsider the construction and reproduction of

knowledge, power, class, and culture" (Pillow, 2000, p. 199). Using Luce Irigaray's work on feminist epistemology, Elizabeth Grosz (1993) shows how bodies are relevant to feminism and to challenging existing knowledges and ways of knowing. She states that, although feminists have frequently "struggled around issues involving women's bodies -the right to abortion, contraception, maternity, reproduction, self-defense, body image, sexuality, pornography, and so on-", there is still a reluctance to see how major of a role the female body plays in women's oppression (p. 194). Using Irigaray's work, she argues that instead of an add-on approach to research and thinking, where women are added to existing theories and research as neglected *objects*, feminism, using the body's relation to knowledge-making, should bring women back as *subjects* of theory and research.

Embodied knowledges (and ways of knowing) in research have implications for what counts as knowledge (or data). Embodied knowing also relates to detachment vs. passionate involvement in research, and to the power involved in knowledge production (the authority of the researcher). And all three of these things relate back to the objectivity debate.

Engagement versus detachment in research

[A feminist methodology of social science] requires that the mythology of 'hygienic' research with its accompanying mystification of the researcher and the researched as objective instruments of data production be replaced by the recognition that personal involvement is more than dangerous bias - it is the condition under which people come to know each other and admit others into their lives.

Ann Oakley, 1981, p. 58

As discussed before, both feminism and poststructuralism criticize and reject the 'scholarly detachment' of androcentric positivist science in favor of an engaged, self-reflexive research, where the researcher accepts (and makes explicit during research and writing) her active involvement in the co-creation of knowledge during research. The issue of engagement versus scholarly detachment is especially important in ethnographic research, where the researcher gets

inside the 'culture' or the worlds of the people she studies not only through interviews but also through participant observation. Reinharz (1992) discusses how feminist ethnographers negotiate "closeness" vs. "respectful distance" attained through "complete observer" versus "complete participant" roles. From a poststructural point of view, such distinctions are not very meaningful, since by her existence in the field, a researcher can never be a "complete observer".

Poststructural feminists are more concerned with the questions of recognizing the nature of the involvement, making it explicit, and being accountable for the consequences of involvement such as betrayal, inequalities between the researcher and the researched (and the shifting quality of power), and accountability in (re)presenting the findings.

In my research, I chose to be actively and passionately involved in the research as a feminist researcher, which influenced my interviews and observations. During the interviews, not hiding my feminist identity freed me to establish a strong bond with the staff of the agencies, and to ask them direct questions about the operations of their agency and how it related to the Women's Health Movement's or feminist goals. During the interviews with the women clients of both agencies, an involved stance allowed me to answer women's questions on my research and on reproductive issues (concerning different birth control methods, procedures such as colposcopy, insurance coverage of birth control and abortion), and to share with them both my personal experiences with different methods, my friends experiences with abortion, and my knowledge on methods, colposcopy, abortion, and state laws and regulations around abortion.

The challenges of this involvement appeared in balancing sharing of my opinions without imposing them on the interviewee or without turning the interview into an intellectual debate (that diverts the focus away from experience). In my interview with Felicia, a health worker in the FHC, for example, when discussing what 'feminism' means now, she brings out the example of a southern woman who previously worked at the center, who did not describe herself as a feminist despite the very feminist parts of her life (according to Felicia). At that point, I brought out the

history of feminism, black feminists' reactions to feminism as a white middle class activity, which turned the last part of the interview with Felicia into an intellectual debate.

Another challenge of taking an involved stance emerged in interviewing the Medical Director of FHC, who did not understand and fully agree with the feminist ideals of demedicalization of women's health services, and in interviewing a 'pro-life' client of WHC, who received an abortion from WHC. In these two interviews, I experienced the difficulty of eliciting their opinions while being honest about mine. However this approach provided benefits as well, In the interview with Duncan, the Medical Director of FHC, my honest questioning of medicalization in his presence brought out in a capsule (and in a more passionate form) the struggle between doctors and feminists on women's health care, making explicit the discourse strategies medical personnel use to establish authority over the women. I have realized only later, during transcription of the interview, how Dr. Duncan established his medical authority (over me) in talking about the benefits of Hormone Replacement Therapy while downplaying the chances of breast and uterine cancer to which these therapies might lead.

In the interview with Christa, an abortion client of WHC, who defined herself as a 'pro-life' activist, among the emotionally intense interview where she shared the difficulty of making her decision and still mourning it (and I empathized with her), there were points where I challenged her views on seeing pregnancy as a woman's fault and responsibility, tried to 'educate' her on why sometimes late abortions are necessary for teenagers who are in denial, and on the scarcity of the abortion doctors due to the pro-life movement. Both of these interview incidents relate to the negotiations of gender and feminist identity in the field, which, as discussed by Reinharz (1992), has been faced by many feminists conducting field research. Reinharz (1992) discusses how various feminist ethnographers have dealt with the roles to which they are assigned by the people (as daughter to be protected, nurse/mother who will care, etc), and with sexist behaviors including sexual harassment.

Adopting an involved versus a detached approach to research also influenced my informal and formal observations in the field. While making informal observations in both centers, I chose to participate in some of their daily tasks, such as folding the laundry with them, or ordering and eating lunch with them. During my formal observations of gynecological visits for abortion follow-up, birth control method check-up or renewal (e.g. as in Depo Provera or Lunelle shots), and in my observations of pre-abortion counseling sessions, I made the decision of not taking notes during the observations (out of respect), and when appropriate participated in the conversation, and asked women questions of clarification.

A section in the observation protocol is "reactions to me being there". While filling that out, I started to write my reactions to being there rather than vice versa. In the gyn and counseling visits, I was at a loss how to sit or stand, or where to put my hands. Watching the whole thing in a sterile way was difficult for me. I remembered something from the ethnography books saying a normal person does not just stand there as if nothing is happening. I hesitated whether to participate in the conversations or not, some places I did participate with either a question or a joke. And I do not think it made the observations less 'scientific'. It only made them more human. At least in my eye.

Field notes, FHC, July 3, 2001.

The issues brought up by an engaged stance in observations were how to negotiate the alliances and sense of betrayal. At the FHC, even though I did form connections with various staff at the agency, I sensed that my close connection to my key informant, Hazel, the education and outreach coordinator, could have provided problems in the long run, since she belonged to the more intellectually trained section of the staff who, as opposed to the self-trained or less educated staff, were also in more administrative positions. At the WHC, my entrance into the agency through the executive director and the head counselor enabled alliances with counselors. My growing connection to the nurse practitioner; however, endangered some of these alliances, since, as admitted by the staff, there existed a division along medical-counseling lines. Though working closely with counselors, nurse-practitioners seemed to be situated (spatially and

symbolically) midway between the medical staff (ultrasound room, procedure rooms and aftercare room) and the counseling staff (counseling rooms, front desk and waiting room).

Betrayal issues came up with my growing uneasiness with the realization that, even though it was discussed with and consented by the key informant, the FHC staff was not fully aware of my informal observations of their interactions with each other. Feeling that it would be a betrayal of their trust and friendship (as well as an unethical and ironic act for a feminist researcher studying a feminist agency), I contacted Hazel and asked her to discuss the issue with the staff, giving them some examples of situations I had noted as observations. After a staff meeting, she informed me of their full consent to use the data and of their support for my research. Use of informal observations was not an issue in WHC, where the Executive Director had made my initial letter on the research and her consent form available to the whole staff in the staff communication book, and I made remarks to and wrote down some of my field notes in an office provided to me, in view of the staff who passed by the room.

The last manner in which an engaged stance affected my research was my decision to offer both sites the opportunity to put one to two questions in my staff and interview forms, which I could evaluate and report to them separately. In FHC, Hazel was interested in knowing why women came there over other places (which was already one of the questions in my interview), and in WHC, Janet, the Executive Director, requested two questions on the staff interview on staff communication and documentation. This was my attempt to move the research from a one-way to a (despite small) collaborative effort, which relates to the power relationship between the researcher and the participants.

Shifting power in research

Due to their emphasis on subjugated groups in society (such as women, blacks and other minorities), and their attempts to avoid further exploitation of these groups within research,

feminists and other scholars working within critical theory frameworks have brought out the power issues in research and aimed for more egalitarian relationships between the researcher and the participants. While realizing that all research is political (involves power relationships), ethical dilemmas generic to all research (e.g. accountable use of data gained through establishing rapport not only as a scientist but as human beings) become more evident in research from these critical perspectives, especially when the interviewer and interviewee share membership of the same minority group (Oakley, 1981).

In their attempt to recognize and decrease the asymmetry of power in research, both feminists and poststructuralists have also acknowledged that interviewees are not completely powerless subjects, but instead are "people with considerable potential to sabotage the attempt to research them" (Oakley, p. 56) or people who do resist and negotiate the interviewer's meanings, and create meanings of their own (Scheurich, 1997). In his book, *Research Method in the Postmodern*, Scheurich (1997) argues beautifully for this shifting quality of power in interviewing. Scheurich states that the postpositivist attempt to decrease the asymmetry of power through "empowerment of respondents" reflects a paternalistic attitude that assumes the researcher as the subordinate who can 'give power to' the interviewee. He argues instead that power is less absolute and more shifting in interviews than it is believed to be, and calls for a recognition that interviewees are active participants in the interaction.

In my research, I was aware of my power as a researcher over the client and staff as a trained researcher, a Ph.D. student, who was embarking on 'investigating' their clients' power in services through looking at the operation of their agencies. My open and friendly (non-threatening) attitude towards the staff and clients both helped establish rapport with them and leveled some of this power imbalance. I believe that, during my interviews with staff, my disclosure to them about how my knowledge (on women's health movement, feminist agencies etc) was theoretical and lacked their applied knowledge (lived experience) also helped negotiate

my power. I was also aware though, of the shifting quality of power: that I sometimes did feel powerless and how the participants did resist research procedures, and created meanings of their own. For example, in my second trip to FHC, when we decided to recruit the clients through the person in charge of the reception area, Iris, who was in charge for Monday (September 10, 2001) told me jokingly that I was "waiting like a vulture" for participants, after which I retreated to the front office, leaving the recruitment to her discretion. With other staff, I had shown myself to the clients when the staff were explaining my research to them. However, sensing Iris' discomfort with this (possibly interpreting as checking on her?), I decided not to show myself until she called me.

Other examples of shifting power were in my interviews with Felicia, a health worker in FHC, and Duncan, the Medical Director of FHC, and the negotiations of how to recruit clients in WHC. At the end of my interview with Felicia, I asked her (as I asked others) how she found the interview. She replied that she was very comfortable, but that she did not disclose everything in her head, especially on the staff dynamics, because of her 'protectiveness of the group". In my interview and interactions with Duncan on the other hand, even though I did not agree with his views and thought that he did not understand feminism, due to staying at his home, his old age (both of which are, in my culture, reasons to show respect to someone) as well as his multisided personality and devotion to his work, I could not get angry at him, and gained a better understanding of the shifting nature of power in research. Lastly, in WHC, I had to negotiate with Lynn (the head counselor) and Shery (a counselor) how to best recruit clients for observation and interviews. Lynn was concerned about the recruitment for observations (when to obtain the women's consent) and about demographic information, especially on income. I finally decided to discard the demographic information (except for age) on WHC observation forms, and we decided to maintain the recruitment procedure of the receptionist giving women the consent form

with their intake form, followed by the counselor's asking the women again, and inviting me into the room accordingly.

Sample

Due to the ethnographic nature of the study, I incorporated the description of the sample into the next chapter (entitled "settings"). The sample consists of a total of 21 staff and 24 clients interviewed and 16 clients observed.

Data Analysis

As mentioned before, data analysis began with the search of the sites, continued through interviews, observations, and field notes, where data from any one of these sources furthered my understanding of empowering processes and led to new questions to be inquired to staff and clients and new things to observe during my time in the agency. The semi-structure form of the interviews and formal and informal participant observations allowed this flexibility. An example of this was a change in the client interview form I made after the initial three interviews at FHC. After my first interviews, I realized the difficulty of asking about empowerment and questioned whether my categories of empowerment related to women's experience and whether women *had any* visions of/expectations of empowerment. This quick analysis led me to add a new question to client interviews, which in exploratory qualitative research is referred to as a "magic wand" question. I added a question asking women to describe their "ideal reproductive health care" with types of services included, staff, environment/space of the center, etc. I also revised the question 7 on "Respect" to read "Did you feel that the staff of FHC or WHC respected you?" and simplified question 8 to have three subsections.

All interviews were transcribed, observations and field notes were typed and all were entered into the NUDIST program. The transcription process constituted physical and emotional labor. Each transcript was printed out and checked with the tape again, for incorrect and missing parts.

Today I was thinking that life is not so much different from transcribing tapes, as I am doing right now. I put on tape after tape, an immense effort. Getting impatient about reaching the end, an end, does not make the process any easier. It actually makes it less bearable.. Instead, when I get into the flow of each tape, each interview, become used to the and harmonize with the speaking, breathing, and stops of each person talking on the tape, as well as the sensitivities and jokes of each conversation, where I leave out a mirroring sigh or a laugh, then the means becomes an end in itself, and everything moves more easily, with less effort.. Each interview has its own rhythm as do the days, seasons, periods of my life.. Each interview is like a puzzle that becomes more clear after a while, the pieces fit into places gradually as the tape rolls on.. I just need to continue, stay with it, move ahead (ahead or not just move I guess).. so in my life, I think, when I continue, as long as I continue, some pieces fit into places, even if for a while.. Then move onto another puzzle or shuffle the existing puzzle to redo it.

Transcription notes, June 5, 2002,

Data analysis continued through transcription, where I kept "transcription notes" on emerging categories, discourse used by the participants, and formulated theoretical and analytic questions to guide later analyses. The data from interviews, observations, and field notes were coded into NUDIST under two projects "Feminist Health Center" and "Women's Health Center", which would allow a case by case analysis followed by comparison of the cases in terms of empowerment. The main method of analysis used in this study was Grounded Theory.

Grounded Theory

The Grounded Theory Approach to qualitative analysis was developed by Glaser and Strauss (as cited in Strauss, 1995) in the early 1960s and is based on the premise that “.... theory ought to be developed in intimate relationship with data with researchers fully aware of themselves as instruments for developing that grounded theory” (Strauss, 1995, p.6). Thus, Grounded Theory analysis involves a grounding in data, working inductively from the data to the

theory, and the utilization of the experiential data of the researcher (data consisting of technical knowledge, and experience derived from research, as well as personal experiences).

In terms of process, Grounded Theory is based on the three major processes of data collection, coding, and memoing. The relationship between these is not linear, but “hermeneutic.” Data collection leads quickly to coding, which leads to memoing and either may guide the researcher to collect new data and sometimes to change the research question itself.

The coding paradigm is based on a “concept-indicator model” which means that the actions and events described in the data are seen as empirical indicators of certain concepts and the coding is done to derive at these implicit concepts at first tentatively, then with more certainty. The road to more certainty involves the steps of “open coding”, “axial coding”, and lastly the establishment of the final categories (called “core categories”) by “selective coding”.

Open coding is done by scrutinizing the data very closely and coding it in terms of categories such as “conditions”, “strategies”, “tactics”, “interactions”, and “consequences.” Conditions could be discovered by words like “because”, “since”, “as” or phrases like “on the account of.” In a similar fashion, consequences of actions can be found by looking for phrases such as “as a result”, “because of that”, “the result was”, “the consequence was”, and “in consequence.” Strategies and the more specific tactics are the way in which people act to reach a consequence. Interactions are those that occur between and among actors, other than their direct use of strategies and tactics. Open coding, described as such, helps to “break-up the data” for further analysis, to start asking questions and detecting first signs of possible dimensions pertaining to the data.

Axial coding is the analysis done around one category at a time, finding its dimensions, and possible relations to other dimensions. This stage is called axial coding because the analysis “revolves around the ‘axis’ of one category at a time” (Strauss, 1995, p. 32). The final stage of

coding is selective coding meaning coding systematically for the core category where other categories become subservient to this key category or categories that have emerged.

Memoing is the act of writing down theoretical questions, hypotheses, summary of codes. It is a method of keeping track of coding results to stimulate further coding and to help in the integration of the theory, i.e., increasing organization of the components of the theory. Integration of the grounded theory is the result of: the obtaining of categories through “dimensionalizing” (finding dimensions and subdimensions) achieved by coding, “theoretical saturation” of the categories where additional analysis no longer provides anything new about a category, emergence of a core category, and the articulation of relationships between the core category and other categories via which the theory gains “conceptual density.”

Poststructuralist tendencies that affected the data analysis

Even though the main method of analysis used in this study was the Grounded Theory approach, due to my growing interest in and passion towards it, I also used ideas from poststructuralism (especially from other post-structural feminists) to reach a more fluid, complex, and playful analysis and representation of the data. The first aspect of poststructuralism I used in my analysis was resisting the desire (that exists in most methods of analysis including Grounded Theory) to code (away) the data too quickly into categories that are rigid, mutually exhaustive, and often reflect dichotomous (either/or) thinking. I tried to resist this desire by coding data into categories simultaneously and rereading the codes to (re)member and bring out the contradiction and multiplicities (multiple voices) of the data. The following quote reflects this effort.

Since I started putting things on the computer, using the NUDIST to organize and analyze data, I realized how much it pleases me to see the "data" put into more or less neatly defined categories. This reinforces my (traditional) sense of moving somewhere with the analysis, moving out of sense of ambiguity, my desires for organization of data into categories.. This is happening at the same time with realizing how elusive the categories are. They LOOK solid, or neat but they are much more

elusive and hard to label in a satisfying way, that describes the happenings fully.. SO I keep putting things in categories which have very general labels at this point.. I also put things in more than one category, add memos to describe what is missed by the label.. and hope that these "general" categories will be defined more and more in time.. Other side of the elusiveness is that what I try to define as two separate and at times opposing sub-codes are actually parts of the same whole. SO I desire dichotomies, and use them even though I realize they will later be combined into one whole category/code.. Example for this: "Agency as evolving" category sub-divided into "evolution" and "resistances".. which are related.. what one sees as evolution (like towards an independent board of directors) is resisted by others.. Another example is category "doctors" that has sub categories "dedication" and "scarcity of providers" .. Doctors in both agencies are dedicated to their work (even though their beliefs in feminism are in varying degrees) but they are scarce.. So it is their dedication AND power leverage through scarcity that keeps them there.

Analysis report on FHC, Jan 3, 2003

Getting away from the dichotomous thinking and looking for multiple voices and contradiction in the data also allowed me to gain an understanding of empowerment as a more dynamic and complex process and thinking of clients (and staff) beyond oppressed or empowered individuals, but more as individuals (and agencies) with shifting power. This fits well with the shifting quality of power and agency in which postmodern and poststructural theorists believe. In this process to get away from dichotomous thinking and gain a more complex and dynamic understanding of empowerment, three questions I borrowed from Weis and Fine (2000) used in their research helped. These are "have I connected the 'voices' and 'stories' of individuals back to the set of historical, structural, and economic relations in which they are situated?", "Have I described the mundane as well as the glorifying stories?", and "Have I considered how these data could be used for progressive, conservative, repressive social policies?" (Weis and Fine, 2000, p. 63-64). Through these questions, I tried to understand the operation of the agencies and the behaviors of clients as they relate to the legal, economic, medical structures and politics of abortion. I included women's responses that reflect ambiguities of abortion (though noting also the differences among the women in this experience that include more mundane experiences of

abortion and birth control as well), and how all of these could be used and misused by conservative or progressive parties.

In line with the poststructuralist emphasis on language, which mediates our understanding and (re)presenting of the data, I also paid attention to the discourses of medicalization used by staff and clients (especially the medical staff), the discourses of abortion used by the women, silences (what is said, what is not said regarding empowerment) and the discourse I used in relating to the participants and in writing the results.

Agreeing with both feminist and poststructural feminists' emphasis on embodied knowledges and women's way of knowing, through the analysis, I looked at how the bodily experiences of women, and my own experiences of listening to the women and observing, and receiving my services, influenced my understandings of empowerment.

The last aspects of poststructuralism I employed in data analysis were (a) self-reflexivity or being aware of *my* role in research with my beliefs, desires, research skills, researcher authority, and vulnerabilities, and (b) experimenting with playful representations of data using metaphors, poetry, and fiction. Examples of the former were the realization (and coding) of the various roles I had adopted in the interviews (such as 'ayse the educator', 'ayse the educated (by the participant)', 'ayse the counselor/advocate for women or the agencies'). Examples of the latter were my representation of FHC as a tree, a poetic representation of an interview with a medical abortion client, and a dramatization of typical surgical abortion and follow up visits in FHC.

Poststructuralist tendencies that affected the writing process

In the writing stage, I attempted to bring out multiple, contradictory, at time ambivalent voices of the clients and the staff. I paid attention to the discourse (language) the participants and I -as the writer- used (e.g. naming the new subcategory "safe care" instead of "medical safety" in order not to reinforce medicalization). In describing the settings, and writing the results and

discussion, I also used playful representations such as dramatization and poem. Even though these aspects of poststructural methods were used, I consider the end result still very traditional because I was not able to be self-reflexive to break down my own authority as a writer.

The trustworthiness of results

In traditional qualitative research, reliability and validity are replaced by *credibility* and *dependability* and by establishing the *trustworthiness* of research findings (Lincoln and Guba, 1985). The ways to "establish the trustworthiness of results" vary according to the framework used within qualitative inquiry; however, a basic method used by most qualitative researchers is triangulation. Triangulation refers to (1) data triangulation in terms of time, space, and person, (2) investigator triangulation, (3) theory triangulation, and (4) methodological triangulation (Denzin, 1989).

Denzin and Lincoln (1994) argue that:

..use of triangulation reflects the phenomenon in question. Objective reality can never be captured. Triangulation is not a tool or strategy of validation, but an alternative to validation (Denzin, 1989a, 1989b, Fielding & Fielding, 1986, Flick, 1992). The combination of multiple methods, empirical materials, perspectives, and observers in a single study is best understood, then, as a strategy that adds rigor, breadth, and depth to any investigation (p. 2).

Data triangulation was accomplished in the present study through the collection of data from three different sources (staff, clients, and archives). Methodological triangulation exists through the use of three different methods (interview, observation, and review of archival materials). Theory triangulation on the other hand applies in the use of empowerment models, feminist and poststructural theories as "sensitizing concepts" in collecting, analyzing, and writing about the data.

In traditional qualitative research, triangulation is used to suggest convergence of findings; however as Denzin and Lincoln (1994) suggest in the quote above, it can also be used to emphasize the breadth and depth of the investigation. Weis and Fine (2000) also emphasize this divergent quality of different methods, that different methods illuminate different versions of the same phenomenon and allow an investigation of points of differences, contradictions, multiplicity in the data. In discussing mixed-genre writing form (one of the forms in postmodern writing), where the scholar draws literary, artistic, and scientific genres to present different "takes" on the data, Richardson (1994) offers crystallization as a metaphor to replace triangulation. She argues that triangulation assumes there is a "fixed point" or "object" that can be triangulated. Insisting that there are more than three ways of seeing the world, she offers crystallization, where infinite variety of colors, patterns, arrays are reflected in different direction and what we see is determined by our angle. This befits the multiple voices, heterogeneity, and the social construction of data (with the representations of the data by the participants, by us and by the readers being embedded in our social and historical realities and perspectives -angles).

Holding the preceding discussion in mind (and heart), in the present study, I believe that triangulation allowed for both convergence of data from various sources as well as provided rich, in-depth data that at times showed multiple versions of the same phenomenon. However, agreeing with Denzin and Lincoln, Weis and Fine, and Richardson, I refer to triangulation in the present study not as a tool to validate claims about a "universal truth" to be fixed by multiple methods, but as a process that unearths multiple sides of a partial historically situated truth. From this point of view, I see the trustworthiness of my findings in the richness of the data as well as in how well (as I borrow from Weis and Fine) the data -on empowerment- is situated within the larger contexts of history, economy, and politics.

In addition to trustworthiness, I further argue (with Weis and Fine, 2000) for the importance of responsibility and accountability in research and in community as new criteria of good social scientific research.

We take for granted the purpose of social inquiry at the turn of the century is not only to generate new knowledge but to reform "common sense" and critically inform public policies, existent social movements, and daily community life. [] This is a critical moment in the life of the social sciences, one in which individual scholars are today making decisions about the extent to which our work should aim to be "useful."

Weis and Fine, 2000, p. 60.

From this position, I believe that this research has important consequences for social policy and community activism.

CHAPTER 4

THE SETTINGS

Feminist Health Center

I started thinking about the agency as a TREE. With roots in the Women's Health Movement and its feminist principles of alternative care, branching into sister organizations (a counseling organization and another health clinic), reaching out to other organizations in the community and at the national level, nurturing and being nurtured by clients and staff. A tree, a lonely tree, in a rather unfriendly terrain that keeps evolving through time.

Analysis Memo, February 7, 2003

Feminist Health Center (a pseudonym) was founded in October 1974, in a mid-size city in the east coast of the US, by a group of women who, after years of discussion, realized the need for "a clinic run by and for women in a nurturing, respectful, and empowering manner, that encouraged taking charge of one's own body and life." The clinic was also envisioned as providing an alternative to the hospital-based abortions in their state, which were both costly and involved little information exchanged between a woman and her doctor. This original group of women founded the clinic with the help of a local male doctor, who helped develop medical protocols, trained the staff, and served as the medical director until his death in 1987.

With a growing demand from the community, and with the help of other feminist groups such as the Boston Women's Health Book Collective that publishes *Our Bodies, Ourselves*, "the founding mothers expanded their focus from providing abortion to full gynecological care with an emphasis on total well being." In order to break down hierarchies in health care, the group hired nurse practitioners to provide gynecological care, and lay health workers with no medical background to be trained on birth control and abortion counseling.

Initially run as a "traditionally structured women's health organization," with an external board of directors, and hierarchical relations between lay and professional health workers, through increased contact with other feminist organizations, the Center changed its structure in 1977 into a worker-controlled one with an internal board of directors and a decision-making model based on consensus; where all workers (except medical staff) were given the job title *health worker* and were reimbursed under the same pay scale. In the late 1970s, the staff decided to include "feminist" in the title of the center. The center became the Feminist Health Center (pseudonym).

Between the mid-seventies and early eighties, the center helped found another feminist collective that provided counseling services and a sister branch (providing abortions and gyn care) in a nearby city in the same state. Feminist Health Center and the new sister branch operated as a single organization, under the same board of directors, until they separated in 1985. The center started publishing a quarterly journal that informed women about their services and about the developments in the Women's Health Movement, and offered workshops in the community on lesbian health and other self-help topics. The Feminist Health Center also helped design and participated in the study that led to the FDA approval of the cervical cap as a contraception method.

In 1983, the center experienced a crisis when the board of directors fired six staff members. After a lengthy arbitration process, the fired workers were reinstated and the directors announced their resignation. This left the staff with "having to learn how to run an organization". The crisis also brought about a more flat, collective structure without a board of directors. In 1990, the center was still running as a collective with staff organized into five teams (abortion services, gynecological services, administration, outreach and education, and overview). Individuals in teams rotated every three years.

In the late 1980s, the Feminist Health Center experienced violent attacks of the anti-abortion groups, including blocking the entry into the center by Operation Rescue, and an arson attack that damaged the office. In 1990s, the center survived a butyric acid attack and anti-abortion activists picketed the house of the Medical Director. In 2000, the center survived another arson attack, for which the center estimated costs to exceed \$20,000 (plus over \$2000 for 24-hour security service in the several days after the fire). All of these attacks were met with increased community support, which, according to the staff remained as "silent support" until then.

At the time of the present study (July-September 2001), the Feminist Health Center operated as a collective, without a board of directors, yet with a staff member designated as the "executive director on paper." The director was mainly responsible for overseeing of personnel policies, scheduling of staff, ordering materials, and fundraising. She, however, would still rotate on daily duties such as phones, lab work, or patient advocacy during the abortion process. The center was organized into five teams: the Medical Services Team, Outreach and Education, Front office, Administration, and the Hiring Committee. Before the 80s, following the "anti-expertise" ideal of the Women's Health Movement, the center staff rotated on duties as well as on the teams. However, in time, the center moved towards more specialization, which included "letting people stay in teams where they felt comfortable, competent, and had acquired a particular knowledge." People were also allowed to "be in two teams" at once.

Among the 25 staff members, only 8 eight were full-time staff. Staff included lay health workers who did abortion and contraceptive counseling, phones, lab, patient advocacy, outreach and education, a physician's assistant who performed abortion follow-up, routine gynecological care, and medical abortion (abortion with the pill), and three physicians who worked on a contractual basis to provide abortions. One of the physicians, a 70 year old male doctor, whose dedication to performing abortions was based on his experience from the time of illegal abortions, acted as the Medical Director, and had the final say in medical protocols and procedures.

Decisions on protocols and other issues were made in staff meetings (attended by full-time staff only) held every two weeks (with check-ins in between) and in biannual full staff meetings. Teams had autonomy in deciding on and implementing smaller issues. On more important issues (e.g. medical protocols or domestic violence protocols), the teams would first do the research and then bring it to the staff meeting to be decided. In voting procedures, the center had transitioned (again in the 80s) from a consensus vote to a two-thirds majority vote (safeguarded by the possibility of reviewing any issue in six months), which the staff believed moved things faster. The new voting system, however, contradicted the flat structure of the collective (with only full-time staff voting). As staff interviews revealed, the new system also did not solve the problems of lengthy discussions on small issues and the manipulation of votes through alliances or abstaining from voting.

The services provided by the center were: first trimester abortion and post-abortion care (with surgical and medical abortion -with pill- options), pregnancy testing and pelvic-sizing, counseling for pregnancy options, abortion, and post-abortion concerns, well-woman gynecological care, contraceptive care including tubal ligation (through the local hospital), STD education, testing, and treatment, colposcopy, cryosurgery, anonymous HIV counseling and testing, menopause management, school and employment physicals, massage, and information and referrals. The expansion of the gynecological services and the additions of ultrasound and medical abortion services to abortion care were due to the work of the Medical Services Team (which worked faster with the changes in the decision making system and increased autonomy for teams) led by Sally, the Physician's assistant. Even though all other medical staff were hired on a contractual basis (to decentralize medical authority), Sally was hired as full-time staff in her second year with the agency. Sally stated her main goal for the facility to be to the improvement of gynecological services to attract the abortion clients to continue with the center for gynecological care and to allow the formation of a separate gynecology clientele.

The staff interviews revealed that the agency was evolving towards a new structure. The Medical Director (Duncan), and a few of the health workers envisioned the new structure to include an external board of directors. Linda, the Executive Director, however, through her contacts with other feminist agencies, was well aware of the potential dangers of such a structure. Linda stated that the "entire mission could go into the hands of the people outside the organization who don't provide direct service, who don't understand the needs of the organization" and "are making decisions that really in application don't work."

Staff and clients

Staff

I interviewed ten of the twenty-five staff members of FHC. These ten members were the ones who agreed to be interviewed. I did not interview the whole staff due to limited time and because the ten interviewed constituted the core staff of the facility. All the staff I interviewed were female except for the doctor/medical director. This fits well with the historical and present composition of the agency. FHC has historically been an all female (a women-run agency) except for the hired physicians and a previous lab director. At the time of the study, there were only two male staff both of whom were doctors hired to perform abortions. The staff I interviewed were white (again fitting with the present staff composition of the agency) and ranged in age between twenty-one and seventy, with a mean age of 40 and median age of 35.

In terms of the previous experience in women's health care or counseling, four staff (including the director) had no previous experience and learned about women's health care at the center. The lab director, the physician and the physician's assistant had previous medical experience. And one member (Iris) had political advocacy experience on women's health care before joining the center staff.

In accordance with the collective mission of the center, all staff (except for medical staff) called themselves "health workers". I had not realized this before my visit to the agency, after which I asked the staff their main position (if any) and all the other positions they fulfilled on a rotational basis. Even though the staff called themselves health workers and rotated on different roles in the day to day running of the clinic, each staff also had a main specialized role, such as outreach and education coordinator (Hazel), administrator (Linda), lab director and administrative team member (Deedee), Medical Services Team Coordinator (Iris). Medical staff interviewed, (the Physician's assistant and the Physician/Medical Director) were even more specialized and did not perform any other (non-medical) roles. Sally, the physician's assistant did perform some nursing roles at times, which included giving IVs, and helping staff prepare snacks for the aftercare room.

Among the staff I interviewed, seven were full-time (including the physician's assistant), and three were part-time workers (including the Medical Director).

Even though the agency was a collective with a non-hierarchical (or flat) structure, rotation vs. specialization reflected power differences across medical, non-medical and across part-time vs. full-time staff.

I asked her if there was a management, she said no, they function like a collective. The full-time staff does take an overseeing role though (compared to part-time staff)

Conversation with Hazel on my first visit, July 3, 2001

And you can't even agree on WHAT FEMINISM IS. AND I CAN'T EVEN like SAY THIS IS A FLAT STRUCTURE. WHEN YOU LOOK round. THERE ARE STILL patterns difference- differentials of power. PART-TIME PEOPLE DON'T HAVE really decision making power here. THEY DON'T KIND OF GET the benefits that we get. I mean it's governed by non-profit law BUT THERE IS REALLY some IMPROVEMENTS WE COULD MAKE..

Linda, FHC, director

Interruption: A note to the reader on interpreting the quotes

In reading the quotes, please bear in mind that capital letters mean a change in intonation to a louder voice, "-" as in "diffe-" denotes interrupted speech, "???" means parts of the speech that were not clear with "(hospital?)" representing guesses at the unclear words. The sign [] denotes that there were utterings between the sentences before and after the sign, which were not included because of their irrelevance. I used the same sign [] with a word inside, as in [the center] to complete or clarify sentences. Lastly, the repetition of letters as in "weeeee" imitates the extension of a syllable by the participant. As mentioned in the methods section before, all staff and client names are pseudonyms that the participants themselves chose to adopt.

Before proceeding with the description of typical abortion and gynecological visits to the FHC, I provide below a table (Table 1) to introduce the individual staff members. This will be followed by a description of the clients.

Table 1: FHC Staff

Name	Sex	Age	Position	Roles performed	Years w/ agency
Deedee	F	47	Health worker (F.T) Lab director Administrative team	Clinic jobs Lab work Balancing budget	21
Duncan	M	70	Contracted physician Medical Director	Perform abortions Oversee physician's assistant and medical protocols	10
Hazel	F	21	Health worker (F.T.) Outreach and Education Coordinator	Clinic jobs Outreach work	4
Felicia	F	35	Health worker (F.T) Medical Services Team	Clinic jobs Quality assurance Of all medical records	6
Iris	F	58	Health worker (F.T) Medical service team coordinator	Clinic jobs Coordination of gyn and abortion service	23
Karry	F	30	Health worker (F.T) Medical service team Administrative team	Clinic jobs but often the "float" Improve front office work (charts and billing)	1 year & 7 months
Linda	F	32	Health worker (F.T) Administrator	Overseeing of personnel policies, staff scheduling, ordering shipping, fundraising	7
Marcie	F	24	Health worker (F.T.)	Clinic jobs (counseling, phones, abortion tech and support person)	10 months
Roxanne	F	20	Health worker (F.T.)	Clinic jobs (phones, flow, procedure room support person, filing)	2
Sally	F	42	Physician's assistant	Gynecological care Abortion follow-up care Medical abortion care Back up for surgical abortions and abortion after care phone calls	2

Clients

In FHC, I interviewed twelve and observed eight clients. The number for interviews were limited to twelve because of time limitations of the project. The observations numbers are directly related to the recruitment success at the center. Table 2 below describes the type of clients interviewed.

Table 2: FHC clients

Type of Service Received from the Agency	Number of Clients receiving the service
Gyn only	4
Abortion + Gyn	3
Abortion only:	
Surgical abortion	2
Medical abortion	3

A woman qualified for the Ab + Gyn category only if the last visit was a gyn exam or a birth control renewal. Otherwise, receiving birth control at the follow-up visit did not guarantee the woman's return to the agency as an ongoing gyn client.

Trying to code Gloria, i just realized that trying to decide if someone is only Abortion or abortion plus gyn is more difficult and I was not clear on my distinction.. it is hard to distinguish cause most AB clients do get pill or depo or something prescribed because the staff asks about the contraceptives and because there is a free supply of pills.. so, they might get the first two pills now and third one at the follow up but then go to another place for the rest.. for depo i am not sure.. but I put gloria back into Ab only.. cause even though she had the depo, i was not sure she would come to this center for the next one.. i would consider gyn if they were there for the pill check, or second depo shot maybe.. I HAVE TO THINK ABOUT IT SOME MORE..

Analytic Memo, January 20, 03

In terms of the observations, three were of pre-abortion counseling sessions, four were gynecological visits including birth control renewal and emergency contraception prescription, and one medical abortion visit that included ultrasound and receiving the pill.

Eleven of the twelve interviewed and six of the eight observed were White American. I interviewed one Rumanian and observed one Asian American woman. In terms of the ages, the mean age of the women I interviewed was 29 (median=30) with four women between the ages of 18-24, three women 25-30 years old, and five women 31-40 years old. The mean age for the women I observed was 27 (median=25) with three women who were 18-24 years old, and two women 25-30 years old. The majority of the women I interviewed were single (unmarried) (n=5) or divorced (n=4) with ten of the total having stable partners and seven of the total having children.

In terms of the payment type women used, women were evenly divided between self-pay and insurance. Among the participants, six of the interviewed and four of the observed paid their current visit out of pocket, while five of the interviewed and four of the observed used their insurance to pay for it.

Below are two tables (Table 3 and Table 4) describing clients' familiarity with the agency in terms of the number of visits and length of time.

Table 3: FHC clients' familiarity with the agency: number of visits

# of Visits	Gyn	Abortion	Ab + Gyn	TOTAL
1 st visit	2	5*		7
2 visits	2	2		4
3 visits	1	1	2	4
4 visits		1	1	1
> 4 visits			1 (~12)	1

* three of these were observations of pre-abortion counseling with health worker or the PA (for medical abortion).

Table 4: FHC clients' familiarity with the agency: Time with agency (data obtained from the interviews only)

Time	Gyn	Abortion	Ab + Gyn	TOTAL
2 weeks		3		3
1 month	1			1
6 months- 1 year	1		1	2
3 years			1	1
Returning (Received abortion from FHC before)			1	1

Typical visits

What follows are "typical" abortion, follow-up and gynecological visits to the Feminist Health Center (FHC). The surgical abortion and follow-up visits are dramatized accounts reconstructed from client and staff interviews, observations, and an article on abortion written in the journal published by the center. Every now and then, the accounts are interrupted to provide additional data or counter cases to remind the reader that, even though the stages of a visit - procedurally- are fairly similar, there are no "typical" visits. The information shared with the women and women's (and staff's) experience of these visits depend largely on the needs, previous experience, and age of the women. The medical abortion visit is described and the experience is represented in a poem. The gynecological visits to the center are described without the dramatization, as based on interviews, observations, and field notes.

Clients' first contact with the Feminist Center occurs through the phone when women call the Center to set up appointments for abortion or gynecological care. The women know the center through previous use, referrals (by another agency, individual provider, or friends), yellow pages, and through connections with other feminist agencies.

Surgical abortion visit

Sandy calls the center. She is twenty six years old. She is White.

Phones are ringing at the small front office of the Feminist Center. Three staff are answering phones. Two of them are new and under training. One of them keeps asking a senior staff member what to do. As Roxanne -a part-time health worker- says, the training for part-time workers changes a lot; most staff start their training by learning phones and counseling, by observing other staff and taking a workshop provided by a full-time worker.

Sandy: Hi, I'd like to make an appointment

Roxanne: Is this for an abortion or gynecological care?

One of the functions phone conversations serve is to inform the women of the services of the center. Roxanne (to Ayse): Lot of people assume we just do ABORTIONS HERE, but we hold like GYN services as well. So I ask them what kind of appointment they want..

Sandy: uhm...for abortion.

Roxanne: ok, sure. First, I need to know whether you had a positive pregnancy test

Writing this line, I realized that in none of my staff or client interviews, there was any mention of asking the client whether they wanted a medical or surgical abortion. Clients who had medical abortions said they called asking for the medical option.

Sandy: yes. I did one of those home pregnancy tests. Twice.

Roxanne: And do you remember the first day of your last period?

Sandy: yes. August 10 I think.. Uhhh, how much will the whole thing cost?

Roxanne: (tells her the cost) We accept cash, credit cards, Medicaid, and major in-state health insurance plans.

In line with their feminist philosophy of not denying any women abortion services for lack of funds, the center first offered a deferred payment option and recently was referring women to an organization. The organization covers one-third of the abortion costs, although, as I overheard from a phone conversation of a staff member, only women who were nine weeks or later were eligible for funding. This limits women's options to surgical abortion only, since the FDA limits for medical abortion were seven weeks.

After receiving her insurance information, Roxanne starts a chart on Sandy, taking her name, address, asking Sandy and circling on the intake form whether sending mail to her home is ok (the center sends a letter explaining the abortion procedure, its complications, what to expect on the visit including bringing quarters for the parking meters). Sandy says it's ok to send info with a plain envelope. Roxanne also asks Sandy whether the center can call her (saying "health center", being discrete, or no calls) and leave a message on her answering machine.. Then Roxanne asks questions to determine whether Sandy has any medical conditions that would

prevent her from being seen in an outpatient setting. She has no such conditions. The appointment is set for Wednesday, which is only six days away. Women I interviewed were, on average, able to schedule their gynecological or abortion visits within a week (ranging from the same day to two weeks). After setting up the appointment..

Roxanne: well, now, I'd like to go over basically what will happen on Wednesday. Well once you come to the center.. oh I almost forgot, I would like you to choose a number. It will be your client number and we will ask you that number and an ID when you come to the center.

Sandy: A number?

Roxanne: yes. Mainly as a security measure, to make sure you are the same person we spoke to on the phone. But also for your confidentiality, so that other people do not request your information from here without your consent, in the long run..

Ayse (to Roxanne): Is this client number thing because of the fire?

Roxanne: Well, we had that I think for really long time. To make sure it's the SAME person that we spoke to on the phone. I think it's also about like...a lot of women just had issues of- around abortion where their- a lot of times partners don't know, or parents don't know, and uhm THERE'VE BEEN INSTANCES WHERE uhm partners or parents have tried to find out if their daughter been seeing here if their girlfriends have been seen here. Things like that. And then, if they call, like six months down the line and would like medical records transferred, we would ask for that number before we even acknowledge they were a client. Just to make sure that somebody isn't trying to gain access to your health insurance information.

My observations also confirmed the strict nature of confidentiality measures. To a phone call from a woman who worried about her cousin's abortion that day, a staff responded with "I can neither confirm or deny she is here, but if you leave a message with your name and number, we could pass it on to her if she is here".

Sandy: (a little surprised) hmm, ok, oh I guess 571.

Roxanne: 571. Ok. So, what will happen on Wednesday.

Another function the phone contact serves is to prepare women for the appointment by explaining the appointment steps and payment, anticipating their needs and communicating these to other staff, putting their birth control information in their intake form for the women to review while waiting, and informing them of possible protesters outside of the center.

Roxanne continues: Once here, we would like you to fill out a form (Sandy: uhummm), have lab work done, to confirm pregnancy and test your blood RH factor, then you will be speaking with one of our staff members (Sandy: ok). It's a time for them to ask you about your

medical history, do a birth control counseling if you do want birth control, and discuss a bit your decision to have the abortion. Do you feel like- do you know whether you'll be interested in birth control?

Sandy: uhh yes. I am not sure. But maybe like the pill or the shot- is that depo?

Roxanne: yes, we have Depo Provera, which is a shot given every 12 weeks. We also have Lunelle, which works like the pill, but is a monthly shot. Would you like me to send you information on these as well so you can read before you come?

Sandy: yes, sure.

Roxanne: ok, will do. Do you have any questions about the visit or anything else?

Sandy: uhmm, how long will it take you think?

Roxanne: Depending on the number of clients, it usually takes from an hour and a half to three hours. So..

Sandy: hmm.

Roxanne: one more thing. we sometimes have protesters outside the door

Sandy: really?

Roxanne (to Ayse): Lot of people who make their appointments, they ask, if there are gonna be people outside.. you know so I think that's a good fear, cause they see and hear things in the media, and they think and you know it's not like we didn't have protesters but it's really not like that. It's not like you have to you know go through millions of people, crowds to get there

Roxanne: yes. They're usually quiet though. But we do have escort services if it gets uncomfortable for our clients.

Sandy: I see..

Roxanne: do you have any other questions?

Sandy: no, I cannot think of any.

Roxanne: ok. so we'll see you on Wednesday and please do call us if you have any questions in the mean time

Sandy: yes, I will. Thank you.

It is Wednesday. A slightly cool autumn day. The sky is blue. Sandy parks her car in front of the center. The center is located in a two-storied Victorian house on one of the main streets of the city. There are parking meters right at front. Sandy and her friend see four old people praying with rosary beads. Two women, two men. "They usually come Wednesday or Friday of every week" says Deedee -the lab manager- "when we have clinics. I wish we didn't have this resistance, didn't have to feel uncomfortable to be here" she says. Marcie says last Wednesday a church group came with fifteen children around ages ten with signs and all.. Today, it is only rosary beads. Sandy and her friend look at each other, and together walk past the people on the sidewalk and ring the bell.

Felicia (at the reception desk): May I have your name and client number and see your IDs?

Sandy tells her number, they both hold their IDs to the camera

Felicia: thank you, come on in.

Sandy and her friend enter the Feminist Health Center and walk over to Felicia who meets them with a smile. To their left is a small room used as the front office, where staff takes phones and prepares the schedules. The reception desk (where Felicia sits) is under a staircase that leads to the second floor. Felicia greets them warmly, gives Sandy the intake form to complete (telling her to hold on to questions on sexual and physical abuse till she sees the counselor). She also gets Sandy's insurance information. Sandy and her friend walk into the waiting room. There is instrumental music coming from a stereo. There is only one more woman in the waiting room. Everything is in pastel colors, there is art work on the walls and lots of brochures and books around. Sandy starts filling in the form, fills out her individual and family medical history (including information on last pap smear, menstrual cycle, past pregnancies), a question on sexual identity (if you want us to know, do you identify as: bisexual, celibate, heterosexual, lesbian), birth control information requested and method of choice, and consent forms for abortion and birth control. On page three, she sees a section on what the center means by having "feminist" in its name (emphasizing self-empowerment, "taking responsibility and control of our health as women", respecting diversity of staff and clients, and "treating the Earth with care and respect"), and a section on the client's rights and responsibilities (to be fully informed, to refuse treatment, etc.). The rest of the form has what looks like consents for birth control and abortion. She can not tell whether she should sign these or wait? Walks over and asks Felicia, who says to hold on till she sees a counselor. Sandy sees the handouts on Depo, Lunelle, and the pill again in this form. She read the versions sent to her home, she does not read them again. Sandy's friend has picked up a magazine and is looking at that.

Felicia: oh you're finished. If you wait a bit, I will tell you when we can have your lab work done.

Sandy waits five more minutes and Felicia calls her to the lab. As reported by the women, the average time (to see the first person) was five to ten minutes. Deedee draws her blood in a

small room at the same floor, while talking to her. Sandy comes back to the waiting room.

Sandy's friend: how was it?

Sandy: Ok. Not bad. You know I don't like needles, but it was ok actually.

Iris comes to the waiting room, introduces herself, and takes Sandy for counseling to a room on the same floor. In the room, Sandy sits on the couch and Iris sits in a chair facing her. The lighting is soft, there are brochures on the bookshelves.. Looking at the intake form Sandy filled out, Iris starts going over her medical history. According to Hazel, the Outreach and Education Coordinator, whether to start with medical history or the abortion decision, depended on the counselor's style. In the sessions I observed of two counselors, they both started with medical history.

Iris: So, cancer in grandparents (Sandy: uhummm) and you smoke?

Sandy: yes.

Iris: any plans to quit?

Sandy: not yet.

Iris then shifts gears and goes into birth control counseling.

Iris: so you have put down pill or Lunelle as the methods you were interested in.

Sandy: yes.

Iris: Have you used either before?

Sandy: I used the pill, but I am not really good at taking it every day.

Iris: yeah, in that case pill is not good for you. Lunelle would work better. It is a monthly shot and our physician's assistant says women are very happy with it. What do you think?

In the other counseling room, Marcie -a health worker- asks Jane, a nineteen year old white woman about her birth control decisions. Jane says she will not have sex anymore! Marcie asks if she wanted condoms, spermicides, just in case.. Jane says "no". Marcie talks about emergency contraception and says "ok, that's that". Staff is well aware of this "I will never have sex" attitude, especially in younger women, and try to have all women leave the center with something, even if those are condoms and vaginal spermicides (which are free). Two packs of the pill are also given free (if the client chooses pill as their method) with a prescription for a third given at the follow-up visit.

Thus, the birth control discussion depends on the client's decisions over a method (refusing all methods -"never going to have sex any more", being decided on a method or exploration of different methods) and her eligibility for various methods based on her medical history of depression, weight gain, urinary tract infections, as well as her age, and smoking

status. A woman's preference of a contraceptive method in turn, depends on her (positive or negative) experience with various methods, perceived positive side effects of the methods (such as skin improvement on the pill or the lack of menstruation on depo), cost of method, and her lifestyle (including the ability to take a pill every day and being in a monogamous relationship).

Sandy: (shuffling the papers she had on Depo, the pill, and Lunelle) Yeah I think I'll try Lunelle.

Iris: And you can switch to another method if you have problems with it. (showing the "birth control release form" section) Could you sign this then?

Sandy signs the consent. Iris goes into the abortion discussion.

Iris: now, I'd like to ask you a few questions about your decision. Could you talk a bit about how you decided to terminate your pregnancy? And does your partner know about it?

Sandy: well, yeah, he knows. We are mainly friends with him, so this is the best option for now.

In all of my observation of abortion counseling sessions, the sessions were similar: very matter-of-factly and relaxed. The women were sometimes nervous, though no intense emotions were revealed. Such is not the case with Sheryll, who came for a medical abortion. She is in another counseling room and finds the counseling to be intense. She wants to have the abortion but is very nervous and says years ago she would never picture herself doing something like this. Then comes more questions from the counselor and she feels uncomfortable, not knowing whether the counselor wanted to "hear it another way".

Abortion counseling may also consist of "Options Counseling" to women who are undecided about their pregnancy. I have witnessed only one time when a staff mentioned they were going to do options counseling.

Iris: is there any one who could support you throughout this, like when you're not feeling well physically, or when you're feeling down?

Sandy: yeah, my girl friend who came with me today, and my sister would.

Iris: ok, just making sure you have people around for support. Of course you can always call us as well.

Iris then goes into explaining the procedure (using the plastic speculum and curette as props), talks about complications and after-care instructions. To watch out for blood clots,

excessive bleeding, and high temperature and call their 24 hour emergency service if any of these occur. If the client never had a Pap Smear before, the counselors also explain that and provide the options of having it on the day of the abortion or at the follow-up visit (at the Center or at their own provider).

Iris: any questions about the procedure or after-care?

Sandy: uhh, I wanna know about the risk of infertility.

Women who felt comfortable asking questions to the counselors usually asked about the pain during abortion, about risks and complications of abortion, especially the risks of infertility and death, about birth control options and when to start using birth control after the abortion. On the risks of infertility and death, the counselors emphasized that abortion was safer than natural childbirth, that death was due to untreated infections, and encouraged the client to call the 24 hour emergency telephone service if they suspected any infections and to come back for the follow-up.

Iris: yes there is a risk but we would know it during the abortion, if something goes wrong, or afterwards with you calling us with any suspected infections. so, as long as everything goes right during the procedure (which is usually the case), and if you call us and come back for a follow-up after three weeks, that risk is minimal.

Sandy: ok.

Iris: any other questions?

Sandy: no, that's it.

Iris: then, if you could sign this (showing the consent form for abortion), and I will be the witness. And you can go back to the waiting room. We will call you to go to the upstairs waiting room to wait for the procedure.

After the counseling, the women were taken in groups of three to the second floor waiting room. They wait there with mothers, partners, friends or alone to have the abortion procedure. Sandy and her friend go upstairs. Another room with pastel colors and lot of brochures, and magazines and books on the coffee table in the middle of the room. The waiting room is adjacent to the Physician's assistant's exam room. The room where abortions are performed is further down the hall, past the ultrasound room. There is a bathroom there too.

Sandy is in the procedure room. She is flat on her back, her legs spread apart in the padded knee holders, a vulnerable position women take. In the room are Iris who will help her (be a client advocate), the doctor, and another staff helping the doctor. Iris holds her hand and says "Take a deep breath in through your nose". Sandy looks at Iris and takes a deep breath. "Now let it out slowly -slowly! I'll count to three. One two three" Sandy's breath is faster than the

count. She flinches at the first shot of local anesthetic injected into the cervix before dilation" Iris had told her in counseling it would feel like pinching. It does. But it's a place where you've never been pinched before. The doctor takes out the dilating rods and murmurs to the technician what size of cannula he wants. Sandy squeezes Iris' hand and she squeezes back, she starts to cramp- Iris was right, it is like menstrual cramps. She keeps on breathing. The vacuum pump starts. It sounds loud, very loud. The doctor calls "almost over, you're doing great!" Sandy keeps on breathing with tears in her eyes. Finally the pump goes off. Silence. It was only on for two minutes, but feels longer. The staff helping the doctor carries the jar filled with blood and fetal tissue to the sink to examine if all is there. Iris is talking to Sandy "are you feeling ok. You did very well. I know it hurts". Sandy says "thank you" quietly, managing a smile "for helping me through this". The tech says everything looks alright. Iris helps Sandy into the after-care room. She is shown the couch, given a blanket. Sally, the Physician's assistant, comes and introduces herself. Says she will be taking her blood pressure and pulse in a minute. "Would you like any juice and cookies?" On the table at the corner is a dish with watermelon, cookies, and cheese, nicely prepared. The room is small and cozy, and softly lit. Music is playing softly from a stereo. "Just water" says Sandy. Sally brings her some water, takes her blood pressure and pulse, records it in a notebook. After half an hour, Sandy is ready to leave.

Three weeks later Sandy returns to the Feminist Health Center for follow-up care. No protesters this time. She waits in the waiting room for five minutes before she is called upstairs to see Sally, whom she met in the after-care room.

Sally: hi. I am the Physician's assistant and I'll do a quick exam to see if everything is fine.

Sandy: I know. We met on the day of my procedure. You were in the room afterwards.

Sally: oh ok. Are you having any problems? Bleeding or anything else?

Sandy: yes some bleeding but nothing else. I am just worried if everything is alright. You know the infertility risk worries me.

Women's questions during the follow-up visit usually centered on continued bleeding and whether all was normal (especially whether any risks of infections or infertility). Some women also asked about birth control during this time.

Sally: I do not see any reasons for infertility but I'll go out now and if you could put on this gown, let's see how everything is.

The gowns women wore during abortion and gynecological exams were night gowns (with floral patterns) a staff member bought from Walmart. Women I interviewed appreciated the gowns (which are different from the paper gowns given at OB/GYN offices). Women found these more humane.

Sally comes back and starts the exam. She keeps a conversation going with Sandy in the mean time. Then says: "you can sit up now, all looks great, no problems. The bleeding should cease soon. I will let you dress but want to ask you whether you have decided on the choice of birth control?"

Sandy: yes, I think I'll go with Lunelle.

Sally: so would you like me to administer it today and we can set up the next one as well.

Sandy: yes. that would be good.

Sally leaves the room. Sandy dresses up. Sandy feels much lighter, learning that all was fine. When Sally comes back, she gives Sandy the Lunelle shot, while talking to her about daily things. They set up the next appointment. Sandy leaves the Center.

Medical abortion visit

The stages of medical abortion visit are similar to that of surgical abortion. There is the wait (filling out of the intake form), counseling, ultrasound for sizing, and then receiving the pills from the Physician's assistant. There is again a follow-up visit two weeks after the abortion. The abortion itself takes place in the privacy of the woman's home:

POEM FOR CLAIRE

*I sat there listening
While she told me
Honestly
 Personally
 Starkly
Her home-made, home-felt abortion
Amongst her brother, her neighbor, and her close friend,
Looking at the family albums
Waiting for "it" to happen.*

*Then it came
 With a sudden cramp
 That "took her breath away"
 She made it to the toilet
 Cried, breathed, cried.
 Exhausted, she gave one push
 And pushed the liver-looking thing into the bowl.*

Was that it? All?

*She slept
 Worried she would flood the sheets
 She woke up to another cramp
 Called friends
 Not to faint by herself
 She passed another flood of blood
 The uterus lining was unlined

*She prefers it a thousand times
 Over the surgery,
 The invasion,
 The intrusion,
 The rushed thing.
 Said the previous time she hated it.
 "in and out" before she was ready.*

*Strong as a steel flower
 Determined as green on a rock
 She made me think
 If only
 If only "they" would hear her
 They who have not ever had to
 Make this decision
 Yet
 Who hold our bodies hostage to our futures.*

*Ayse Dayi
 September 10, 2001. After an interview with an abortion client*

Gynecological visits

Gynecological visits consisted of annual exams, emergency contraception provision, birth control acquisition or renewal, or a combination of annual exam and birth control

acquisition/renewal. As in the calls for abortion appointments, women calling for any of these gynecological visits are told about the steps of the visit, what to bring (e.g. medical records), and informed about possible protesters outside (due to their abortion services).

WHY WOULD A WOMAN go through a line of of protesters JUST TO RENEW HER BIRTH CONTROL PILLS. Why would she? But a woman who needs an abortion can't get one from her doctor, can't afford one from somewhere else, IS GONNA COME HERE. One way or another. She's gonna walk that line. SO BASICALLY, we had a horrible time trying to increase our GYN you know clientele. A REALLY horrible time to come back. Why would they? They would just go back to their own doctor.

Linda, FHC, Executive Director

All women seeking contraceptives from the Center are required to have an annual exam within the last year (from the center or their provider as long as they can bring their medical records from their provider). All women seeking contraceptives from the center for the first time are also required to go through birth control counseling, which is brief (approximately five minutes) if the woman is already decided on a method or is familiar with the method from previous use. During counseling, the counselor goes over the medical history, asks the questions on abuse, and discusses the birth control method(s) and their side effects, and has the client sign the birth control consent. Women who come for repeat annuals and/or birth control renewals see the Physician's assistant (Sally) without going through counseling.

In the annual visits, Sally reviews the woman's medical history (surgical and sexual history) updating it from the previous year and deciding whether she might be at risk for STDs (based on her answers to number of sexual partners and monogamy questions, as well as her general risk taking behaviors such as wearing seat belts, drinking habits, etc). This indirect assessment of risk -based on sexual partners- was noticed by a client, who was taken aback by the question and preferred a direct question on it.

Checking for risks for STDs is part of Sally's "preventive stuff" which includes paying attention to the family history and the client's history of osteoporosis, breast cancer, colon cancer,

and the client's diet (for any signs of anorexia nervosa or bulimia). Sally also states that she routinely screens women for domestic violence (depending on her medical history and how she was doing at the time).

The exam itself is gentle, and not rushed (especially slowed down for initial exams), where Sally talks to the women, telling them what she is doing and checking on how they feel.

[the exam] was fine. Uhm very comfortable. She definitely Uhn I app- I kind of appreciated LIKE Uhm Pap Smear since they involve a needle. That she was very careful like talked to me and kind of like keep (the conversation?) going WHICH I KIND OF RECOGNIZED AS (PAUSE) you know I could tell like she was doing, her tone kind of changed a little bit. I could tell she was trying to keep me comfortable. But I mean it wasn't a problem. I KIND OF APPRECIATED that they do do that. uhm from the standpoint, it doesn't bother me. But I do know that I have a friend that kind of bothers I appreciated that she ?? it. It wasn't dead silence like that

Mary, FHC, Gyn Client

Once the exam is over, Sally talks to the woman about what they need (mammogram, STD testing or information, birth control information or provision).

In birth control renewals, Sally weighs the client and takes the blood pressure, discusses the medical history, updates it from last time, and asks the woman how she's doing on the method. She asks the client about the side effects she might be experiencing on this method (e.g. any spotting?). In my observations, during this time (which lasts around fifteen minutes) Sally and the clients talked casually about daily things and about insurance coverage of the present method and other methods. Women's questions to the counselors or to Sally center on learning about alternative methods (to choose a method or to switch methods), about side effects of the method used, insurance coverage, and weight gain on methods.

Women's Health Center

Women's Health Center (a pseudonym) was founded in 1978 in a mid-size city in the East Coast of the U.S. to provide low cost, outpatient abortion and routine gynecological care to women in the county, where the only other abortion provider was the hospital with higher fees. The first director of the center was the education director of a Planned Parenthood of a neighboring county, founder of the Abortion Rights Association and a non-profit information service for pregnant women in her county. From the beginning, the center (which was called as an "abortion clinic" in the local newspapers) faced resistance from anti-abortion groups and the mayor, which led to a temporary losing of its zoning permit. The most violent form of resistance came in 1991, when Operation Rescue blockaded and occupied the center chaining themselves to pipes. The FBI was called in and it took ten hours to take the occupiers out. All the while, the services continued, the patients were taken in from another door that opened to the after-care room. Regarding violence, staff also talked about having doctors who wore bullet-proof vests, had their children harassed at school, and some of whom would not allow the Center use their names (for fear of being targeted in the "Army of God" website).

From the founding to the time of my visit, the changes in the agency structure were increased security measures, expansion of gynecological services from post-abortion care to full gynecological care (mainly with the initiative of the two nurse-practitioners in the last 12 years), high turnover of Executive Directors, increased alliances with individual doctors and hospitals (for referral and back-ups), and the restructuring of abortion services to accommodate the Abortion Control Act (which requires a 24 hour waiting period) and the Parental Consent Law their state passed. Due to this increased legal scrutiny and worries about medical law suits, staff mentioned a change towards balancing patient care with liability (which meant increased documentation and hiring of RNs for procedures and after-care).

Regarding the high turnover of Executive Directors, Mary (Lab Manager and Director of Ancillary Services), in her twenty-two years with the center, witnessed the change of six directors. She describes one such change as initiated by the staff:

I'VE SEEN US GO THROUGH A LOT of executive directors uhm, SOME GOOD, (PAUSE) some dreadful. Dreadful! Their people skills were just awful. Their agendas were VERY PERSONAL to their- their situations, their life situations. And when we have an executive director who knows how to manage A STRONG STAFF OF WOMEN (PAUSE) it's wonderful. Then when we had somebody who's (PAUSE) NOT INSIGHTFUL THAT WAY, I think that the staff has risen the occasion and (PAUSE) done the right thing and they managed to UNSEAT the executive director they didn't care for. Didn't care for is being VERY VERY GENEROUS. The woman was a horror. And she was very very detrimental to the staff and we all- staff rallied together to have her removed.

Management under the current director (Janet) was seen as less micro-managing and more in touch with staff in making decisions.

At the time of the study (March-September 2002), the Women's Health Center operated as a for-profit center with an executive director and a board of directors. The executive director (Janet) reported financial issues to the board of directors, oversaw the staff, and filled in various duties as needed in daily operation (which made her very visible to the staff and clients). The executive director (Janet) worked with the medical director (Sam) on medical issues. Sam oversaw all staff physicians, nurses, and nurse practitioners. Janet also worked directly with Chipper, the medical services coordinator, who would act as the director in her absence and who oversaw all staff except for medical staff and nurse practitioners (i.e. front-office personnel, counselors, telephone counselors, head nurse, head counselor, accounts receivable coordinator). head counselor, Lynn, provided abortion, options, and post-abortion counseling, and supervised counselors and telephone counselors. The head nurse oversaw procedure assistants, recovery room nurse, recovery room back-up, and autoclave. The lab and ancillary services coordinator (Mary) performed lab services, maintaining records for state, and ordered lab and office supplies.

The center had four departments: Administrative, Medical, Counseling, and Front Office (reception). Decisions on policies and protocols were discussed first within the management committee (consisting of the department heads) and then moved to either the medical committee (for medical policies and complications) or to full-staff meetings. The medical committee consisted of the physicians, head nurse, and nurse practitioners of the center, physicians from the community, and the executive director. The medical committee met twice a year. Full-staff meetings were held four times a year. Only five of the over twenty staff of the center were hired as full-time staff. These were the executive director, head counselor, medical services coordinator, lab director, and the accounts receivable coordinator. All other staff (counselors, doctors, nurses, and nurse-practitioners) worked on a part-time, contractual basis.

The center provided medical abortions (up to seven weeks) and surgical abortions with local or full anesthesia (5-16 weeks), pre-abortion consultation and counseling services (which included abortion counseling, options counseling, post-abortion support group, and general individual and family counseling), abortion follow-up care, and expanded gynecological services (e.g. routine gynecological exams, colposcopy, STD checks, and birth control provision and renewal).

Staff and clients

Staff

At the time of the study, the executive director of WHC, Janet, estimated the staff of WHC to be between fifteen and twenty with fluctuations due to the large number of part-time staff some of whom worked only two days a week or only on Saturdays. In WHC I interviewed 11 staff members. These 11 were the staff who agreed to be interviewed and did provide a good representation of staff, including those at key positions, such as the Executive Director, Head Counselor, Medical Director, Nurse Practitioner, and counselors.

Nine of the staff interviewed were female. This fit with the current composition of the agency where all positions (except the physician positions) were filled by women. The staff I interviewed were white, although there were two non-white physicians of Indian-American (male) and African-American (female) origins. The participants ranged in age between 21 and 74, with a mean (and median) age of 33.

In terms of previous experience in women's health care or counseling, only one of the interns had no experience. Five staff members (including the director) had counseling experience, two staff had experience in birth control and outreach education experience, and medical staff (nurse practitioners and the physician) and the lab director had medical experience before working in WHC.

In WHC, there was a clear job specialization, especially in the roles of Medical Director, Executive Director, Head Counselor, Counselors, and Lab Manager. However, due to staff shortages and turnover, there was also a fair amount of rotation on daily clinic jobs where the Executive Director, Medical Services Coordinator, and Lab Manager rotated on performing front-desk (reception) duties and answering phones, which they said prevented them from completing their own work. In contrast, counselors and the medical personnel (physicians, nurses, and nurse practitioners) did not take part in the rotation, revealing their specialized status in the agency.

As stated by the Executive Director, WHC only had four full-time staff (Executive Director, Head Counselor, Lab manager, and Medical Services Coordinator). However, a person was hired recently to fill the fifth full time position of "accounts receivable coordinator." All other staff -including the Medical Staff- were either part-time workers or were hired on a contractual basis. Among the staff interviewed, four of them were full-time and seven were part-time or contracted.

Table 5 below introduces the individual staff members I interviewed followed by a narrative description of the clients interviewed and observed.

Table 5: WHC Staff

Name	Sex	Age	Position	Roles performed	Years w/ agency
Bridget	F	51	Nurse practitioner (part time: contracted)	Gynecological care Abortion follow-up care	12
Chipper	F	34	Medical services coordinator (full time staff)	Clinic jobs (float, flow) Supervising protocols Staff training Staff scheduling Oversees head counselor, accounts receivable, lab coordinator, and head nurse	9
Janet	F	30	Executive director (full time staff)	Staff and patient case management Liason with the board Business functions (advertising, purchasing of equipment, hiring, firing of staff) Resolving staff conflicts	8
Jill	F	21	Intern (counseling) (part time staff)	Phones, counseling, group video facilitation	2 months
Laura	F	30	Recovery room counselor (part time staff)	Record vital signs, offer crackers and juice, and go over after care instructions (all in after care)	5 years 4 months (5 yrs full-time)
Lynn	F	33	Head Counselor (full time staff)	Pre-abortion counseling (including options counseling) Post-abortion counseling Overseeing and training phone counselors Updating and buying new brochures Maintaining database on referral sources	1 ½
Mary	F	54	Lab manager Director of ancillary services Coordinator of medical records	Clinic jobs as needed Lab work (and training staff for lab) Ordering office products Maintain medical records for the center, State and the National Abortion Federation	22
Sam	M	74	Physician Medical Director (part time: contracted)	Perform abortions Work with executive director on medical decisions (daily and protocols) Oversee all physicians and nurse practitioners	8-9
Sarah	F	21	Intern (counseling) (part time staff)	Phones, counseling, group video facilitation, procedure support person	7 months
Sharon	F	34	Counselor (part time staff)	Pre-abortion counseling	4 years (full time before)
Sherry	F	27	Counselor (part time staff)	Pre-abortion counseling, group video facilitation	5 months

Clients

In WHC, I interviewed twelve and observed eight clients, matching the number of women interviewed and observed at FHC. Table 6 describes the type of clients interviewed. The abortion clients interviewed include surgical abortion clients only, since, in WHC, I did not interview any medical abortion clients.

Table 6: WHC Clients

Type of Service Received from the Agency	Number of Clients receiving the service
Gyn only	1
Abortion only:	
Awake (Local anesthesia)	3
Asleep (with IV sedation)	2
Abortion + Gyn	3 (all abortions awake)
Gyn + Abortion	2 (one awake, one asleep abortion)
Gyn + Abortion + Gyn	1

In terms of the observations, I conducted one pre-abortion consultation and two pre-abortion counseling sessions, three gynecological visits (including birth control renewal, annual exam, and STD follow-up), and two abortion follow-up exams.

All the clients I observed and interviewed (except for one Hispanic woman interviewed) were White. In terms of the ages, the mean age of the women interviewed was 28 (median=24), where half of the women (n=6) were between the ages 18-24, two women were ages 25-30, and four women were 31-40 years old. The mean age for the women I observed was 24 (median=22-24), where five of the women were between the ages of 18 and 24 and two were 25-30 years old. The majority of the women interviewed were single (unmarried) (n=9), and eleven out of the total twelve had stable partners and two out of the twelve had children.

In terms of the payment type women used, five women paid out of pocket, three paid with insurance, and four women had insurance but chose to pay out of pocket. The last category

of women includes women who were going to request reimbursement later, who were not sure whether their insurance covered the services, and those who preferred to self-pay for confidentiality purposes. Below are two tables (Table 7 and Table 8) that describe clients' familiarity with the agency in terms of number of visits and length of time. If the clients came for a consultation visit to the center as well, then a typical abortion client would have at least 3 visits (consultation, pre-abortion and abortion, follow-up). More than 4 visits indicated long-time clients of the center.

Table 7: WHC clients' familiarity with the agency: Number of visits for the women interviewed

# of Visits	Gyn	Ab	Gyn + Ab	Ab + Gyn	Ab + Gyn + Ab	TOTAL
1 st visit	1	1				2
2 visits						
3 visits		3				3
4 visits						
> 4 visits		1	2	3	1	6

Table 8: WHC clients' familiarity with the agency: Time with agency for the women interviewed

Time	Gyn	Ab	Gyn + Ab	Ab + Gyn	Ab+ Gyn+Ab	TOTAL
1 st visit	1					1
2 weeks		1				1
1 month		1				1
6 months- 1 year						
2 years				1		1
3 years		1	1	1		3
7 years				1		1
10 years			1			1
Returning (Ab and/or gyn before)		1			1	2

Typical visits

As is the case with the Feminist Health Center, the first contact of women with the Women's Health Center was also through a phone call. Women know the center through using its

services before, working there before, through referrals by providers and friends, and the phone book. Janet, the Executive Director, had concerns about whether the Center was confused with another clinic on the state border. However, only one woman (out of the nine who used abortion services) experienced this confusion.

When a woman called in to set up an appointment for an abortion, the phone counselor tried to discern whether it was the woman or her mother (or boyfriend) calling, and if so, told them to have the woman call them herself. The same rule held for gynecological patients (in WHC, women were called "patients" not "clients"). The Center had one Spanish-speaking phone counselor who worked few days a week to serve the growing Hispanic population of the city.

The Abortion Control Act passed by the state requires that all women to receive the state-mandated information on abortion from a physician at least 24 hours before abortion could be performed. The phone counselors would explain this Act and provide the women with the options of receiving this information from the center through a consultation visit or through a "phone consultation" (from their own physician or from one of the physicians at the Center). According to Jill (an intern), phone counselors listened to the tone of the woman's voice, their conflicting statements about the decision, and if they sounded conflicted, encourage them to come to the center for the consultation visit.

Chipper (Medical Services Coordinator) says that the Abortion Control Act made both the scheduling on the phone and the visits more time consuming. The Center adopted the phone consultation service both as a business strategy (due to the loss of patients to clinics in near-by states without waiting periods), and to decrease the inconvenience of two visits for the patient. All abortion patients I interviewed used consultation visits.

After deciding on the phone consultation or consultation visit, the phone counselor would ask the woman the date of her last menstrual period to determine her eligibility for medical or surgical abortion services. If the woman chose the medical abortion option, the counselor asked

further questions to screen for medical conditions (such as high blood pressure or cholesterol problems) that would prevent her from being eligible for this service. Then the visit was scheduled. Both gynecological and abortion patients I interviewed were able to get an appointment within a few days to a week (with an exception of three weeks for a Depo Provera renewal visit). Abortion patients scheduled their second visits on their first visit. Women calling in for gynecological or abortion services found the phone counselors very accommodating in working with their work schedules and in finding them a spot if they were close to the eligibility limits period for medical or surgical abortion. On a contrary note, two gynecological patients noted having difficulty scheduling gyn visits, due to limited hours of operations. However, there was no indication of limited hours in staff interviews and observations.

Consultation visits were scheduled for Tuesdays and Thursdays. Abortion was provided consistently on Tuesdays, Thursdays and Saturdays; however, depending on the doctors' schedules, they were also scheduled for some Wednesdays and Fridays. Every other Thursday was an "IV day", where they only scheduled women who wanted full anesthesia (called "twilight sleep" in the brochure) for abortion. Gynecological services were performed on Mondays, Wednesdays, and Fridays (occasionally on Thursdays as well).

The consultation visit

It is a Thursday. As I drive in to the Center's parking lot, I see two protesters, a man and a woman, probably in their seventies, holding up signs. The man's sign has a picture of a baby with "LIFE" written on it. I did not read the sign the woman was holding. The two are walking on the borderline that marks the Center's parking lot. "They are here only for an hour or two in the mornings, sometimes with rosary beads, sometimes with signs. And they walk right on that borderline, the line that says 'patients/clients only' knowing they can not come into the parking lot. It's trespassing," says Lynn, the Head Counselor. The very first day I came into the Center,

Janet was talking with security officers about protesters. The staff found the protests much milder than the ones in the past (referring sometimes to the blockades) and milder than the experience of other clinics. Even though the protests were milder, the Center had increased its security after the blockades and for staff, sadly enough, both the protesters and the heightened security measures became "commonplace" or normalized. That was not so for the women who walked through the protesters (to receive abortion or gynecological care), and who were further alarmed by the heightened security of cameras, showing IDs, and locked doors. Only one of the women I interviewed, who was a pro-life opponent, said that quiet protesting was acceptable.

The Center is located in a two story building. There are two other offices downstairs. I walk up the stairs, say my name to the speaker phone. I am buzzed in.

When a woman comes for the consultation visit, she walks to the reception desk at the left of the entrance. To the right is a small room used by phone counselors to schedule appointments. At the reception, the woman is given a cup for a urine sample. When she comes back, she is given the intake form to fill out in the waiting room. The waiting room has thirty-eight chairs, coffee tables with a lot of magazines, diaries to write in (for the Center's use and for the Women's Law Project to fight against anti-abortion laws), a bookshelf with books to borrow or to take, a small TV, a round table at the corner with puzzles/board games, posters and pictures on the wall, and a board with advocacy messages (e.g. vote to repeal the State Act, info on Catholics for Choice, etc). The waiting room has no windows but the illuminated painted tiles on the ceiling provide some light and a cozy atmosphere. On the days that the TV is not on (which was most of my experience), there is music playing on the radio.

The intake form consist of sections on contraceptive history, personal history (racial, educational, and marital status required by the State Department of Health), how the women heard about the clinic, type of insurance, menstrual history, pregnancy history, medical history, very detailed consent forms for abortion, type of anesthesia preferred, request for additional

narcotics (with local anesthesia), and consent for oral contraceptives. The intake form is eight pages long; however, the last three pages contained "Procedure", "Recovery Room", "Follow-up visit", and "Counseling" sections, which were filled out respectively by the physicians, recovery room personnel, nurse practitioners, and counselors. Inserted into the intake form is a one page optional counseling questionnaire, which asks the women about their support person (whether they want them in the counseling session, and whether this person would like individual counseling as well), and about their decisions and feelings regarding the abortion decision. This questionnaire was meant to help the counselor see "where the woman's at" and what her main concerns are. Sandy says most women either do not fill it out or leave out the feeling part and check the boxes for concerns on possible complications and future birth control.

After turning in the intake-form, the woman is called in for blood work and vaginal ultrasound (which are respectively for testing anemia and RH factor and for determining her gestation). Then, she watches a short video with a group of women.

I observed the group session with the video on my second day at the Women's Health Center. The women, the staff guiding the group, and I sat in a small office around the TV. Women could bring in their support person, and minors had to have their parent or guardian present (due to the parental consent law). In my group, there were two young women with their mothers, a woman alone, and another young woman with a boyfriend. On TV (video) was the medical director of the Center (Sam) reading the state mandated information on the abortion procedure, its complications, and its alternatives. It was very monotonous and technical. Medical abortion was not discussed as much either. Sandy, a counselor, said the state information made abortion seem to be a very complicated procedure with many complications, as if to act as a deterrent. One of the young women with the mother was not paying attention to the video, her mother was upset and tearing. The boyfriend of the other woman also looked upset and was

blushing. I wondered whether any of this information was getting through to the women, especially those who were occupied in their nervous or sad states.

After the eight-minute video, the staff guiding the group handed out the forms to be signed (as proof of being informed of the state mandated information). If minors, the parents had to sign the form. The staff told the women where to sign and said that they had a right to view the additional information the state provides on alternative services. Only one in this group of four women requested to review the information. The information came in the form of a booklet named "Abortion: Making a Decision" and a binder called "A guide to Services for Pregnant Women."

The booklet had pictures of fetal development in different stages from five weeks to thirty eight weeks (called "development of an unborn child"), and further text on abortion methods and medical risks, emotional reactions to abortion, medical risks of childbirth, and information about state health care programs that pay for prenatal care, childbirth, and neonatal care. As noted by Lynn, the Head Counselor, and in an editorial letter published in the local newspaper (in 1994), the state booklet's discourse (unborn child vs. fetus) and use of enlarged pictures of fetuses "to convey the impression that fetus is developmentally larger and more fully developed than it is" are tactics used by the anti-abortion activists. The editorial letter also emphasizes another common tactic of anti-abortionists used in the booklet: the intense attention on second and third trimester abortions. The writer finds this emphasis unrealistic, since 90% of the abortions provided by the clinics in that state are first or early second trimester abortions.

The binder "A guide to Services for Pregnant Women" on the other hand, listed resources for pregnant women. These services, in the order of listing, were: Adoption Services, Alternatives to Abortion Services, Financial Assistance, Child care, Food and Nutrition services, General Medical Care, HIV Services, Pediatric Care Services, Pregnancy Counseling Services, Prenatal Care Services, and Social and/or Counseling Services.

After the video, the women return to the waiting room and wait for their individual counseling sessions. In the counseling session, the counselor reviews the intake form, to see whether the patient left any areas blank (especially on the medical history), quickly reviews the optional questionnaire to see what their concerns and feelings regarding abortion are, and then goes into a discussion of birth control methods used before and what is preferred after the abortion. "I talk about contraception FIRST. Kind of like am ICE BREAKER" says Sarah, an intern counselor. Then the consents for abortion (including consents for IV or an additional narcotic with local anesthesia if those were chosen) are explained, if IV sedation is chosen, a handout for pre-operation instructions (e.g. not eating or drinking anything from midnight the night before, and having a driver stay at the Center for driving you back) is reviewed. The counselor also goes over the post-abortion care (from another pamphlet handed). The final step of the consultation visit is the discussion of the decision. Although the majority of the counselors listed this as the last step, it seemed to depend on the emotional state of the woman and the judgement of the counselor.

Based on the feeling I get from the client if I should go through the chart first and then move into the decision process. OTHERWISE, I'll start with the decision process and then go into the chart after that. But it's really a clinical judgment. There's no (clinical data?) to rely on. I rely on feeling.

Sherry, WHC, Counselor

The discussion on the decision centers on how the woman came to the decision, how certain she is of her decision ("as far as your decision goes today, are you certain that this is something you wanna do?" "how are you feeling today? Is this the decision you want to make?"), whether anybody forced her to make this decision, how she thinks she is going to feel afterwards, and whether she has a support system to help her.

[the counseling was] excellent. They really make sure this is the decision you wanna do, it was private like a making sure you weren't forced to any decision you know, theee they have him they had him wait outside and they asked me to make sure this was the decision I want to do. Then he came in and you know we you know discussed the (abortion?)

Elizabeth, WHC, abortion patient

Staff reported that depending on the emotional state, decisiveness, and family control over the woman (e.g. having a mother who has the opposite decision), counseling sessions (at either consultation or procedure day) can take from five minutes (average 10-15 minutes) to one or two hours.

We had a couple [of counseling sessions] last week that were two hours long. The one girl was a minor, so she was staying with the MOM. (Ayse: turn into a full blown session yeah?) RIGHT! Turn into a full blown session. SO, depends how much they wanna tell you. How much they wanna get in depth. But how much of their emotions they wanna (PAUSE) RELEASE to you. SO. If they are perfectly fine, could take 10-15 minutes. If they're an emotional WRECK, could take 2 hours. But usually I (LAUGHS) I see them 15 to 20 minutes. That's usually the norm. Not a lot of two hours (Ayse LAUGHS) thank god.

Jill, WHC, Intern Counselor

When the woman is undecided and clearly torn between two decisions, the counselor provides "options counseling" where alternatives to abortion are discussed.

When the counseling session is completed, the woman goes to the reception desk, makes an initial deposit, schedules her next appointment (the abortion visit) and leaves. In the Center's pamphlet provided to all abortion patients at the initial visit, it is mentioned that the consultation visit usually takes 1 1/2 to 2 hours. The women I interviewed confirmed this estimate: for these women, the duration of the consultation visit ranged between one to three hours.

Abortion visit

The procedure visit consists of counseling, payment, waiting in the waiting room, abortion procedure (with IV or local anesthesia), and after-care. In the Center's pamphlet, women

are told to expect to be in WHC two to five hours if receiving local anesthesia, and three to six hours if they will be under IV sedation. My interviews confirmed these waiting periods.

Counseling on the day of the abortion follows the same pattern as the consultation visit (going over the medical chart again to see if anything is missing, birth control discussion, abortion discussion, and after-care instructions). The difference from the consultation visit is that the birth control discussion is less detailed (mainly checking their decision and answering any questions they have) and that the woman is screened about not eating, drinking, and taking street drugs if they were undergoing IV sedation that day. If the woman had not come to the center for the consultation visit (but had a phone consultation), then the session would include medical chart review and a more thorough birth control discussion.

In WHC, I observed four consultation sessions and three pre-abortion counseling sessions. All the consultation sessions I observed were emotionally intense sessions where women brought up a lot of important issues and expressed sadness and sometimes being upset. I wrote in my fieldwork notes how these sessions that I observed one after the other in my second day at the center were emotionally hard on me as well. Compared to the consultation sessions, the pre-abortion sessions (except one conducted by the same counselor who conducted the consultation sessions I observed) were less emotional and more matter-of-factly. Although based on a small set of observations, I wondered whether the consultation sessions do provide a space (and time) where women can explore and work through their thoughts and emotions, which then makes counseling on the abortion day easier and less emotional. However, I do want to point out that all the more intense sessions I observed (in consultation and pre-abortion sessions) were conducted by the same counselor who had a counseling degree, whereas the rest of the sessions were performed by lay workers trained in counseling. Thus, one factor might be the psychologizing of the sessions by the therapeutic approach of the counselor. From my observations and interviews with staff I saw that the intensity of the sessions (and thus the time)

also depends on the characteristics of the women, such as her knowledge on and previous experience with abortion, her feelings around the issue, and her decisiveness. Staff also mentioned intense counseling sessions at the day of the abortion, where the women would be asked to reschedule if she is undecided. My tentative conclusion is that consultation sessions are likely to be more intense than counseling sessions and the intensity is mediated by the counselor's approach to abortion counseling (related to her degree) and the women's characteristics.

After the counseling session, women wait in the waiting room to be called back to the procedure area. When called back, they pass to the procedure side (back side of the building) through the locked doors after the staff enters the code. Before the abortion starts, the doctor asks the woman again whether she is definite about her decision.

We ask them if they are certain this is the decision for them. Nobody's forcing them to be here. And typically, if the woman is wavering, uhm on the day of her surgery, we go through her options, you know with why she wants to have the abortion, this is why she would wanna carry the baby to term, uhm and basically do problem solving with them. To uhm help them come to the decision that's gonna be right for them. So basically THEY- they're leading the session in a way that way but we do you know complement with questions. Just to try to find out what they think is their decision and after going through all of that, we ask then again, "Are you certain of your decision? Is this what you will do?" If they are not a 100% certain (after?) the session, we tell them go ahead to reschedule the appointment, our physician ?? choose they want before surgery (LAUGHS) if they don't give a response they're 100% certain uh. Because we were here to support their decision. So if they're not totally certain, we recommend them to reschedule. Because when we go to the back room, you know the physician's gonna ask them uhm if they're certain. IF THEY SAY NO, then (they will?) not to make the surgery.

Shery, WHC, Counselor

Women experienced abortion differently based on the procedure chosen (IV or local anesthesia), previous experience with abortion, and experiences of pain and discomfort.

Ayse: HOW WAS the abortion procedure itself? DID YOU go through awake?

Eileen: I was awake, I was awake..Uhm IT WAS NOT COMFORTABLE. IT WAS VERY PHYSICALLY uncomfortable, uhuh. BUT, I kinda, even though I KNEW I knew what to expect. I knew from working here, what you know, what should happen and

when it happens. IT WAS STILL, uhm, PRETTY UNCOMFORTABLE. UHHm yeah it was, it was painful. There's a lot of cramping.

Eileen, WHC, Gyn + Ab patient

that- (referring to abortion) that was like the hard part. It was like the last part of it. So, just being in that room made me (Ayse: nervous?) yeah nervous, and scared and uncomfortable but. And that's why I chose to be asleep. Just to like help me get through it.

Keri, WHC, Ab patient

I ASKED MORE ABOUT THE PROCEDURE, because I- WAS ASLEEP at first so I didn't know what to expect. But she walked- she walked me through the whole thing. Which was really nice. You know she did told me what to expect, when she was giving me the shot of Novacane, and everything else (Ayse: you mean the doctor?) yeah. She said there was gonna be a little discomfort at first. She said more like bad cramping. And that's what it felt like. It felt like bad- really bad cramps. When they just there's blood suctioning, when it starts. It wasn't- it wasn't as bad as I thought it would be. If I would have known that the first time I would have it done it the same way. Because I- I'D RATHER BEEN AWAKE. It's both the procedure's a lot quicker. When you're awake. Cause you're in and out a lot quicker than you're under THE ANESTHESIA, it takes longer.

Ashley, WHC, Ab patient

The pain and discomfort were reduced through the help of the support person (if the person wanted a counselor help them through the procedure²), the nurse, and other staff. These staff would talk with the woman beforehand and during the abortion to help the woman through the procedure as well as to distract her from focusing on the pain.

they pretty much explained it (referring to the abortion procedure) pretty well in the pamphlets before you came in. things to look you know what to expect at the procedure. But the uhm, I just didn't expect it to be that painful. I I was in pain. Major pain (Ayse: yeah, SO there was a nurse and a doctor) and a counselor. Counselor came in to help me not to think about the pain yeah that was really good. Then afterwards I felt fine.

Elizabeth, WHC, Ab patient

² In contrast to the FHC, in WHC, due to liability and security issues, women are not allowed to have their own support person in the procedure room or in after-care with them.

They give you a basket to put clothes in. AND WHEN I GOT INTO THE ROOM, we actually were talking about TOM CRUISE (Ayse laughs) and in the movie "Interview with the Vampire". They think he fit THAT ROLE- AND AND as they were doing that the anesthesia was going and then I WOKE UP IN ANOTHER ROOM, and THERE

Sonia, WHC, Ab + Gyn + Ab patient

There was a NURSE IN THERE. UHHM utilizing conversation during the procedure THAT WAS, A, ABSOLUTE (PAUSE) GOD SAVING, uhh, uhh a FOR UP HERE for in your mind, as to you know you're talking this and that and uhh (A: hmmm.Distracted). Absolutely. Yeah that was great. That was very helpful. UHHM because there's such a stigma attached uh. And and I HAD PRECONCEIVED notions prior to having the procedure that individuals WHO who go through that- (A: ok) I've never NEVER in a billion years that I'd see myself in that predicament. BUT YOU HAVE TO walk through their shoes. TO SEE WHAT IT'S LIKE UHHM but the staff, procedure, and after the procedure EVERYTHING WAS FINE. Yeah

Nancy, WHC, Ab + Gyn patient

Except in the case of Ashley presented above, most women reported having little to no conversations with the doctors. The doctors seemed to ask the women their decisions one last time and then "get to business" (while some visited the patients later in the after-care room).

After the procedure, the women are brought on wheel chairs to the after-care room. They are still in the paper gowns and some are under the effect of anesthesia. To me they looked very vulnerable.

I saw lot of women crying at the recovery room or on their way to there today. I started disliking abortion more and more. Because the process, no matter how much easier and comfortable it is made to be, seemed dehumanizing. Women with paper dresses, open at the back, coming or being wheeled into the lazy boys at the recovery room. So, you have this vacuum cleaner like sounding vacuum inserted and sucking your insides out and then move either conscious or unconscious (due to IV sedation) into a room with other women. Why do they have to wear nothing at the top for example? I still don't know how the women themselves feel at the room or the recovery room.

Field notes, WHC, April 11, 2002

Unlike the one in the Feminist Health Center, in the Women's Health Center the after care room was quite large with multiple recliner chairs, a desk where the recovery room person

sits and records the women's vital signs, and a small stand with coffee makers. This room had a door that opened to the outside where the woman would meet their support person with whom they came (and who is their driver if it was an abortion with IV sedation). In the room, the women are given heating pads and blankets (for helping with cramps and for comfort), their vital signs are measured, and cookies and juice are offered. After walking around a bit, they are allowed to dress and leave the center.

Because the next thing you know I WAS WAKING UP IN THE WAITING ROOM. (A: yeah) And you know I woke up. And ANESTHESIA doesn't seem to have AN EFFECT ON ME like everybody else. I came ??, bam like I wake up and I'm like ready to go you know. I'm a little groggy at first but I'm you know- I'm really ?? and ready to go after. (Ayse laughs) so I was there in the waiting room (Ayse: ready to go) I thought it was nice that you got to be in recliners. And they were comfortable. And the women in there were so nice. They gave you the heating pads and the blankets and you know I woke up and they were like I said "could I have drink" that's all I wanted all morning. Cause you couldn't have anything to drink since midnight. AND SHE SAID OH SURE. So I drank some soda and. You know after a couple of minutes, she let me get up and walk around and you know then she checked to make sure to see if I was bleeding bad and they let me GO HOME. BUT EVERYBODY, and I told the woman at the desk I said "You know, I don't know how many times you get told but IT WAS so nice to come here to go through something SO HORRIBLE." (Ayse: in a nice way) AND yeah in a nice way. TO HAVE SOME like- THEY'RE JUST so friendly and supportive and I didn't feel like anybody was LOOKING DOWN ON ME

Christa, WHC, Ab patient

AFTERWARDS I was a little bit shaky but I think that's normal. UHH, but in the recovery room, uhm shortly after I sat down and had a thing to eat, had some juice and cookies. IT HELPS! (BOTH LAUGH) IT DOES HELP. Cookies make everything better. BUT And I got a little weepy afterwards. Just a little- a little tearful. UHM, it was- it was a huge comfort to me that, uhm, one of the- Chipper that works here, SHE WAS THERE. You know, she kind of held my hand and I kind of- I did my little thing woo thing and a couple of minutes later I was fine.

Eileen, WHC, Gyn + Abortion patient

Follow-up visit

Women's Health Center requires women to have a follow-up check 2-3 weeks after the abortion. The follow-up fee is included in their payment, so they could come back to the center (within two weeks) or choose to go to another provider (due to distance or comfort with own

provider). As Janet (Executive Director) told me, 33% of the abortion patients come back to the center for their follow up care.

When women come to the Center for the follow-up visit, they meet with one of the two female Nurse Practitioners who are responsible for all the gynecological care (which includes post-abortion follow-up care). I met both of the Nurse Practitioners and have observed them both in gynecological sessions, however, most of my time (in observation and discussions) was spent with Bridget, whom I interviewed as well.

Bridget is a nurse practitioner and talks more like a researcher or teacher (She is teaching 60% at a nearby university). When she talks, she mentions articles, "data" being very fascinating on this and that. She mentioned new research (meta-analysis) on oral contraceptives and antibiotics, for example.

Field notes, WHC, March 21, 2002

During my time in WHC, I learned a lot from Bridget about STDs, colposcopy, history of nurse practitioners, the hierarchy between NPs, PAs, and doctors, on alternative methods. I shared with her my self pelvic exam attempt, gyn experiences, and we exchanged research articles.

Based on my observations and the women's accounts, the follow-up visits start with a discussion of how the women are doing after the abortion (physically -bleeding, clots- and sometimes psychologically), then goes into discussion of the birth control method used (or to be used), and the pelvic exam. One of my observations involved a woman who also needed an ultrasound and a re-evacuation procedure to get the blood clots out of the uterus. In the pelvic exam, Bridget talked to the women about what she was doing (e.g., feeling the uterus, the ovaries, looking at the cervix, seeing a thick lining of the uterus in the ultrasound) and checked with the women about any discomfort while doing these. Women's questions were on whether everything was ok (despite heavy bleeding or not bleeding as much as they thought), on birth control issues, and on the time of their first period after abortion. Birth control discussions centered on how the

women were doing on their method of choice. If the woman did not want any birth control (as in the case of where a thirty year old woman who told Bridget she will not have sex any more) emergency contraception was prescribed and a free pack was offered.

Medical abortion visit

In 2001, there were 51 medical abortions performed at the Women's Health Center. This makes up only 1.83% of the total abortions (n=2783) performed in that year. At the time of my visit, the center offered two types of medical abortions: with the pill (Mifeprex) or with a shot (Methotrexate). However, information on their web site shows that only the pill option is currently employed.

As mentioned before, women are screened on the phone for their eligibility for medical abortion (based on gestation period -should be less than 7 weeks- and medical history). The visits follow the same pattern as surgical abortion visits (phone consultation or consultation visit, abortion visit, follow-up). The differences are that the follow-up visit is required (to check on the completion of abortion) and the birth control discussion takes place at a counseling session added to the follow-up visit.

In the day of the abortion, after urine and blood work, ultrasound, and counseling, the woman sees the physician who reviews her medical chart, asks her about her decision again, does a pelvic exam, and gives her one tablet of Mifeprex (200 mg.) to be swallowed. The physician also provides the woman with 4 tablets of Misoprostrol (800 mg.) to be inserted vaginally 48 hours after taking Mifeprex.

At the follow-up visit, a vaginal ultrasound is performed and if the abortion is complete, the woman meets with a counselor to discuss "birth control and future care". As mentioned on the Center's web site (and in the consents), if the abortion is not complete, surgical abortion will be performed (with an additional charge of \$100) and another follow-up visit is required.

I do not have comparable statistics on the frequency of medical abortions in the Feminist Center (FHC), however based on my observations and interviews at both sites, I tentatively conclude that medical abortion is utilized less in WHC. In FHC I observed and interviewed women who have used medical abortion. In contrast, in WHC, I did not encounter any medical abortion patients in my counseling or follow-up observations, or client interviews. Aside from a potential difference in the population of women served by each center, an important reason might be the difference in the centers' approaches to medical abortion. Due both to liability concerns and medicalization of services, WHC's presentation of medical abortion (on the web and then in the visit to the women) is more detailed, complicated, and presents higher estimates of failure rates (reporting 5-8% failure rate). In WHC, the pill is administered by the physicians. In FHC, in contrast, medical abortion description is less detailed and complicated and the failure rate is reported as 1-6%. In FHC, the pill is administered by the Physician's assistant and not the physicians. As suggested by the following quote, there could also be a difference in staff's beliefs and preference regarding medical abortion.

I was originally considering using the- THE abortion pill. But at that point I also TALKED TO A- A counselor, but also Mary who's the lab. SHE'S ALSO A FRIEND OF MINE. And she was you know very frank and honest with me as far as the abortion pill that the side effects were more severe. And theeyy uhm you know you're talking about, you're actually passing pregnancy tissue on your own. So you know, you're missing days of work, you don't really know what to expect. And uh, after talking to the counselor, I made the decision that uhm, I'd rather have the surgical procedure. BUT THAT WAS- you know that's just another testimony that they're- they're very honest with- either very frank you know. They could have just- because really it's, on their- AS FAR AS they're concerned, you've just ?? just go ahead, give the woman a chance to swallow a pill than go through the whole procedure. They've got lots of people they have to see. BUT THEY WERE HONEST WITH ME. And and they explained to me exactly what the pros and cons to BOTH WERE.

Eileen, WHC, gyn + abortion patient

To gather some information on WHC patients' experiences on medical abortion, I reviewed the "Mifeprex Evaluation" forms completed by 47 women who had medical abortions from WHC between January 2001 and September 2002. As also confirmed by Janet (who gave

me the forms), the main finding was that the experience varied widely among women across the areas of pain, cramping, bleeding, passing the pregnancy, reasons to choose the method, preparedness by the center, satisfaction with the method, and comparison to previous surgical or medical abortions.

For example, women were asked when the cramps and bleeding started (in relation to insertion of the vaginal tablets). The answers on cramping ranged from a day before, 20 minutes after, 6-8 hours after, to no cramping at all. The answers on bleeding also varied from the day or night before, 2-4 hours after, to 11 hours after insertion. The center tells the woman to expect cramping and bleeding 2-4 hours after insertion. Intensity of the bleeding also varied among women from 1-4 hours to a week and a half of heavy bleeding. Women's reports on when they passed the pregnancy tissue ranged between 1 1/2 hours to 3-4 days after insertion (most were within the 24 hours). The pain experienced also varied from no pain to bearable pain (like menstrual cramps) to excruciating pain (like childbirth). When women compared the medical abortion to previous abortions (mainly to surgical abortions), slightly more women reported medical abortion to be less painful than surgical abortion. The main differences (which constituted the reasons for choosing this method) were in the emotional arena: privacy, invasiveness, feelings of being in control, and safety (i.e., less chance of infection with this method):

I would rather have had this unpleasant but necessary procedure at home not an impersonal environment with people I didn't know (no offense!)

Because it's more natural. I didn't like the idea of having something sucked out of me.

Felt like I was more in control and not that it was being done to me.

Was emotionally easier to deal with. Wasn't invasive, less chance of infection. Less pain. More natural.

The safety and decreased chance of infection might be due to information women received during pre-abortion counseling (since it is not on the web site), and if so, provides contradictory evidence to my previous claim: that medical abortion was not favored by staff. To summarize, women's experiences of and satisfaction with the method are mediated by the amount of pain and bleeding, and what is important for women. Medical abortion seems to be best for women who prefer a less invasive method where the woman is in control (but one which lasts longer). Surgical abortion, in contrast, seems more suitable for women who prefer the procedure and pain to be shorter.

Gynecological visits

Gynecological services at WHC include routine physicals and gynecological exams, birth control counseling and renewal, pregnancy testing, testing and treatment for sexually transmitted diseases (for women and their partners), HIV testing and counseling, treatment for abnormal Pap smears (colposcopy and cryosurgery), and information and referrals for tubal ligation and vasectomy. Types of birth control offered at the center are: birth control pills, emergency contraception, the patch, Depo Provera, Lunelle, the ring, diaphragm, IUD, Norplant, condoms and spermicides. According to the staff (and my client interviews), the most popular methods of birth control were the pill and Depo Provera. Lunelle was quite new at the time of my visit, and not as much preferred by women as in FHC (due to unfamiliarity and break-through bleeding in the first months). Staff stated that requests for IUD, Norplant or diaphragms were very rare.

When I asked the staff whether they would recommend certain methods over others, they stated their beliefs on providing all possible options to the women after checking for medical reasons that would make them ineligible for any method. For example, smoking and being over 35, depression, high blood pressure, blood clots, and migraines would make women ineligible for certain hormonal methods (such as the pill or Lunelle). Women's choices of a method, on the

other hand, depended on positive and negative experiences with methods, being in a monogamous relationship, concerns over weight and bleeding, being good at taking pills or not, and positive and negative side effects of the methods (not having to menstruate on Depo and skin improvements with the pill were positive side effects).

At the gyn visits, women would take a urine based pregnancy test. Cindy, the second nurse practitioner stated that it was not required, but they did it anyway. After filling out intake forms (that, in annual check-ups, included updating the medical history) and filling a reminder post-card for self (on Depo), the woman went to the back to see the nurse practitioner. She was weighed and her blood pressure was taken. I noticed that when the visit involved a pelvic exam (as in annual exams, STD checks, or colposcopy, etc.), nurse practitioners saw the patient first when they were still dressed up, to ask about their medical history and satisfaction with the method used etc. The exam (or colposcopy) that followed was quite gentle and informal, during which the nurse practitioner chats with the patient, walks her through the steps and checks with her (while putting in the speculum, or when putting pressure on ovaries), and explains/informs the woman on how to do breast exam, what to look for in a vaginal discharge (ovulation vs. infection), etc. I noticed not only the gentle behavior of the nurse practitioners but their attention to detail in providing a soothing environment for the women.

Talking over colposcopy, Bridget told me that they took extra precautions to keep instruments and bloody sponges out of the patient's sight. She also mentioned using her voice as distraction, allowing the patients to focus on her voice rather than on the clicking of the instruments. She said this could be scary and invasive experience for the women which might be exasperated by metallic voices. "those instruments gain a whole different feeling when you think of them as they are going to be applied to you, to your body". She said some doctors take no notice of how the patient feels, too much focused on their whole thing, that they pass bloody sponges and instruments at eye sight. Nel (the intern who worked with Bridget) brought a CD for Bridget as a present, to play in the exam room. She always plays some soothing music. At some point Bridget and Nel were talking about what more they can do to make the exam room, exams and colposcopies better. Nel came up with the idea of using crutchless pants which can be bought as underwear. She also said they could use heat pads to warm the mittens they put on the stirrups. Bridget told her to check the price on that. "People are going to fall asleep here" I joked. "with what we are doing, you could be sure they won't" said Bridget. Talking

with them and experiencing the room, I thought what a difference it would make if they had music playing in the exam rooms in the University Clinic and that how time goes by faster and things are more normalized if I talk with the doctor (or he talks with me). "you have to remember that it's a non-sick, non-medical person that is lying there" said Bridget. Meaning treat them as a person, not parts of a sick person, disregarding their fears, worries, etc..

Field notes at WHC, April 11, 2002

If the visit involved a birth control renewal as well, that would be done after the annual exam. The birth control renewal visits (without annuals) consisted of the pregnancy test, filling out intake forms, weighing/blood pressure, talking with the Nurse Practitioner briefly on how they are doing on the method (any concerns, side effects) and then the renewal.

CHAPTER 5

RESULTS

The purpose of this study was to investigate the legacy of the Women's Health Movement in the 21st century, especially in relation to the concept of empowerment of women in the reproductive arena. The specific research questions that guided the study were:

- (1) What is the current meaning and experience of empowerment for women clients of reproductive services?
- (2) What are the agency and societal factors that mediate women's experience of empowerment?
- (3) How do the two agencies differ in enabling empowerment?

As discussed in Chapter 3 (Methods), in this study, the Grounded Theory approach with post-structural influences was used to collect and analyze the data. In data analysis, the coding moved through the Grounded Theory phases of "open coding", "axial coding", and "selective coding". In order to help the integration of the emergent theory on empowerment, throughout these phases, theoretical and analytic memos were kept on theoretical questions, hypotheses, relationship between categories, and on my personal observations as a researcher. As discussed in Chapter 3, ideas of post-structural feminism were also used. These were resisting dichotomous (either/or) thinking of categories, avoiding quick categorization, allowing multiple and at times contradictory voices to exist, telling mundane stories of the data as well as the glorifying ones, connecting the stories of individuals back to the set of historical, structural, and economic relations in which they are situated, using self-reflexivity (being aware of my role in research

with my beliefs, vulnerabilities, and authority), looking at the discourses or language used by participants, and using playful representations of data.

OPEN CODING

In the open coding phase, interview transcripts, observations, and field notes were entered into the NUD*IST program. In NUD*IST, two different projects -The Feminist Health Center and Women's Health Center- were created to allow the analysis of empowerment separate (within each case) and together (cross-case comparison). Coding began with the highlighting and moving of sentences and entire paragraphs into initial categories. The first themes that emerged in both agencies were very broad themes, some of which mimicked the interview sections (e.g. agency history, staff treatment of women, etc).

The themes that emerged at the initial phase of open coding are the following themes except for "demographics" which was created to organize the demographic information collected from the participants. Within staff demographics though, job position (degrees of specialization) and job rotation, and full-time versus part-time status) was found to relate to the category "agency structure", through its implication of the level of hierarchy in each agency:³

Feminist Health Center (FHC):

- Demographics (staff demographics and client demographics)
- Agency history
- Agency structure
- Motivation to work (at the FHC)
- Feminism
- Nurturing agency

³ Please see the "index trees" for FHC and WHC in Attachment E for the detailed listings of all categories and their sub-categories.

- Structural factors
- Abortion (experience)
- Motivation to choose FHC
- Staff treatment of clients
- Environment
- Women's knowledge -ways of knowing
- Access to services
- Respect
- Women's visions
- Free nodes (my resistances, submissions, my feminist assertions, protective of the group, my self-disclosures, my inappropriate declarations -interruptions, ayse as educator, communication problems, interrupting questions)

Women's Health Center (WHC):

- Demographics (staff demographics and client demographics)
- Agency history
- Agency structure
- Structural factors
- Motivation to work (at the WHC)
- Access
- Feminisms
- Violence -protesters
- Abortion (experience)
- Women's visions of care
- Staff treatment of clients
- Women's ways of knowing
- Motivation to choose WHC
- Previous or current providers
- Environment
- Self-efficacy
- Empowerment

After multiple reading and rereading of the quotes, codes listed above were reorganized under the categories of "agency factors" (for both agencies), "community" (for both agencies), and "terrain" (for FHC) or "structural factors" (for WHC), and a category describing the type of care in each agency. The category that denoted the type of care in each agency derived from women clients' descriptions of the abortion and/or birth control care they received from the agencies, what set this care apart from other agencies and providers, and how this care related to their visions of ideal care. Staff's descriptions of their women-centered or feminist care, my observations (of counseling, gynecological exams, abortion follow-ups), and field notes were also used in this category to support women's perceptions and to provide depth to the code by, for example, emphasizing the individual differences in women's needs and wants. I initially named this category "providing alternative care" which, in FHC, seemed to be seen as "nurturing", and in WHC, as "caring" ("they take good care of you here").

During open coding, I also noticed a category I called "time dimension", which denoted the evolution of each agency in time. This dimension became apparent to me very early on in the research.

Transcribing Iris' interview, I realized that I was asking her questions from a point of view that I held feminist organizations as static forms, whereas throughout her interview, she talks about "changing", "evolving" as an agency.

Transcription note, April 8, 2001

This revelation was reinforced by later staff interviews and my review of archival material (FHC newsletter, and WHC newspaper clippings) that recorded the history of both agencies.

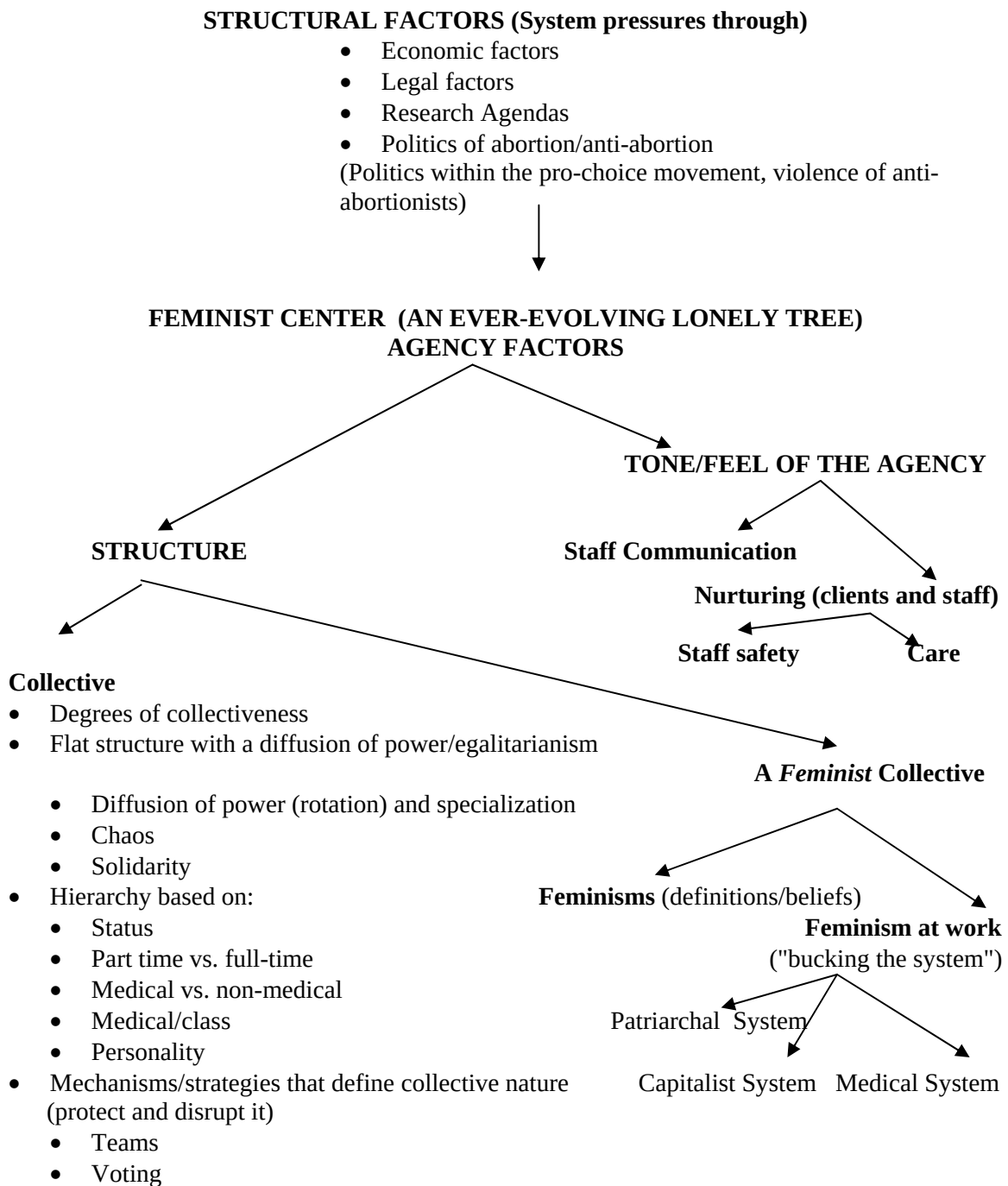
Lastly, around the end of open coding, I started visualizing the Feminist Health Center as a tree, with its roots in the Women's Health Movement and its feminist principles, its branching into sister organizations, and reaching out to community with various success. I saw it as a tree in

an unfriendly terrain, for the staff felt alienated and not supported (by community and clients) as much as they wished to be.

AXIAL CODING

Axial coding refers to the analysis stage where coding is done one category at a time, with an aim to find the dimensions of the category and its relations to other categories. It is hard to tell the exact time when open coding ended and axial coding begins in a research. Looking at my analysis notes, I see the difference in a note called "second level of analysis". This is a record of how I dimensionalized the FHC category of "agency factors" into "structure" and "tone/feel of the agency", where "structure" was further divided into "collective" and "feminist collective" and "tone/feel of the agency" included the dimensions of "staff communication" and "nurturing" (see Figure 1 below). Figure 1 also comprises the relationship between "agency factors" and "terrain" (now called "structural factors"). In WHC, the category "agency factors" had the dimensions of "structural factors" and "personal/emotional factors".

Figure 1: Example of axial coding: Axial coding of "Agency factors" for the Feminist Health Center



As exemplified by the category of "agency factors", during axial coding, all categories that emerged from open coding (e.g. agency factors, community, terrain/structural factors, and alternative care) were coded one at a time to reveal their dimensions and the relationships between them and other categories. Figure 2 and Figure 3 below are visual representations of all categories and their dimensions (represented by bullets under the category name) that emerged in each site at the end of axial coding.

Figure 2: Feminist Health Center: A lonely tree in an unfriendly terrain

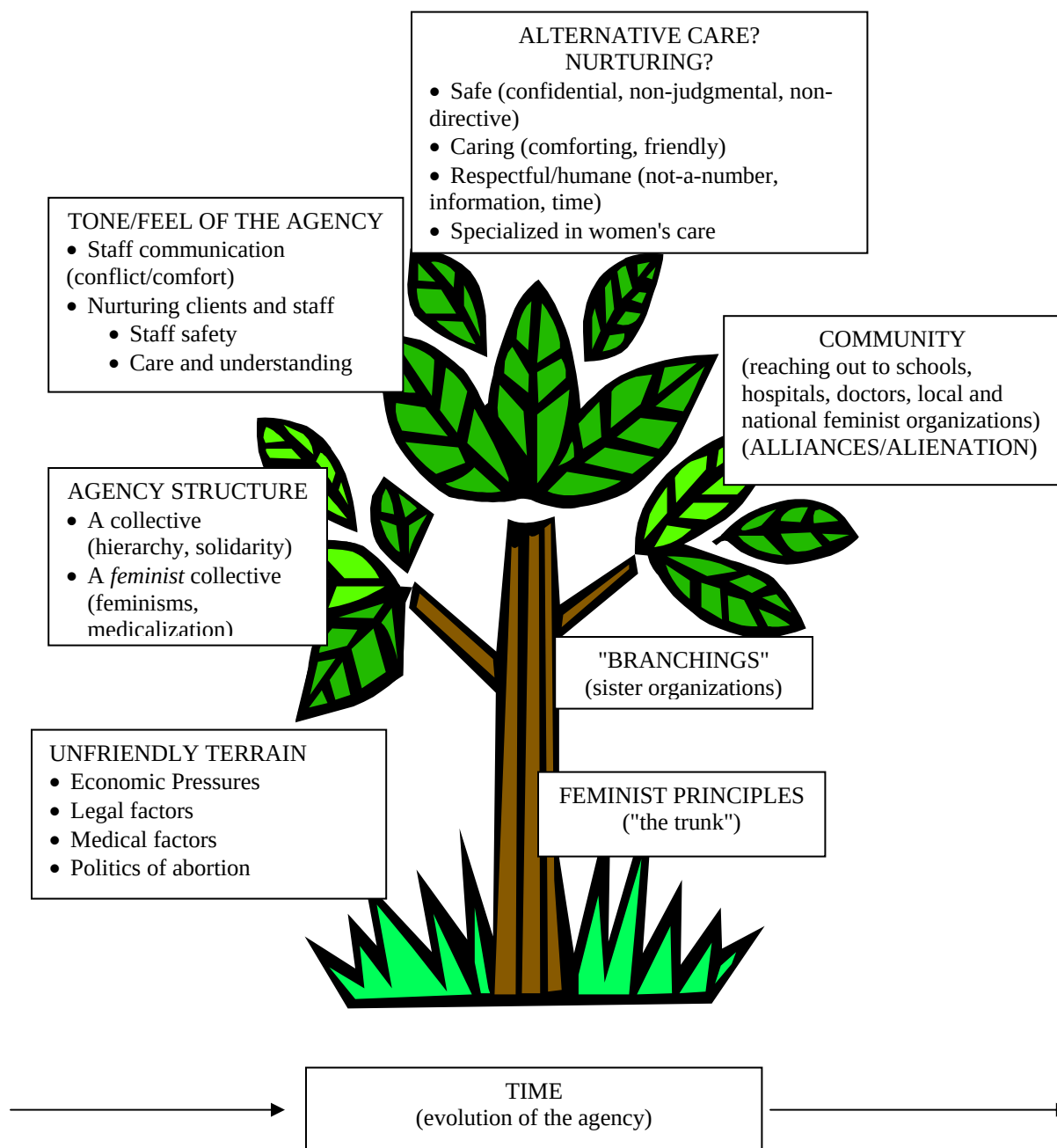
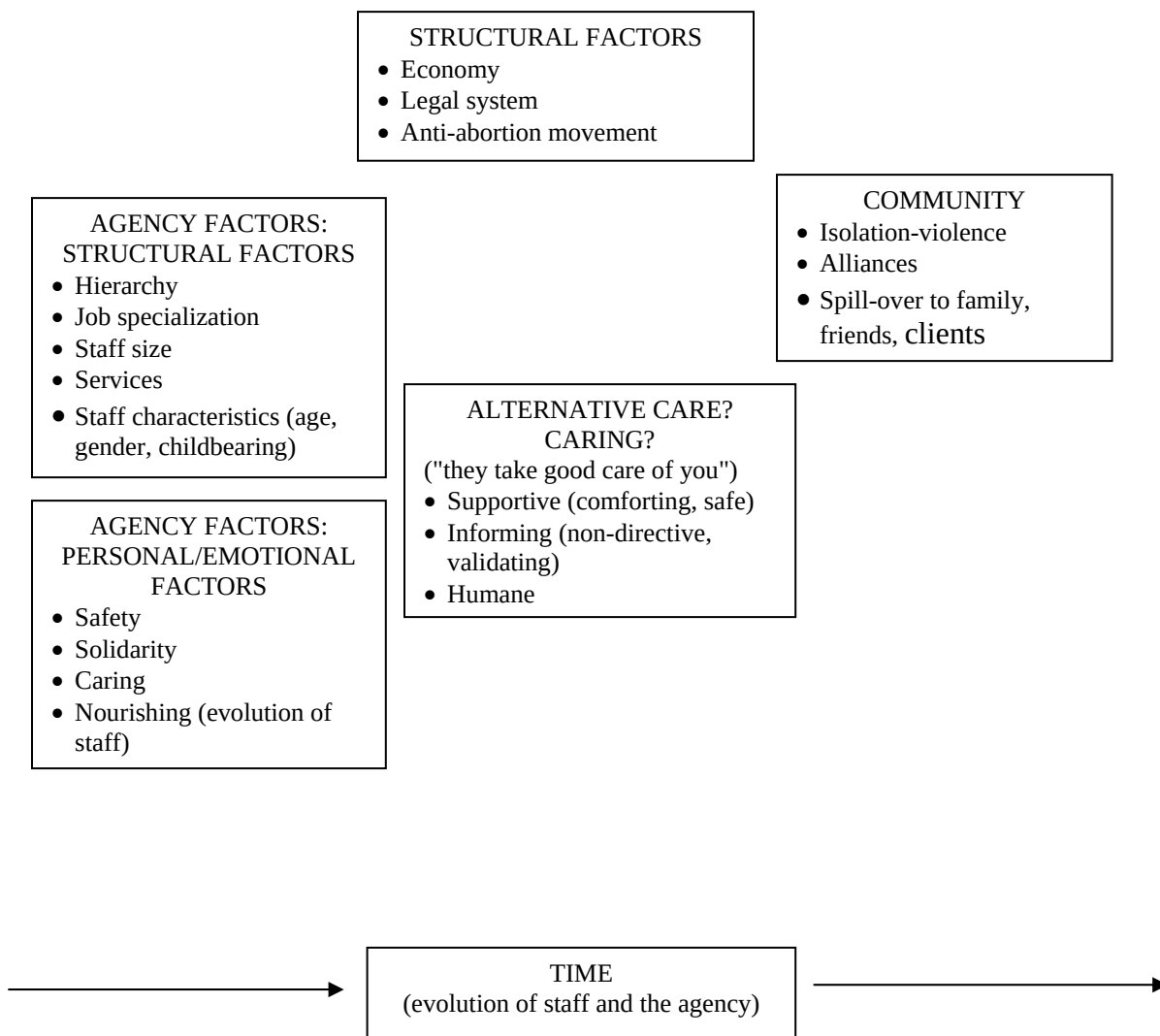


Figure 3: Women's Health Center



During the axial coding phase, relationships between the categories and sub-categories also started emerging. For example, in the FHC, the "unfriendly terrain" affected "agency structure" through economic, legal, and medical factors. In terms of economic factors, policies on insurance reimbursement decreased the use of lay workers in FHC for procedures such as gynecological exams, pelvic sizing, or cap fitting. Decreased use of lay workers in "medical" procedures reinforces specialization and medical authority, which feminist collectives were trying to avoid. FHC, in turn, was not passive and navigated the "terrain" (or "bucked the system") in legal and medical spheres through their attempt to use the loophole in the state laws to train mid-level practitioners for abortion and through participating in the clinical trial that led to the FDA approval of the cervical cap as a birth control method.

In the WHC, "structural factors" also influenced the "agency structure". For example, the 24-hour waiting period and parental consent laws led to the restructuring of the abortion services by the agency from one day to two day visits. However, again, the agency was not a passive receiver of societal influences, but adopted strategies such as phone consultation and video watched in groups, with an aim to keep the services convenient for the clients and to be able to compete with agencies in neighboring states without such laws. I will not discuss the rest of the relationships here because the relationships between categories were redefined after selective coding.

The core category

During the later stages of axial coding, I started the search for the core category.

I am reading Strauss' book on Grounded Theory and was reading on coding and how to find the "core" category or categories, for which he suggests asking the questions "what are the major issues involved in the situation you are studying?" "what is the main concern or problem for the people in the setting?" "what sums up in a pattern of behavior what's going on in the data?".

I thought about my main issue, main problem. The main issue I am studying is "empowerment" of women in health care. Then I started asking myself: empowerment is about power, but power against whom?

- Women's power against medicine?
- Women's power against the state (laws)?
- Women's power against capitalist system?
- Women's power against patriarchy that cuts across these?
- Women's power in the society?
- Women's power in the community?
- Women's power in the family?

Analytic memo, November 22, 2003

While keeping in mind women's power in the contexts mentioned above, I focused my attention on the individual woman client's perceptions of and power in the service context, as mediated by the agency, community, and societal (structural) contexts that surrounded these services. When the woman client's perspective was privileged, the category that described the type of care in each agency and was tentatively named "nurturing" in FHC, and "caring" in WHC began emerging as the core category. Focusing on the dimensions of this category which had similar codes in both agencies ("safe, caring, respectful, and specialized in women's care" in FHC, and "supportive, informing, and humane" in WHC) and revisiting the data (with the help of my co-chair) to find out the overall theme that connected these categories in both sites, I found that core category was "seeking safe and humane care." For women receiving birth control and

abortion care, at the core of empowerment were safety and respectful humane care. Feeling safe and being treated as a human being defined empowerment. Safety had both physical and emotional dimensions: being safe from anti-abortion violence, and not feeling vulnerable, judged or cajoled. Humane treatment meant receiving dignified, egalitarian, individualized, and holistic care. Before the detailed discussion of the core category, I will briefly discuss the last analysis phase, selective coding, and the theory reached.

SELECTIVE CODING

Selective coding refers to "coding systemically and concertedly for the core category", where all categories become subservient to the core category and are re-coded to understand how each relates to the core category (Straus, 1987). Once "safety and humane care" was established as the core category, all other categories (agency structure, agency tone/feeling, structural factors, community factors, and time/evolution) were recoded to discover their relationship to safety and humane care. In recoding the categories in relation to the core category, I discovered that the components of "agency structure" that enabled and restricted "safe humane care" were staff characteristics, staff beliefs, agency atmosphere (non-medical atmosphere), medicalization and psychologizing of services, and the business aspect of the services. At this selective coding stage, I realized that the components of "agency tone/feeling", which were safety/support and staff growth, related to other categories (such as "division of labor" and "staff beliefs") but not to "safe humane care." Therefore, the category of "agency tone/feeling" was omitted from the final analysis and the theory.

"Community factors" that affected both the agency factors (e.g. division of labor) and the safe humane care were the level of acceptance and support (alienation and alliances) the two agencies experienced in their communities. The category of "structural factors" that influenced all

of these categories (community, agency, and care) was renamed as "politics of reproduction" because the main effect of laws, the economic system, and the medical system on "safe humane care" was through normalizing or stigmatizing women's reproductive events. The category of "time/evolution of the agency" was discarded as a separate category and merged into the other categories. For example, in "agency factors", "time" was reflected in the evolution of staff beliefs and the increase in economic pressures (liability, competition) over time. In "community factors", "time" became change in violence towards the agency and agency alliances over time. In "structural factors", it was reflected in changes in laws around abortion and birth control, and in insurance coverage. The relationships of all of these categories to the core category and to each other are discussed below in more detail.

INTEGRATING THE THEORY

All of the steps of Grounded Theory described above were done with the aim of arriving from data to a theory.

The goal of grounded theory is to generate a theory that accounts for a pattern of behavior which is relevant and problematic for those involved. The generation of theory occurs around a core category (and sometimes more).

Straus, 1987, p. 34

In this research, the phenomenon studied was women's empowerment in reproductive services and the theory reached is that *current generation of women experience (and define) empowerment in relation to safe and humane care, as mediated by agency and community factors and by the politics of reproduction at the societal level*. The rest of this chapter includes the discussion of "safe and humane care" which is the core category. This is followed by a discussion of how agency, community, and societal factors (politics of reproduction) relate to the core

category and to each other. These discussions help explain the theory reached as well as answer the first two research questions on the meaning and experience of empowerment and the factors that influence it.

Research Question 1: What is the current meaning and experience of empowerment for women clients of reproductive services?

THE MEANING OF EMPOWERMENT: SEEKING SAFETY AND HUMANE CARE (THE CORE CATEGORY)

As mentioned before, for women receiving birth control and abortion care, at the core of empowerment were safety and respectful humane care. Safety has both physical and emotional dimensions: being safe from anti-abortion violence, receiving safe abortion care, and not feeling vulnerable, judged or cajoled in abortion and birth control services. Humane treatment means receiving dignified, egalitarian, individualized, and holistic care.

Seeking safety

Over and over in the interviews, women brought up the importance of feeling both physically and emotionally safe. Physical safety refers to being safe from anti-abortion violence, and receiving safe abortion care, whereas emotional safety means having a space where one does not feel vulnerable, judged, or directed/cajoled, but receives safe, non-judgmental, and non-

directive care. Figure 4 below is a visual summary of the “safety” dimension to be used as a reference throughout the following discussion.

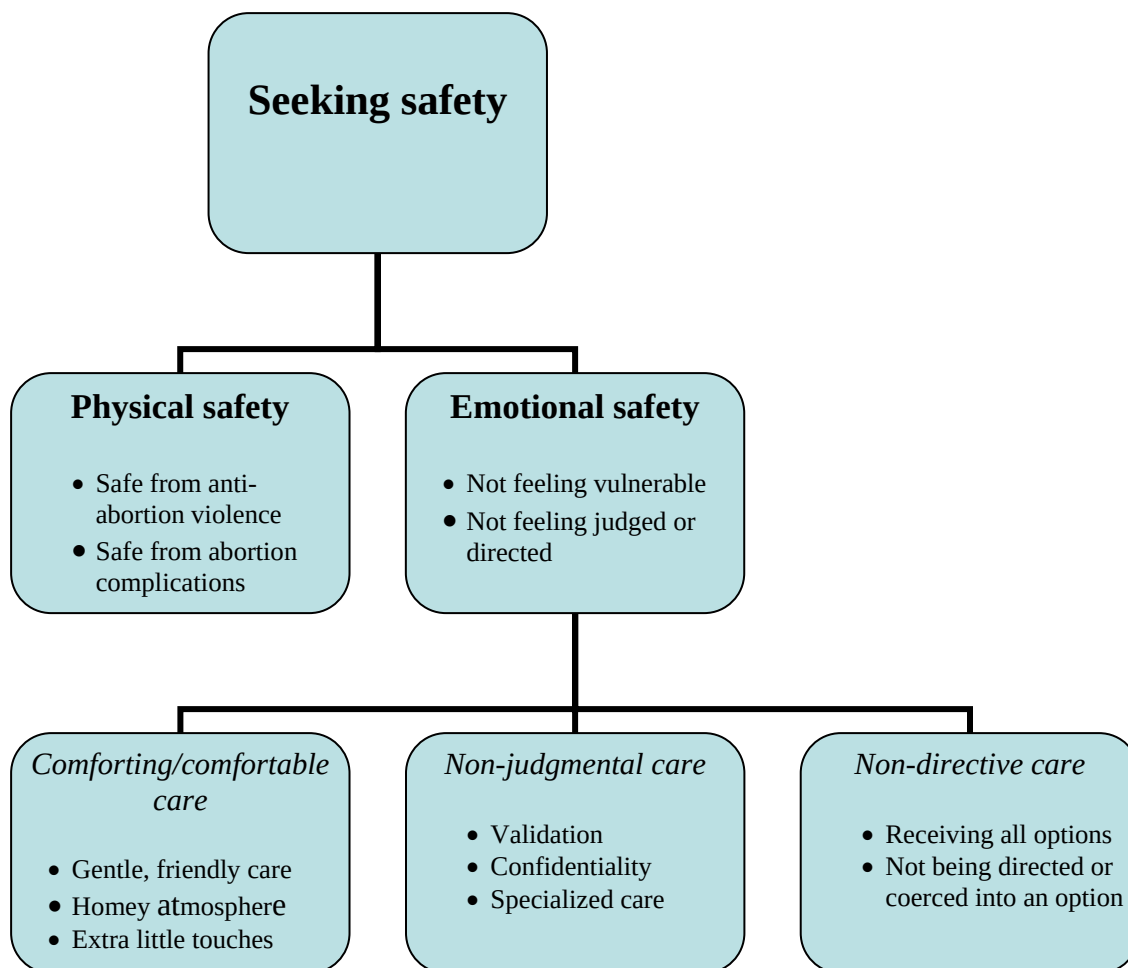


Figure 4: Seeking safety

A safe space: Physical safety

As discussed in the description of the settings, both centers had a history of violent attacks. In my experience, the protests outside of WHC were more consistent and active (with

signs), while the protests outside of FHC consisted of people quietly praying with rosary beads. However, the client and staff interviews at FHC showed that FHC also had more active protesters who carried signs and shouted at the women entering the center.

Due to the violent attacks of the past, such as the occupation of WHC and a fire experienced by FHC (and due possibly to the awareness of attacks on abortion providers at the national level), both centers had adopted high security measures including cameras and asking for IDs at the door (in both), and a locked entrance to the surgery and aftercare area (in WHC). In WHC, these measures were adopted ironically at a time when the protests became "milder" (in the eyes of the staff) compared to the past and to other clinics.

FOR THE MOST PART THOUGH, we haven't drawn a lot of (PAUSE) uhm (PAUSE) A LOT OF negative action. I mean we have the protesters. They kind of walk with their signs, and THEY WAIT. They're here for an hour or two, they're gone. You know. But uhm in other places, and I'M SURPRISED, who actually do much less ABORTIONS, and mostly GYN, there's a lot more VIOLENCE. And a lot more camera-filming of people's ?? ?? leaving a note, having their addresses on the internet. And TARGETING. BUT HERE, for the most part, (LOWER VOICE) it's been quiet.

Bridget, WHC, Nurse Practitioner

That's the border of our parking lot. THEY TEND TO WALK RIGHT ON THAT LINE. Uhm, knowing that they come into the parking lot, it's trespassing. They're not allowed in the building. Trespassing so yes we do have protesters. Sometimes they're vocal, they yell at us as we walk in. Uhhh we are VERY FORTUNATE, cause we have the parking lot and a lot of clinics (Ayse: true yeah) You know THEY CAN BE right outside your door. We're very fortunate. And our group, uhhh, tends to be, you know a good group compared to others. I have- you know you've seen on TV, you read about them in the papers then you know. MUCH MORE SERIOUS. It's not that they're not SERIOUS BUT THEY'RE- they're just a MILDER bunch so to speak.

Lynn, WHC, Head Counselor

In FHC, women scheduling abortion or gynecological visits were told over the phone and in letters sent home about possible protesters. In contrast, in all the client and staff interviews in WHC, there was only one mention (by a staff member) of informing women of possible protests, so it is not clear whether it was a consistent policy of WHC or not. Whether informed by the centers or not women who knew about the abortion services of the centers, were already aware of

the possibility and did worry about being subject to protesters' violence. Their expectations derived from the media images and previous personal or vicarious (from friends and family) experiences with these and other centers.

I don't know. Lot of people who make their appointments, they ask, if there are gonna be people outside. You know, so I think that's a good fear, cause they see and hear things in the media.

Marcie, FHC, part-time health worker

And first when I called to set the appointment, they said "well you have to be aware that, they're keeping protesting outside because we do abortions here" yeah I heard all this good stuff and you can't walk into ANY BUILDING that offers ANY KIND OF FEMININE (Ayse: service) SERVICES, without worrying about there some fruitcake sitting in the parking lot. I've definitely seen the PROTESTS. When I lived down in Florida, they targeted one of the women's clinics all the time. They'd be out in the front lawn, picket signs and handing out papers and (figure?) the only way to be and don't you dare walk in this building or we're gonna harass the hell out of you.

Crystal, FHC gyn client

I was (nervous?) a bit that day at the Center. ONE DAY my friend went there, over there. She was like oh god. (Ayse: praying or protesting or what?) PROTESTING, "oh don't kill the baby", and killer and I have different ?? of what happened.

Jana, FHC, abortion client

it's like YOU KNOW I know like- my dad used to have a building round here and he said that, you know, he'd come to work sometimes and there'd be a group of people protesting and..

Amber, WHC, Gyn patient

Ashley: yeah I'm six seven trailers away from them. I cut through that little field.

Ayse: So you seem to see all these protesters.

Ashley: I- YOU KNOW WHAT, that was one thing I was surprised when I went on Saturday. There wasn't any.. Yeah cause when we come into the trailer park, they START, WITH US. You know and I- I was so happy cause I told the girl I said don't take me on Saturday. I said there may be protesters there. He said don't worry about them because I'll take care of them. ohhh. That was like that the first time I had [an abortion], in 1986 there was protesters there.

Ashley, WHC, Ab patient

Women's awareness of -and expectation of- protests went so far as comparing clinics in terms of "relative safety".

well, I figured it was probably the SAFEST PLACE TO GO. Since there is more violence in [Names the neighboring state], at the clinics. And uh, [names a city in the neighboring state] would probably been a little bit closer I would think. UHM BUT it was- it was just here in the news about you know violence ?? that. AND THIS- I checked it out on line and it seemed like the best place to go

Jane, FHC, Medical Ab client

It was these protesters (or expectation of them) that made women feel unsafe, vulnerable, at times angry, and brought about the importance of physical safety.

Frances: I think sometimes it's very scary going there though because. Those activists that go outside and stuff. Can be terrifying

Ayse: well. Were there ANY, LATELY?

Frances: yeah. But they talked to them over the microphone and made them go away. Was either when I had the abortion or at my follow-up or whatever. And they're out there on the sidewalk, jumping around making noise and (Ayse: god yeah) you know, you're afraid to go in there, afraid to go out of course and they might be hiding in the bushes

Frances, FHC, Ab + Gyn client

Women said they were angry at the protesters because they did not "know about the woman's situation/her reasons for abortion."

they can believe that but they don't have to go the place cause they don't underSTAND. They can- they should put themselves in like, THE WOMAN'S SHOES for a day. And SEE, how they feel. Like with me going to school and working a lot, I was just so tired, withdrawn I felt you know, if I have this kid, my boyfriend has a job like, I gotta save money and I gotta do this and that and then live. HOW AM I GONNA DO THIS, if I can't keep myself awake to go to work. And I just figured (Ayse: they just don't understand) yeeah. I was ready to write a letter to the newspaper about like HOW I think it's so ignorant that people would be standing up there like that.

April, WHC, Gyn + Ab patient

In WHC, they were also angry because protesters inflicted unnecessary pain on gynecological clients and on the clients of the other two businesses in the same building.

"Woman's situation", though, did include at times attempts to judge other women's reasons for having an abortion. This showed how much women were affected by the stigma over abortion brought out by the anti-choice movement, where their wish not to be judged was complemented by judging other women for undeserving reasons for abortion. These will be discussed in more detail later under "non-judgmental-non-directive care" and "societal factors".

Made to feel unsafe and vulnerable, women liked the security measures adopted by the centers.

well I thought it was pretty cool that everything was under lock and key. I thought that was great. (Ayse: security yeah) I think security was great, how you have to show your face to get in. How when you go in the back room, they have to punch in their numbers to actually get in. I THINK (PAUSE) that's a totally great thing.

Christa, WHC, Ab patient

However, ironically, the mere existence of such measures were constant reminders of possible violence, and as such, kept women from feeling completely safe.

I was a little nervous because they were asking for the ID number, that you have an ID. It was very- I was VERY WORRIED. Because it seemed like there's tight security. It's good. That's very good and it's important but I was like "oh GOD. I wonder if there's like security issues", like people trying to get or something SO. Yeah. And I never experienced that before so. BUT uhm other than that it was good. It was a little (Ayse: shocking?) yeah yeah. BUT then WHEN I CAME, I just showed my ID, and then I had to fill out the forms and everything

....

UHHM I LIKE THE SECURITY HERE although I had never seen that before. I do like that. Just to protect other people who are coming in like along with yourself (A: sure) and everything. so that's good and I like.

.....

I was nervous when this woman going in early she didn't have like the right number ?? oh my god why doesn't she have one you know. It's VERY ODD. They do abortions here? (Ayse: yeah) ohhh.

Andrea, FHC, Gyn client

of course with their security you feel very safe but you know, you feel very SAFE to some degree.

Claire, FHC, Ab client

In addition to safety from violence, physical safety also referred to receiving safe abortion care. As discussed previously under the "settings", in both agencies, one of the main concerns of the women receiving abortion services was the risk of possible complications, including infections and infertility. These concerns were addressed in both agencies in counseling, as well as through mechanisms such as the 24-hour hotline for emergencies, and required follow-up exams. At WHC, women whose uteri were unable to contract and thus retained clot clots, were required to go through a re-evacuation followed by a D & C (Dilation and Curettage). This was seen by Bridget, the nurse practitioner, as an unnecessarily aggressive treatment, which traumatized the woman and increased (through scraping) the possibility of scarring of the uterus. She advocated instead the use of re-evacuation through a manual vacuum aspirator, which the medical director refused to use. In this sense, (physical) safety in relation to abortion care also depended on the level of medicalization in the agency, where doctors and nurse practitioners defined "safety" differently. There was also a difference in WHC between the medical staff (doctors, anesthesiologists, and nurses) and counselors in defining safety.

THE ONLY REAL schism I see is sometimes between MEDICAL STAFF and the counseling staff. Because they have DIFFERENT AGENDAS. UHM you know, the nurse, the anesthesiologist is interested in making sure that the patient has no MEDICAL PROBLEMS, and gets out of here safely AND THE COUNSELOR uhm, WANTS HER TO BE OK EMOTIONALLY and get what she needs- and sometimes a woman will come in and she'll say (PAUSE) "I smoked marijuana last night" NOW, she can't have an abortion at that point. It had to be 24 hours. Even though I KNOW, AND THE DOCTOR KNOWS, and EVERYONE ELSE KNOWS that smoking a little bit of marijuana is not, going to make this a dangerous, it doesn't invalidate her competency. So I mean THAT IS really no cutting corners if like something she had an aspirin yesterday. Then the counselor's back there with the nurse, saying "BUT YOU KNOW SHE'S GOING TO BE FINE" and you know, she drove three hours to get here, give her the abortion you know. AND SHE CALLED IN, she's gonna get fired if she takes another day off work. And the nurse if like "NO! because the medical protocol". [] And people DO ACCOMMODATE EACH OTHER. It's not completely it's not this stark

dichotomy. BUT I think there's some friction. Uhm, JUST BECAUSE we have DIFFERENT AGENDAS. We're responsible for one thing, they're responsible for something else. (A LAUGHS) And sometimes the two don't exactly JIVE. (A: yeah. How is it resolved?) UHH WELL, usually MEDICINE TRUMPS PSYCHOLOGY (LAUGHS) Uhm they err on the side with PHSYICIAL SAFETY. SO what if they have to drive another six hours ON SATURDAY, she COULD DIE, OR she could be at risk for this or that. EVEN IF IT'S REMOTE, DO YOU WANNA BE THE PERSON that's responsible for that? NO! So, you know, I think it's just hard for the counselors to be more (S LAUGHS) we don't wanna tell her.

Sharon, WHC, part-time counselor

In FHC, there was also a difference between the staff and the medical director in defining the safety of training mid-level practitioners (nurse practitioners or physician's assistants) to do abortions. While the staff pushed for the training, the medical director blocked the process because he defined abortion work as "tricky business."

Safe abortion care was also secured in WHC by requiring the women who choose IV sedation to have a designated driver with them on the day of the abortion for emergency purposes and for driving them home.

A safe space: Emotional safety

Comfortable/comforting (addressing vulnerabilities)

While the agency security measures and abortion and post-abortion procedures affected the physical safety of clients, the homey atmosphere of the agencies and the friendly, welcoming, supportive behavior of the (medical and non-medical) staff comforted and soothed the women for whom both abortion *and* gynecological procedures were sites of anxiety, discomfort, and vulnerability.

it's [the gynecological exam] NEVER FUN! It's never fun to have something like that but you try to make you know the surrounding (A: ??) right. Because no woman likes that done. But I mean, one thing that's great about Bridget and Cindy because they do it (quickly?) (Ayse and Eileen LAUGH) You know, somewhat create an environment, comforting and comfortable and soothing.

Eileen, WHC, Gyn and Ab client

You know just it's really important for me to feel- to feel comfortable and respected you know. Cause it's not a very pleasant to go (Ayse LAUGHS: yeah) TO AN APPOINTMENT you know. And no matter how many times you do it, still not comfortable. I think THE MORE the people are friendly and just welcoming. I think that makes a big difference. That's really important to me.

Sally, FHC, Gyn Client

It [the environment] is very friendly it's very comfortable. I I think probably it helps a great deal IT'S IN such AN OLD HOUSE, rather than being in a glass and metal office building (Ayse LAUGHS: yeah) Because they always just look SO COLD and unfriendly AND THE FACT this is an old house is very cool (Ayse LAUGHS: yeah). It is. It is. It's Something where you wanna wander around, you don't MIND SITTING. AND when you're in a setting LIKE THIS, you're gonna feel more relaxed. (Ayse: true) And that's important, especially when NOT NECESSARILY MY CASE, I know what I'm here for, BUT I can see that IF SOMEBODY was coming in for counseling (Ayse: abortion) or abortion something like that. Walking into a glass and brass office building could JUST BE VERY VERY COLD and very unfriendly. This is MUCH MORE RELAXED. You can feel like you're sitting in your living room, at least somebody else's living room (Ayse LAUGHS) rather than yeah sitting- sitting in a very sterile office building (Ayse: true yeah) I think it's a- THE BUILDING IS A GOOD CHOICE. For the business.

Crystal, FHC, Gyn client

Providing a comfortable and soothing environment and gentle care was even more pronounced for three types of women: young women who have never had a gynecological exam before (yet came for annual exams or for abortion), women who had experienced painful and/or demeaning (dehumanizing) care in abortion and gynecological services, and women who had been raped.

[The doctor] He was VERY VERY NICE. Like very very nice. made you feel comfortable. Don't make you feel nervous at all. that's very important YOU KNOW. I know how you know. Cause in my life, I've been raped in the past you know. I know how awful it could be.

Gloria, FHC, Ab Client

Duncan's pelvic exams, they look like you know this little light tapping. Like you're fine you know. Same with P [female physician]. Rob, LIKE, will HOLD DOWN on the woman, and I mean IT JUST LOOKS IF- IT LOOKS EXCRUTIATING you know like I HAVE NEVER had a pelvic exam where the physician is like shaking cause he's pushing so hard and I'm not exaggerating. AND IT LOOKS HORRIBLE. (A: hasn't any body told him -laughs) HE- you know we'VE CHECKED HIM ABOUT IT, BUT

LIKE he has to do what he has to do you know. If he has poor like I don't know if it's not dexterian, but if he has poor like sensation (A: yeah maybe) with his fingers, if he think he presses hard he might get a better feel. I don't know what his deal is BUT WE DEFINITELY TALKED TO HIM ABOUT IT and I JUST FEEL BAD for that you know 14 year old who- this is her first gynecological experience with him and she's like a twig and here's this big guy like (IMITATING PUSHING SOUNDS) WRRR WRRRR (LAUGHS) you know you know AS TECH, I ALWAYS TELL WOMEN like THIS IS IT for the annual exam you know everything from here on is really proportionately not as excruciating probably.

Hazel, FHC, Outreach and Education Coordinator

Hazel explained that [in annual exams] Laura the PA goes over the woman's medical history with her, reviews BC methods and does NOT RUSH the client in reviewing or in the exam. Especially the initial exam is really slowed down.

Conversation with Hazel, FHC, July 2, 2001

The homey atmosphere that relaxed the women consisted of pastel colors, home-like decoration of the waiting room, counseling rooms, or after-care area, pictures on the walls, mellow lighting, music or TV played in the waiting room (and in the exam room in WHC). This homey atmosphere, which the women compared to the "sterile" or "professional" atmosphere of doctors' offices or hospitals, helped set the women at ease and even distracted some who were too worried.

I really- I LIKE THE ENVIRONMENT they have over here. They have the nice paintings up on the walls. They have music playing which is nice and it's not dentist office music. It takes your mind off of what you're there. (Ayse: yeah distracts) Which I like.

Ashley, WHC, Ab patient

And the ceiling in there. I love the ceiling in there. (A: oh yeah I do too) Only with this last week they didn't have a radio. Oh like when I came in, (A: in the?) the procedure there was no music going on so but I mean it was ?? and everything. They make it so it's a nice calm yeah not so much like an INSTITUTIONAL DOCTOR'S or SMELLS IN HERE

Sonia, WHC, Ab and Gyn client

IT'S JUST DIFFERENT and I mean. It's like somebody's house kind of thing really. Used to go to a hospital or you know an office building or something. It's like, THIS IS DIFFERENT (LAUGHS) you know

Frances, FHC, Gyn and Ab client

I EXPECTED IT TO GO TO A building (A LAUGHS) you know with doctors wondering around (J LAUGHS) and screaming you know. It's one of these movie scenes. BUT I I walked it was like wow. I don't know it was something about- Like I'm very- IT WAS the COLORS AND STUFF the colors and the seating and IT AS JUST so comfortable. It made you not really- The MUSIC- they have music. The hospitals don't have music you know (A: no) AFTER, you know THE PLACE when I was getting the procedure DONE, they had pictures in the room and you know, the colors really relaxing. It was a- like SILVER knives and stuff all that make you like scared. It was very comfortable.

Jana, FHC, Ab client

it's more RELAXED. It's not as- like WHEN YOU GO TO A HOSPITAL, you kind of sit there all uptight because you don't wanna touch anything, (Ayse LAUGHS) cause everything looks STERILE. (Ayse: true) here it's like more or less you know. I DON'T KNOW IT'S JUST, it's IN A HOUSE. It's comfortable working you know.

Jane, FHC, Medical Ab client

Added to the general atmosphere were "the little extra touches" such as tea and crackers provided in aftercare (in both), little hearts on the walls of the waiting room and exam rooms with empowering messages from previous clients (in WHC), nice gowns provided for gynecological exams (in both) and for abortion (in FHC), and even the choice of magazines for women.

They're not uhm, clinical-looking (Ayse: yeah. STERILE) YEAH. I think that's nice it's just like the extra touches of having like the tea bags out there (A LAUGHS) the magazines and stuff, THAT IS GOOD, because I know from when I was young you know, when I came to the Center to get an abortion, THAT IT WAS TERRIBLE to think about what I was doing. And any kind of uhm, (PAUSE) COMFORT like things on the wall, like pictures anything that makes you comfortable, just feeling or distracts you, you know it would be terrible to walk into a place to get an abortion and have it look like a laboratory. (Ayse LAUGHS: yeah) That would be horrible. I think.

Emma, FHC, Ab and Gyn Client

I was gonna say, AFTERWARDS, afterwards the blanket then very homey you know THE after snacks, juice you know.

Jana, FHC, Ab client

I think it's fantastic that they keep the speculums in a warm blanket. I think that's (Ayse: THEY DO?) They DO! and they keep it in warm blankets. UHHM, it's just uhm, MAKE IT A VERY, PRO-WOMAN ENVIRONMENT.

Eileen, WHC, Gyn + Ab patient

There were red paper hearts on boards on the walls of the waiting room and exam rooms in WHC. These had supporting, encouraging remarks from women who had undergone abortion at the center:

♥ If people can't trust you with a choice, how can they trust you with a child? Heads up. Keep smiling. G. K

♥ It's over and done with before you know it. The staff are very supportive and understanding. Thanx

♥ At this time in my life, this is the best thing I can do for ME!!

♥ Be strong. There are people who came for you. You get through this. You are not alone.

Field notes, WHC, March 18, 2002

upstairs and so she brings me to upstairs waiting room and the nurse practitioner came in about 10 minutes later. Says we can meet now. Have kind of it like you know put on quality shirts which just surprised me. just used to paper shirts. (Ayse LAUGHS: yeah) I really appreciate it. They are much nicer. Much nicer.

Mary, FHC, Gyn client

The homey, non-medical atmosphere of the centers also provided women with a vision of how reproductive services *can* be because women had no such expectations before they saw these types of non-medical environments.

I wasn't turned off by it- but in Planned Parenthood I didn't really NOTICE YOU KNOW. It was like it just like a normal kind of doctor's office. Like the information everywhere. You know the little rooms but I think you don't TEND TO NOTICE IT so much when you walk into a place like that cause it's what you're used to. Than you walk into a health center LIKE THIS! And like "WOW! This is REALLY NICE! (Ayse LAUGHS: yeah) you know. You tend to notice it more than just- what you're used to. I think it's good. It definitely makes you feel more comfortable

Sally, FHC, Gyn Client

In addition to the homey atmosphere, friendly, polite, welcoming attitude of the staff, as well as the use of humor, talking the woman through gynecological and abortion procedures (checking with them and supporting them), and having "chit-chat" before and during abortion or gynecological care also helped comfort women. These strategies comforted women because the staff informed women about what to expect through the procedures and acted as distraction techniques. In addition to comforting, these strategies also normalized reproductive care (making them feel like a normal and not a sick or an immoral person).

I would much rather go through what I went through with the clinic, then to go and have (PAUSE) a surgical (Ayse: oh I see) abortion through a hospital or where I didn't even know any of those those people you know THEY TREATED ME, and welcomed me like my obstetrician would and I've been going to him for almost you know 20 years SO. For them not to even know me and to take me in a- just wonderful can't say enough good things about them

Sheryll, FHC, Medical Ab client

Client said well can you do it quickly because I will fly to California next week. They all laughed and said that was great. Bridget started doing the exam and asked how old her daughter was. 4. Client said the name etc. The exam. Wendy put pressure to feel the ovaries and asked if that was giving her any pain. She said no, just discomfort a bit. [] Bridget suggested an ultrasound to see how clotty it was. Ultrasound, they were talking about her pregnancy, childbirth, had to have a C-section. Nel -the intern- was chatting with her while Bridget did the ultrasound.

Observation of a follow-up exam, WHC

Bridget talked about gloves being kept in this tight box. She inserted the speculum, asked if the client was alright.

Observation of a gyn visit, WHC

They give you a basket to put clothes in. AND WHEN I GOT INTO THE ROOM, we actually were talking about TOM CRUISE (A LAUGHS) and in the movie "Interview with the Vampire". As they were doing that the anesthesia was going and then I WOKE UP IN ANOTHER ROOM.

Sonia, WHC, Ab + Gyn + Ab client

uhh THEY'RE ALL NICE. They made me feel VERY COMFORTABLE. The place itself is VERY RELAXING. It doesn't make you TENSE UP YOU KNOW. UHHM, THE DOCTOR WAS NICE you know he is. He made me feel comfortable. He wasn't like NOT TALKING TO ME. HE WAS TALKING TO ME THROUGH IT, you

know, just relax whatever you know. There was people there holding my hand, through, you know VERY NICE. I felt very comfortable. Very thankful THAT, I went to that place very relieving.

Jana, FHC, Ab client

Yes it was fine. Uhm very comfortable. She [Sally] definitely Uhn I app- I kind of appreciated LIKE Uhm Pap Smear since they involve a needle. That she was very careful like talked to me and kind of like keep a (conversation?) going WHICH I KIND OF RECOGNIZED AS (PAUSE) you know I could tell like she was doing, her tone kind of changed a little bit. I could tell she was trying to keep me comfortable but I mean it wasn't a problem. I KIND OF APPRECIATED that they do do that. uhm from the standpoint, it doesn't bother me. But I do know that I have a friend that kind of bothers. I appreciated that she ?? it. It wasn't dead silence like that

Mary, FHC, Gyn client

There was a NURSE IN THERE. UHHM utilizing conversation during the procedure THAT WAS, A, ABSOLUTE (PAUSE) GOD SAVING, uhh, uhh a FOR UP HERE, for in your mind, as to you know you're talking this and that and uhh.

Nancy, WHC, Ab + Gyn client

Non-judgmental care

In reproductive services, women felt vulnerable. They also felt that they were being judged for using abortion and birth control services (which also implied sexual activity, especially for young -unwed?- women), and judged for asking questions to the provider.

In regard to abortion, women talked about the "silence over abortion" in the society (to be discussed later), and felt judged by society, by parents (especially mothers), partners, and even their own Ob/Gyn providers.

So it's one thing if you go into the doctor to have a baby, (LAUGHS) whole other thing for (LAUGHS) other services you see. So I didn't wanna (go to him).

Frances, FHC, Ab + Gyn Client

before I went to them [WHC], I was seeing a doctor out in the west of town and he was more of a sports' medicine doctor. He- the insurance I had you had to pick a primary doctor. And it was a guy that I was seeing. The doctor was a male. And he kind of made me feel really uncomfortable. Then when I did find out that I was pregnant I TALKED WITH HIM about the possibility of terminating and THEY TREATED ME (PAUSE)

NASTY just like they- they (Ayse: That was a family practitioner?) YES. AND and EVEN THE WOMEN IN THE OFFICE, like I felt they were like (Ayse: judging) JUDGING ME. Because I- I'm in the situation and I NEEDED SOME OPTIONS. BUT I REMEMBER WHEN I- WHEN that happened, and I wanted to talk to him I didn't feel comfor- comfortable talking to him and I felt like you know he didn't wanna HEAR any other option that has to be. I think like when they called me, the girl who called to confirm [the pregnancy test], she was so upbeat (IMITATING THE VOICE) "?? You're gonna have a baby!" and I didn't REACT cause I didn't WANT a child (A: it's an assumption) and I'm like (A: that you- you were expecting) yeah so and I said well that's really nice to hear but now I need to schedule an appointment with the doctor to discuss some OPTIONS. That's when like (A: ??) I think she finally dropped the phone or something (A LAUGHS: what?) yeah. So I just felt uncomfortable from that point on going in there. I did talk to her been like well you know uhm I GUESS I kind of asked for referrals or some place that I could go to. And he really didn't just kind of brushed off those questions.

Susan, WHC, Ab + Gyn client

The judgment was also internalized. Some women judged themselves and other women as well in terms of legitimate reasons for abortion (mistake, rape, incest) and those that do not really deserve it (women with multiple abortions and promiscuous women).

Because of these judgments and in some cases abusive experiences of abortion (where they felt punished by the provider for having an abortion), it was important for the women not to feel judged again, this time by the center staff.

[at the aftercare] I told the woman at the desk. I said "You know, I don't know how many times you get told but IT WAS so nice to come here to go through something SO HORRIBLE." (Ayse: in a nice way) AND yeah in a nice way. TO HAVE SOME like- THEY'RE JUST so friendly and supportive and I didn't feel like anybody was LOOKING DOWN ON ME

Christa, WHC, Ab patient

definitely you don't feel that they- uh how do I explain it? Like I didn't feel any ?? of guiltiness, I DID by myself but none of the staff made you feel this was the wrong decision or this was ?? it was ?? (Ayse: so they weren't judgmental) yeah weren't judgmental.

Elizabeth, WHC, Ab patient

[they] don't make you feel like you're doing something bad. (A: yeah so not judgmental) supportive and try to help you out.

Keri, WHC, Ab patient

Not being judged was also important for gynecological clients in both centers. Judgment for them meant being judged for using birth control, which implied being sexually active.

Judgment also meant being judged for asking questions to the providers.

Andrea: like I've been to- I've used the pills over the summer and I went to like a Planned Parenthood. And sometimes you just feel like you're like a 16 year old girl and you're not supposed to be GOING THERE and stuff like that. Or sort of feels like PEOPLE LOOK AT YOU. You know going there and stuff like that but

Ayse: who the?

Andrea: other people like on the street you know. Cause it's right up on the street in my town so if you're- so if your car is there, people are like "OHH. You know"

Ayse: oh she's getting lucky

Andrea: YEAH yeah

Andrea: yeah. But it's not

Ayse: for the abortion, it's just ?? So it's stigmatic

Andrea: yeah. Just being like that. BUT NOT HERE. No, people seem very nice.

Ayse: interesting yeah. SO it wouldn't be confidential (Andrea: yeah) if you go there.

Andrea: that's right YEAH. Cause it's right on the main street SOOO it seems so. BUT HERE, like I don't know any one and no one knows me. I'm walking up here no one knows you know what

Andrea, FHC, Gyn Client (age 21)

All these years I kept coming. Like my very first gynecologist was a mean man. You know when I was sevenTEEN and he was just this angry like "oh you shouldn't have sex and tatata" (A: really?) I come here with like crazy questions (LAUGHS) And they answer them so. Well on the- when you come for your yearly like, one of the questions is how many partners have you ever HAD? I was like "in the same bed or like do you mean like overall?" (Ayse LAUGHS) and they looked at me like how many times HAVE YOU

HAD AT THE SAME TIME? I'm 25. I'm a little freak. ?? answer my questions for me. (Ayse LAUGHS) They don't judge. They're so nice.

Sonia, WHC, Ab + Gyn Client (Age: 25)

Uhh and any questions I did have when I came in, they were DEFINITELY ADDRESSED. Without a question. Uhm nothing was TOO FOOLISH. I didn't feel silly FOR ASKING. I mean today I asked questions that normally would be EMBARRASSED to Sally. oohh like like RIGHT NOW, I'm still bleeding not a lot just a little bit, but the blood has a smell. I was like "before you get there", (A LAUGHS: let me just tell you) "let me just tell you there's a smell and I don't know why "uhhh" she said "ooohh normal, old blood". ok fine. I feel better. I mean, so this is no SURPRISE because I'm thinking like did I get an infection? (A: maybe who knows) all I know is when I get my period, it doesn't smell like. You never know but I thought Ohh I mean it's- Like I said normally I WOULD BE EMBARRASSED TO ASK THAT, and I WASN'T. Was just THEY'RE VERY uh- they're VERY HUMAN PEOPLE HERE.

Claire, FHC, Ab Client

The strategies that helped to relieve judgment (for using abortion or birth control and for being sexually active) were validation, confidentiality measures, and receiving care from a place specialized in birth control and abortion relieved

Validation: "They made it ok to decide". As revealed by the staff and client interviews at both centers, women's responses to unwanted pregnancy and the consequent decision to abort ranged from complete confidence in one's decision to denial, confusion, guilt, feeling irresponsible and being disappointed in self, which challenged women's views of self and pro- or anti-abortion views.

well I'm very much of a feminist. And I I always support. Uhm, you know, abortion on demand I actually think we should have free abortion in this country. And free birth control so maybe even further LEFT THAN lot of PEOPLE. I really have no problems about it. I the one thing I've learned FROM WORKING HERE, is just more the emotional aspect of it. Uhm I think- I don't think I ever I thought seriously about the RANGE OF RESPONSES that one might get. Cause I've had abortions. But it has just you know, it wasn't pleasant but it wasn't a traumatic emotional experience. I mean everything from complete denial of their emotions to ACCEPTANCE, to "I'm going to burn in hell, but I HAVE NO CHOICE". Uhm and everything IN-BETWEEN. Women

who are very very confident of their decision, always been pro-choice, YET FEEL UHM be doubt or doing something wrong or that they have some anxiety how they'll do emotionally. Even though they WERE SURPRISED BY IT. And the opposite women who uhm consider themselves PROLIFE but find themselves in a position where they believe abortion is required and they're basically ok with it. IT SEEMS AMAZING. the mix that you can have

Sharon, WHC, Counselor

knew I WANTED TO HAVE IT [the abortion] DONE. And I guess when I SAID [to the counselor], I can't believe that I'm in here doing this because of YOU KNOW, YEARS AGO, I would never picture myself going in there annd I DON'T KNOW it [the counseling] was just very INTIMIDATING I THINK for me (LAUGHS) Just and I knew I wanted to have it done and I didn't mean it to be I would never DO THIS IN MY LIFE you know. Cause you know maybe some day that would happen to me but IT DID. I'm glad I have that right TO BE able to be THERE. And do it without being judged.

Sheryll, FHC, Medical Ab Client

It was partly because of these mixed emotions that women sought validation of their decisions.

[THE STAFF] WERE WONDERFUL. Right from the get go. Like from the first phone call, they were just- [The phone call] was difficult. I was crying, and UPSET AND (PAUSE) devastated and didn't know WHAT TO DO and and nervous and afraid. ?? feeling all these different emotions and I THINK BEING HORMONAL, being pregnant too, and scared and "oh my god, should have known better and" You feel everything a lot (more?). So I think HAVING SOMEONE WHO'S EXTREMELY UH sensitive to that and helping me decide this is WHAT YOU FEEL you know and helping decide for some of the mixed feelings you have Uhm, I JUST felt very comfortable. [] They just, BASICALLY EXPLAINED EVERYTHING that they could. ALLOWED YOU TO ASK WHATEVER QUESTIONS that I I wanted to ask UHH BASICALLY MADE ME FEEL like- you're not a stupid person because it happened to you. IT HAPPENS. And and you have to move forward and you gotta make decisions and BE OK with your decision. But to to BEAT YOURSELF over it, it's not worth it. So I just felt VERY comfortable. Well I made a mistake BUT IT'S OK. Now I have the the CHOICES uhm the different choices that I need to make. That will, you know decide the outcome. BUT IT WAS OK TO DO IT. [] So THE DECISIONS that I'm MAKING, I felt very validated in what I- what I DECIDED TO DO and the way I feel about it.

Claire, FHC, Medical Ab Client

[The counseling was] wonderful! Wonderful. Weeee- uhm, K was great because SHE, you know she went through everything you have to, explained the procedure and everything, but then she, you know she just asked me HOW, I was feeling, AND then LET ME, talk

about my feelings. You know everybody is different. Everybody has uhm a different reaction, a different mindset. UHMM, and you can't uhm, YOU CAN'T REALLY ASSUME what somebody else is feeling. And K really didn't do that. K just let me, let me talk and validated that. You know everything that I was feeling would be normal, that a lot of women experience what I felt. AND EVEN THOUGH I WORKED HERE, AND I'M PRO-CHOICE AND EVERYTHING, it still was not an easy decision for ME TO MAKE. I mean we- we, MY FIANCE AND I, AGONIZED OVER IT. [] So she was wonderful. We talked about the birth control, BUT ALSO ABOUT YOU KNOW some of the- some of the feelings I was experiencing (A: yeah. sure) Some of the conflicts I was having. Uhm. But mostly she just listened. And and that confirmed my feelings and assured me that what I was feeling was normal.

Eileen, WHC, Gyn + Ab patient

Even the women who thought that the abortion was the best option for them needed to hear that what they were feeling and doing were normal and ok to do. This relates to the stigma of abortion and the feelings of being judged. It shows that validation did not only serve to provide a safe space to sort conflicting emotions, but also a space to make a decision without being judged.

USUALLY, THEY START VOICING THEIR OPINIONS, like financially I can't do this. You bring out (PAUSE) ADOPTION WITH THEM. Also MEDICAL ASSISTANCE IF THEY DON'T- do they qualify you know. Is that an option, you could apply for medical assistance. UHM, you know, different programs like WIC, Women, Infants, and Children. You know, would they be willing to do that. Uhm, MOST OF THE TIME, the the patients that I've counseled, uh (PAUSE) KNOW, that this is THE BEST THING FOR THEM. It's just that they really, I FEEL THAT THEY NEED someone to validate their feelings. Cause they feel alone. They feel like they're the only ones going through this. And having all these feelings. BUT UNTIL SOMEONE VALIDATES IT. Especially a counselor that's counseled OTHER PATIENTS, YOU KNOW, "your- these are normal feelings. A LOT OF WOMEN go through them". I really think that they just need the validation of- That you're not alone, THIS IS VERY COMMON.

Sarah, WHC, Intern Counselor

I think this whole situation has changed my opinions on a lot of things. Before I was very anti abortion. And uhm I'M ADOPTED. so I WAS LIKE, well MY MOTHER if she believed in abortion, I wouldn't be here. SO I HAD ISSUES with that. And then I TALKED TO SOMEBODY HERE and and they were great you know I was like I KNOW THAT I'm here (A: what did they say?) well they were just very friendly and I had lots of questions WHEN I FIRST CALLED I had lots of questions. She'd put me on hold and go ask somebody else you know THEY WERE GREAT. Uhm I KNEW WHAT I HAD TO DO, because I take care of my mother and my grandmother. SO it's like I couldn't. And the work, I can't JUGGLE ANYTHING ELSE in my life. And my relationship is a good one and it's stable. BUT I don't know if that's the person I wanna have ties with, for the rest of my life and I'm not ready to settle down and I'm not, I don't

know I mean I've got too much going on. SO I KNEW that this is what I had to do. And they made it OK to do that. They made it ok for me TO DECIDE THAT. And so it- it changed my VIEWS. If they'd been rude and nasty, I don't know what I would have done. I'd probably wouldn't have gone through with it.

Jane, FHC, Medical Ab Client

As can be seen from the preceding quote, going through abortion in a safe space where the women felt validated did at times change or lead to the questioning of the anti-abortion views. There also emerged a group of women for whom abortion was an empowering experience.

I mean I FEEL (PAUSE) I was able to do this you do pretty much on your own. You know I mean you got the support of the people (A: others) HERE. And certainly they- they give you ALL THE TOOLS to do this, with the knowledge and everything you need to do it with. UHH AND OF COURSE, I had the support of others you know at home with me. But you feel like I MADE THIS DECISION AND I'm GOING THROUGH WITH THIS. And I'm dealing with this on my own. It's good to know that you're strong. You can feel like, it's a good feeling. To know that you can be self-reliant. That you can make these decisions and that you can handle these things. It's pretty amazing. I mean I learned a lot about myself too like I said now (PAUSE) that I'm a lot stronger than I thought. That regardless of what you've been through in your life, this was a COMPLETELY DIFFERENT EXPERIENCE uhhh it's not a position where you should weak about it. You should feel self-empowered. I feel really happy about that. FOR YOURSELF, you were able to do things for yourself

Claire, FHC, Medical Ab Client

actually, coming here made me feel stronger. Like after the abortion, cause it's- it is hard thing to do like I had THIS, MENTALLY like PREPARED MYSELF for it and stuff BUT, I feel I don't know I feel lot stronger now, having gone through it. And knowing that I can handle it. but like every once in a while, it bothers me, ESPECIALLY NOW, because MY BROTHER AND HIS WIFE, they found out, SHE WAS PREGNANT when I was having my abortion. SO now she SHE ACTUALLY IS DUE when I would have been due. So I don't know if it's bad karma (S LAUGHS A LAUGHS TOO) But you know what I mean though. She's like going through a pregnancy now. So every once in a while I'm like "oh you know, that would have been me" but I don't know I feel STRONGER. I really do.

Susan, FHC, Ab + Gyn Client

I think IF ANY WOMAN MAKES THAT DECISION, to go there, feels a whole lot of like this is my body my decision, I have the power to do this you know. That's very nice, that they still, do this stuff you know. And I have a lot of issues about abortion, and stuff like that but till you're in the situation, facing it, you don't understand through that person's head, what they're FEELING YOU KNOW. So. really nice to have that ??

Jana, FHC, Ab Client

Going through with abortion also made some women aware of the importance of the right to abortion.

I knew I wanted to have it done and I didn't mean it [in counseling] to be I would never DO THIS IN MY LIFE you know. Cause you know maybe some day that would happen to me but IT DID. I'm glad I have that right TO BE able to be THERE. And do it without being judged.

Sheryll, FHC, Medical Ab Client

I don't know. I don't know. I think (PAUSE) (DESPERATELY) I DON'T KNOW. (LAUGHS) It's just it's uhm and it's kind of sad to say it's liberating to know that you could do this. BUT at the same time, it's such a right you know. It's good to know you have it. I hope I never need it again

Jane, FHC, Medical Ab Client

it- it- it has REALLY confirmed, MY, BELIEF, that uhm, abortion should be safe and legal. I can't explain how, how thankful my fiance and I both were that, I had a place to go. THAT WAS SAFE. That was uhm where I would get supportive care. UHHM.. That other women, who are in circumstances that are far direr than myself, can come cause of reduced rates you know. Uhm SO, ON A- you know ON A LARGE SCALE, just sort of reaffirming the fact that this place and places like it are (PAUSE) so needed.

Eileen, WHC, Gyn + Ab patient

As can be seen from the preceding quotes on empowering experience and rights, there is still an ambivalence toward abortion. I have to also point out that, except for the very last quote, all of the empowering experiences and the awareness of abortion rights came from the interviews with FHC clients. The only exception was Eileen, who in the past worked as a counselor in WHC and already held pro-choice views.

Confidentiality: "They will never know". In addition to validation by staff, confidentiality was also an important factor in relieving the fear of judgment and making women emotionally (and physically) safe from those who judged or harmed them. Many women at both centers chose the centers because they wished to stay anonymous.

[you mean the ob/gyn] in D-town. I didn't even go to her. yeah. I didn't go to her..I think because I didn't want my family to know. I didn't want them to know I was pregnant. They still to this day they don't know about it

Susan, WHC, Ab + Gyn client

oh how you don't really wanna go back to your obstetrician and ask for an abortion you know (LAUGHS) you wanna go somewhere where they're not gonna KNOW YOU. Someplace you haven't been before. (Ayse: yeah. they don't judge you. You feel?) yeeeah. (PAUSE) But the anonymity kind of. Kind of made you more comfortable than going to regular person. (Ayse: yeah. So that was really different from the center? hospital would be) Well, the hospital too but as I was saying MY DOCTOR. My dad was a doctor in the same area and he knows all those people. So you certainly (A: there goes your confidentiality) uhummm. So it's one thing if you go into the doctor to have a baby, (LAUGHS) whole other thing for (LAUGHGS) other services you see. So I didn't wanna [go to him].

Frances, FHC, AB + Gyn client

uhm FOR ME, I wanted no one to know it was very personal for me. I didn't want my family to know uhm they wouldn't judge me, of course BUT you know. (Ayse: still) Another grandchild you know (LAUGHS). Uhm that's why I didn't call my (Ayse: gyn) MY DOCTOR that I would have gone to for a very long time. I DON'T- I don't want anybody to - I didn't want anybody to know. (Ayse: yeah you didn't trust him or her enough?) I wouldn't think so. If I did, I would call them. But obviously you know I just I- I want this kept to me.

Sheryll, FHC, Medical Ab client

The preceding quotes show that women did not trust their Ob/Gyn providers on confidentiality. Women also liked that their confidentiality was respected not only *during* the abortion process, but also in future -gyn- services from the same agency.

just basically reviewing the history of my family [] you know just basically going through that. Nothing about any prior (LOWER VOICE) abortions or anything you know

just very basic simple questions. I think they're very professional and uh RESPECT YOUR CONFIDENTIALITY there as well.

Susan, WHC, Ab + Gyn Client

UHHM, I felt respect when WE GOT IN THERE, that day you were there and it was boomboomboom. And everybody was talking to me LIKE YOU WERE a regular person NOT LIKE uggghh "oh this is a girl who had ISSUES two years ago and I know everything about her" ah you weren't JUDGED. I WASN'T JUDGED FOR ANYTHING. SO I'm just, ME MYSELF AND I.

Nancy, WHC, Ab + Gyn client

Specialized in pregnancy prevention: "You are in the same boat". The desire not to be judged for using birth control or abortion was also evident in women's choice of the centers for their specialized care. Women at both sites chose the centers because of their specialization in reproductive care (which meant staff with specialized knowledge and skills in contraceptive and abortion services). Within reproductive care, though, the centers' specialization in *preventing* pregnancy (rather than having pregnancy and childbirth services) made women feel safe from judgment of providers and other women.

uhh, I think the environment here is fine. Because you are in a room with bunch of people in the same boat as you. And when I go to a regular doctor's offices ?? think like the people in ?? are looking down on you like if there is a pregnancy test, like if they're older married women, like how old is this girl? She's taking a pregnancy test. And like they're kind of staring at me like (it is wrong?) or something (LAUGHS) But when you come here, it's all people that were probably women my mom's age, coming for abortion, and you're not gonna feel like an (outsider?).

April, WHC, Gyn + Ab patient

And it's ALSO it's really nice to be in a place that uhm IT'S JUST dealing with the women's issues and women's health and also dealing with reproductive health because uhm it might be a little daunting to go to- to go to places where they're dealing with ALL ISSUES OR EVEN I even went to the city OB/GYN on ?? street where who were there were women who were there for INFERTILITY TREATMENTS, women who were there for who're more older and there were other things. I DON'T KNOW IT'S DEFINITELY I really like coming here and knowing that they have specialized in one thing and women that are here are here for the same thing again. It's just- it's kind of a

COMFORT LEVEL. [the city Ob/Gyn] uhm IT IS MUCH MORE GEARED TOWARDS like older couples and like for the people- it's more of a kind of starting a family type thing. I kind of got the impression that women there had children or were looking to start a family ?? and I COME HERE it's the opposite. With the younger staff it's- most of the clients that at least while I was here, I've been here- HAVE BEEN YOUNGER it is just kind of a peer. Ok this is definitely a peer atmosphere quite a bit. I feel like this may not be true at all. But I feel that that kind of environment makes me at least be more reassured that it is more geared toward like MY HEALTH CONCERNS you know

Mary, FHC, Gyn Client

As Mary did, other women also stressed the importance of being with a similar age group, which shows how compartmentalized women's reproductive care is (according to type of service and age of women).

I've used the pills over the summer and I went to like a Planned Parenthood. And sometimes you just feel like you're like a 16 year old girl and you're not supposed to be GOING THERE and stuff like that.

Andrea, FHC, Gyn Client

PREVIOUS TO ME, going to an OB/Gyn, I've been going to uhm I don't know the name of it but it was a BIRTH CONTROL CLINIC and that was in R down south, and uh (PAUSE) THAT WAS MORE OF THE TYPE OF PLACE, where teenagers would go And I just KEPT GOING THERE, just because I was going there and getting birth control pills since I was 18 I was there from age 18, 18 until age 25.

Emma, FHC, Gyn Client

Non-directive care

Closely related to not being judged was the importance of receiving non-directive care. This simply meant receiving all options in abortion (types of abortion, alternatives, IV or local anesthesia) and in birth control (different options of birth control) services, and being allowed to make one's own decision without being cajoled into a choice. This sub-category overlaps with the

sub-category of "being informed" in provision of information to be discussed later. However, "non-directive care" has the emphasis on *how* the information is presented.

In terms of abortion care, women at both centers reported being given all options without being forced into one. The lesser use of medical abortions in WHC and a client interview there, though, pointed towards a possible preference staff had toward surgical abortion.

I was originally considering using the- THE abortion pill. But at that point I also TALKED TO A- A counselor, but also Mary who's the lab. SHE'S ALSO A FRIEND OF MINE. And she was you know very frank and honest with me as far as the abortion pill that the side effects were more severe. And they uhm you know you're talking about, you're actually passing pregnancy tissue on your own. So you know, you're missing days of work, you don't really know what to expect. And uh, after talking to the counselor, I made the decision that uhm, I'd rather have the surgical procedure. BUT THAT WAS- you know that's just another testimony that they're- they're very honest with- either very frank you know. They could have just- because really it's, on their- AS FAR AS they're concerned, you've just ?? just go ahead, give the woman a chance to swallow a pill than go through the whole procedure. They've got lots of people they have to see. BUT THEY WERE HONEST WITH ME. And and they explained to me exactly what the pros and cons to BOTH WERE.

Eileen, WHC, Gyn + Abortion patient

There was also a difference between the two centers in the use of "options counseling". There was an explicit mention of options counseling in staff and client interviews at WHC, whereas in my time in FHC, I have seen only one counselor using options counseling. This difference might be due to the feminist mission of the center (in trusting women's decisions unless a woman was clearly undecided in which she would be told to reschedule). Another difference relating to counseling was the heavy emphasis on counseling (what I call "psychologizing services" under agency factors) in WHC, which does not affect women's decisions yet might be directing women to view abortion as a psychological issue. The evidence for this comes from my observation that pre-abortion counseling sessions in WHC (especially those conducted with staff who had counseling degrees) were more intense than those in FHC.

In terms of the birth control services, women reported being provided different options and not being directed into choosing one. Counseling and medical staff (nurse practitioners at WHC and the physician's assistant at FHC) at both centers showed a strong belief in providing women with all the options and letting them choose.

I TRULY BELIEVE, THAT, IF YOU GIVE A WOMAN ALL THE INFORMATION that SHE NEEDS to make a decision, she'll make the right decision FOR HERSELF. And I- that choice is hers. I- I WOULDN'T DECIDE FOR HER you know. I think that I'll give her everything that she's medically eligible, to have. "THESE ARE YOUR OPTIONS, pick one" "Whad'you wanna TRY?" What do you think might work well for you? You know any problems? Can you just ?? that ?? Can you take a pill every day. Everyone wants the pill cause you know it makes them look like your skin's been ?? Are you able to do this, SERIOUSLY you know. SO I talk to them and if it doesn't work, that's ok. We'll try something else.

Bridget, WHC, Nurse Practitioner

UHM MOST OF THE TIME I SHY AWAY from- from recommending ONE OVER THE OTHER unless they've been on one before and they've- and they haven't been happy with it OR IF SOMEONE SAYS THAT like (PAUSE) uhm (PAUSE) you know I'm a pill but I really can't remember to take it every day or take it the wrong time, I wanna get something I don't have to worry about every day then I would you know recommend something like Depo or Lunelle or something like that that you don't have to worry about every day.

Roxanne, FHC, health worker

IF SOMENONE REALLY WANTS TO DO SOMETHING, UNLESS I FEEL THERE IS A MEDICAL REASON for them not to do that, uhm. I won't steer them away from doing that uhm. THEY SAY I REALLY don't PROMOTE CAPS TOO MUCH, CERVICAL CAPS. Uhm (Ayse: why?) I THINK THEY'RE HARD TO USE. Hard to USE. Uh (A: I haven't tried. I tried the diaphragm but not much) right AND I'LL YOU KNOW, I USE TO FIT A LOT OF DIAPHRAGMS I'm doing less and less and less EVERY YEAR. UH (PAUSE) I REALLY- I THINK MY my HIGHEST PRIORITY is making sure that women don't get pregnant. If THAT'S WHAT THEY WANT, I WILL MAKE SURE they understand the birth control method THEY'RE USING and its effectiveness rate and what they can do to optimize that

Sally, FHC, Physician's assistant

In FHC, staff would also provide birth control options that would not be provided by other providers.

Sally: SAY WITH IUD. I- we do- we do ALLOW WOMEN TO CHOOSE AN IUD WHO have not had children, WHO are of CHILD-BEARING AGES, uhm ALL OF

WHICH ARE MANUFACTUR- manufacturer will tell you, they don't qualify for an IUD. WE PUT THEM IN. Uhm, I was a little uncomfortable DOING THAT AT FIRST (FASTLY) cause it wasn't my TRAINING. And the women that I put them in WHO'VE NEVER HAD CHILDREN KNOW and UNDERSTAND (PAUSE) THE RISK. SO so THERE ARE, EVEN THOUGH I I WILL TELL THEM, I WILL PUT AN IUD IN YOU, but as long as you underSTAND that there is a small chance that you're gonna have some inflammatory REACTION and you might get scar, you might have infertility issues (A: uhummm) UHM IT'S NOT a STRONG, (PAUSE) THERE'S NOT A STRONG SUPPORT IN THE LITERATURE FOR THAT, but you've seen it enough and they understand that I mean you have a foreign body in your body and that's a REACTION that's NORMAL for your body to produce AND IF YOU HAPPEN TO BE SITTING UP by THE opening of the FALLOPIAN TUBES you get SCARRING THERE, YOU'RE GONNA HAVE infertility on that side SO I- I LET THEM KNOW WHAT THE RISKS ARE and THEY can CHOOSE UHM and THAT'S PRETTY MUCH HOW- how I pretty much base it. I do have QUITE A FEW WOMEN IN THEIR 20S who were, NOT HAVE ANY CHILDREN, have IUDs in uh

Ayse: what about tubal ligations? That's the- (the one?)

Sally: (INTERRUPTING) I DON'T HAVE ANY PROBLEM with tubal ligation. [means referral for it] IF SOMEONE TELLS ME THAT THEY- THEY don't wanna have any children and they're in their 20s, and you counsel them and THEY'RE PRETTY CLEAR that that's what they wanna do, (PAUSE) WE'LL DO IT. I THINK WOMEN HAVE A RIGHT to make a choice regardless of the AGE. I don't think age should be a factor.

Sally, FHC, Physician's assistant

As seen from the preceding quotes, the main limiting factor in providing all options to women was "medical eligibility" (looking at such factors as blood pressure, clotting, depression, age and smoking, urinary tract infections, etc.) As alluded to in the quotes as well, in providing the options the staff would also pay attention to women's preference of a method, her past experience with certain methods, her lifestyle (monogamous or not), her closeness to menopause, and her ability to take pills every day. There were, though, certain indications of staff's preferences of certain methods over others. As in one of the quotes above, Sally's beliefs about the cervical cap influenced the promotion of caps. In WHC, on the other hand, Bridget believed that birth control pills and IUDs were safer than women thought them to be.

I believe that, in addition to the staff beliefs, access to methods (especially cost) might be affecting "non-directive care". At both centers, the initial free prescription of birth control pills might direct especially the lower income women into choosing the pill over other methods.

Seeking humane care

The humane treatment aspect of the core category refers to receiving dignified, egalitarian, individualized, and holistic care. Figure 5 below is a visual summary of the "humane care" dimension to be used as a reference throughout the following discussion.

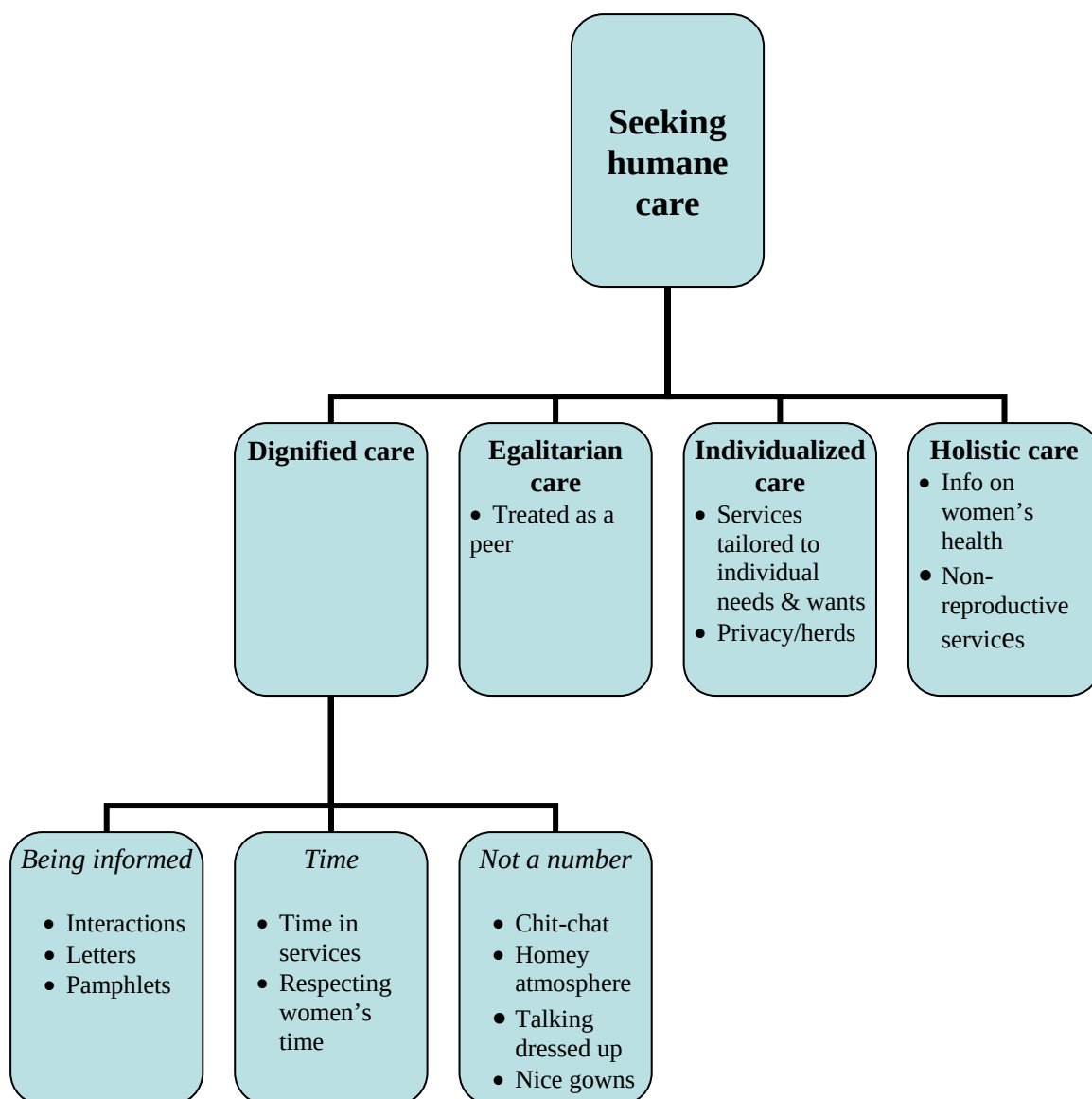
Dignified care: Being treated as a human being

Dignified care refers mainly to receiving care that reveals basic respect for women as humans, through keeping them informed about their services, giving them time and respecting women's time, and not turning them into numbers as in mass-produced service settings.

Being informed

Both centers provided abortion and gynecological clients with a lot of information, through interactions with staff (in phone contact, abortion and birth control counseling sessions, abortion follow-up visits and gynecological visits), as well as through the letters sent home (in FHC), videos shown (in WHC), and pamphlets, posters, and books on all kinds of women's health issues. Both centers had a multitude of pamphlets in their entrance, waiting rooms, bathrooms, and exam rooms. The pamphlets were on birth control, abortion, STDs, AIDS, emergency contraception, domestic violence, stalking, etc. There were also pamphlets for specific populations such as Spanish speaking women, for men (pamphlets called "men and abortion" and "men and birth control"), and for Catholic women (brochures by "Catholics for Choice").

Figure 5: Seeking humane care



The provision of information through multiple methods was helpful. For example, as one client put it, pamphlets allowed women to obtain information discreetly on issues they did not feel comfortable talking about.

The staff provided information by explaining all options of abortion (and after care) and birth control (and side effects), by walking women through gynecological and abortion

procedures, by explaining reasons for gynecological problems (e.g., vaginal discharge, clotting of the uterus, pimples around the breast during pregnancy) and by giving clear instructions.

Explaining reasons included going beyond answering women's questions to informing women on their bodies.

Client also said left side feels more pain (ovary side) and right breast feels sharp pain. Nel [Bridget's intern] asked any discharge? No. Although in pregnancy there were white pimples that she would squeeze. Nel said you're not supposed to squeeze them. Bridget said they actually serve a great purpose. To prevent nipples from drying and to keep the skin soft. Client got dressed. Bridget suggested an ultrasound to see how clotty it. Bridget then showed her the image on the screen and explained that what looks like a line there should have been a single line but is not, which means a lot of clots there. She suggested that the doctor do an evacuation on her, explained what that was.

Abortion follow-up exam, WHC

when they do something ?? ?? they tell you step by step and like. They agree ?? I'm comfortable and you know. They're VERY (PAUSE) They're very nice. I mean the most of doctors offices are like they come in, you wait here, you wait there.

Sonia, WHC, Ab + Gyn + Ab client

Then Cindy said she would do a breast exam. She explained that they usually recommend the women do the self-exams one week after the periods but with Depo, since she doesn't have any, she can do it after the shot. She said they recommend linewise movements (up and down) instead of the circular ones, since research shows that women make too wide circles and miss lumps. She started breast check and talked about what she should be looking for "a pea stuck" "a lump that doesn't move" "nipple discharge" "indents". She also checked armpits which she said was forgetting. I realized that my doctor doesn't do them.

Annual exam and Depo Provera renewal, WHC

Being informed did not only mean the amount of information provided but also *how* it was provided. It was important that the information was provided in an interactive way (where women had the time for and felt comfortable in asking questions, voicing concerns), that it was tailored to the specific needs of the woman and explained in non-technical language.

They were out of this solution that is attached to the cervix after biopsy is done. so that the skin if covered there and infections are prevented. Bridget explained it to me very clearly and showed the substance. I heard her explain it in the same simple language

(with the reasons of why it's used) to a patient and that if she feels any discharge from her vagina that looks like mud, that's why.

Observations, WHC, April 4, 2002

OHH. I adore [Sally] (Ayse LAUGHS) she was wonderful. Made me feel so comfortable. I adore her so much. She was just absolutely wonderful. (A: how did she make you- make you comfortable?) UHMM JUST YOU KNOW, she just she SAT WITH YOU and she wasn't you know she didn't have the big lab coats on. She wasn't you know HOW A LOT OF DOCTORS ARE. Very specific on what they do. (IMITATING A DOCTOR'S VOICE) "ok now you do this. thisthisthisthis" and rush you out the door. SHE sat with me explained you know what was happening, WHAT WAS GONNA HAPPEN YOU KNOW, and then she was just very, she was just wonderful.

Sheryl, FHC, Medical Ab Client

you know I didn't feel like I was being rushed through. Which I sometimes feel like it you know there's LIKE A LONG LINE and you're kind of rushed through it. Feel rushed. I felt like I could take my time. Ask as many questions as I wanted to that was very good, that was very helpful. (Ayse: not like an assembly line) right. Exactly. Particularly on the second appointment, that I have cause I was having problems with the first pill that they put me on. And SO my second appointment was a lot more in depth and uh INTERACTIVE cause I had a lot of questions about the different kinds of pills uhm you know WHY I MIGHT HAVE BEEN FEELING the side effects that I was. And if there are any differences between the pills and SO, uhm, Sally, the woman I saw was REALLY REALLY HELPFUL and like I didn't feel like I was annoying her by asking (A LAUGHS) her all these questions. She was JUST BEING VERY, you know, she wasn't like "Oh YOU SHOULD DO THIS" just telling me what to do. It was more like was GIVING ME information so I could make my own decision. So, that's really helpful. You feel like often when I see other health care providers, OTHER LIKE DERMATOLOGISTS, or whoever, like I just feel that they're MORE RUSHED and they're not- (PAUSE) and they're not AS OPEN TO YOU asking as many questions (LOWERING THE VOICE) as you might want. You know it's kind of like they might be standing by the door and you don't feel as comfortable. And I always have a lot of questions SO I appreciate ?? the difference. just feeling I can ask those questions here instead of being rushed.

Sally, FHC, Gyn Client

Below is an example of an interaction that was dehumanizing because of the way it was provided (mainly through pamphlets), which according to the client, lacked individualized information, and diminished human contact.

I don't remember HER [THE COUNSELOR'S] NAME. Everything was just a blur at that point ALL I REMEMBER is just being handed pamphlets. Pamphlet after pamphlet after pamphlet! Annd and I didn't EVEN WANNA TAKE THEM. And I didn't feel AS

IF she was giving ME ANY INFORMATION that was gonna stick UP HERE. VERSUS If you have a question, here's a piece of paper, read it. If you have a concern, here's a piece of paper read it. Because she didn't seem like she wanted to SPEND THE TIME tooo. BUT SHE ASKED ME a couple of QUESTIONS LIKE "HEEEY, how do you feel about this" and all that good stuff BUT (PAUSE) uhm it was- it was- I MUST HAVE HAD (A LAUGHS) I kid you not, A STACK. LIKE LIKE at least this thick. And I'm like YOU KNOW, THE LAST THING YOU WANNA DO would be reading a pamphlet. You want that HUMAN CONTACT VERSUS cause nobody's gonna read it.

Nancy, WHC, Ab + Gyn client

Both Sheryl and Sally's quotes above show how being "informed" is related to sub-categories of "non-directive care" and "comfort" (in asking questions) discussed under "safety". Sheryl, Sally, and Nancy's quotes also show the importance of "time", which, for women, was another important indicator of care and respect.

Time

Time meant having time to listen to women's concerns, answer questions, and going through the counseling, gynecological and abortion procedures at a comfortable pace. Time also meant respecting women's time: accommodating women's schedules in scheduling them, decreasing waiting time, and returning calls promptly.

[at my physician's office] they're a little bit more rude. Everyone's here really kind. Uhm Just they seem really rushed. And put out I don't know. Could call in and ask someone to get back to you like if you have to talk to a nurse or something, and THEY'LL TAKE THEIR TIME calling you back. WHEN I CALLED HERE, last week, I called here today because I was having a problem WITH MY PILL, I CALLED, she told me to call back in half hour cause I was at work AND when I called back, SHE HAD MY ANSWER FOR ME SHE SAID like they were really tight with their scheduling and she MADE ROOM for me.

Susan, FHC, Ab + Gyn Client

Yes. I DID HAVE A SURGICAL ABORTION three and a half years ago. And it was THE MOST UNPLEASANT EXPERIENCE. It was (PAUSE) I DIDN'T feel- I felt like ok maybe ? decision going in. HOWEVER, it's VERY SCARY. The people that I I dealt with at this place, Uhh (PAUSE) they weren't very KIND. It was more like you're here to do something, just get on the table (CLAPS HANDS) "let's do it. that's it" (A: get out) (CLAPPING HANDS) GOGOGOGOGO. And and it it THERE WAS NO TIME even

TO THINK or decide what I was feeling. And by the time that it was already happening, that's when I was saying that I don't want this to happen, STOP! And it was TOO LATE. SO, it was- I think it was more emotionally traumatic cause I wasn't prepared for it. I didn't know WHAT TO EXPECT.

Claire, FHC, AB Client

Hazel explained that Sally the physician's assistant goes over the woman's medical history with her, reviews birth control methods and does NOT RUSH the client in reviewing or in the exam. Especially the initial exam is really slowed down.

Conversation with Hazel, FHC, July 2, 2001

[our female physician] is great. She's awesome. SHE TAKES HER TIME with women. SHE REALLY uhm MAKES THEM FEEL COMFORTABLE like if it's their first Pap smear ever, she'll take a really long time. Uhm MAKING SURE THEY UNDERSTAND what's part of a normal pap smear and what part- what part is just the abortion aspect of it so they don't have this association in their mind.

Roxanne, FHC, health worker

Regarding the preceding quote, it only seemed to apply to the female physician whom the FHC staff preferred to the male physicians providing abortion services.

the counseling was, uhm, they took as long as they needed with each individual. Wasn't just 15 minutes each person. However long the person needed, they got it. They make sure that, THEY HAD A PAPER, asked you questions to so they have an idea what you feel like. And they made sure that when we had questions, they were answered

Keri, WHC, Ab patient

yeah but uhh it was a long day because you have to wait. Like it's how they schedule the appointment times cause they take time with each patient. I understand if they don't wanna rush someone who's uncomfortable through it. Like they give each person the amount of time you need. So I was here probably five hours waiting. Yeah but THAT they're not like in the procedure like ok come in now, stick your arm, you're out, you're done. Don't rush you in here they took their time.

April, WHC, Ab + Gyn Client

As discussed before in the description of the settings, the clients of both centers were able to schedule their gynecological and abortion appointments within a week and found the staff very

accommodating (including getting them earlier if they are close to the eligibility limits). There were only two gynecological clients in WHC who had difficulty scheduling appointments due to limited hours of operations. There was no indication in staff interviews that the gynecological hours were decreased. They might be referring to a change in gynecology days. In addition to accommodating in scheduling, in WHC, one client also discussed how one of the Nurse Practitioners, Cindy, would allow her to get the Depo shot a week early in cases when the client's schedule was very busy. Due to heavier client volume and the use of IV sedation, WHC had longer waiting times than FHC. The pamphlets provided to WHC clients at the first visit, though, did include expected times for the consultation and procedure visits.

Not a number

The most telling component of dignified care was being treated as a human being and not a number. Women recounted their abortion or gynecological experiences, where they became numbers in mass-produced service settings.

[in the previous clinic where I had an abortion] There was nothing personal. You didn't have a name, you got a number. (A: that's really- that's really dehumanizing) I wasn't like who I am, I had no identity, I've been number 19. Uhh so that's difficult. Difficult. And you feel like you know, you're TREATED DIFFERENTLY. You think you're being poorly treated because of the situation you are in. LIKE like punished. It was like WHY I don't wanna feel like this. You feel bad enough as it is coming to your own conclusion.

Claire, FHC, Medical Ab client

I was in that clinic from age 18, 18 until age 25. THAT I did not like that AT ALL. Because it was more like a birth control factory. You know, you go in there and they don't make you feel as warm, possibly like what you're doing is wrong. It's like an income-based thing where you go in and if you are just working part-time, then you only pay like 5 dollars FOR YOUR PILLS. SO I DID THAT FOR A WHILE. You know they never said anything rude, but I really felt like (PAUSE) THAT, they weren't providing a high level of care. THEY WERE GIVING, written information, telling you the risks, of being on the birth control pill. They would give it to you and ask you to read it. But they weren't- they would just say do you have any questions. And I FELT LIKE, they were just, rushing people in and out. And when I would look, be in the waiting room and look at my surroundings, it would be ALL YOUNG GIRLS. And I just felt, kind of like one of, (A: (millions?)) yeah, one of the MILLIONS OF YOUNG WOMEN, who are on birth

control pills. You know it's just it was a little bit degrading BUT NOT because THEY SAID ANYTHING but maybe I was just feeling that way.

Emma, FHC, Ab + Gyn Client

uhhm yeah the doctor that I went to before yeah I went there one time and he- they were OK but it was just kind of like one of those busy offices when they were running around, you were just another number basically

April, WHC, Gyn + Ab patient

As can be seen from the quotes, women talk about "becoming a number" as closely linked with feelings of degradation, punishment and with dehumanizing/demeaning care. In contrast, agency factors such as the homey atmosphere, the nice gowns, the chit-chat with the women, taking care not to show bloody instruments, and talking to the woman dressed first (before a gynecological exam) made the women feel treated at a "human level." Some of these issues were discussed before, under the category of "safety", as factors that comforted the women by addressing their feelings of vulnerability. The very same things relate to humane care because they show basic respect for women as human beings and not as numbers or medical subjects. The reason behind considering these factors under humane care is alluded to in the first excerpt below and will be more clear with the discussion of "medicalization".

Talking over colposcopy, Bridget told me that they took extra precautions to keep instruments and bloody sponges out of the patient's sight. She also mentioned using her voice as distraction, allowing the patients to focus on her voice rather than on the clicking of the instruments. She said this could be scary and invasive experience for the women which might be exasperated by metallic voices. "those instruments gain a whole different feeling when you think of them as they are going to be applied to you, to your body". She said some doctors take no notice of how the patient feels, too much focused on their whole thing, that they pass bloody sponges and instruments at eye sight. [] At some point Bridget and Nel were talking about what more they can do to make the exam room, exams and colposcopies better. Nel came up with the idea of using crutchless pants, which can be bought as underwear. She also said they could use heat pads to warm the mittens they put on the stirrups. Bridget told her to check the price on that.

Field notes at WHC, April 11, 2002

and so she brings me to upstairs waiting room and the nurse practitioner came in about 10 minutes later. Says we can meet now. Have kind of it like you know put on quality shirts which just surprised me. Just used to paper shirts. I really appreciate it. They are much nicer. Much nicer. (A: yeah. I agree. We don't need to be naked)

Mary, FHC, Gyn Client

For me, the staff is fantastic with the friendliness. THEY TREAT YOU LIKE A HUMAN BEING. Not like this is- you know the common doctor like it's like Bridget she's one of the ones. Oh call me by my first name, not Mrs or something. It's more homey atmosphere which means A LOT. [Previous doctor] was more hospital professional. That, where doctor M was HERE, it's more of a HUMAN BEING LEVEL it's like they'll treat you WHAT race you are, what walk of life you are. They treat you as a human. You know they are- the girls are all great. From those girls- yeah they treat you like individual a human being yes. You're not a number. That's important- For other ones like the bigger professional buildings, you are, you are a number.

Veronica, WHC, Ab + Gyn Client

Egalitarian care: Treated as a peer

Through her mention of calling the nurse practitioner by the first name, Veronica is touching on the peer approach to services that existed (to varying degrees) at both centers. Even though women did not explicitly express a desire to be more equal with their practitioners (except for the first quote below from a feminist client), I am including it here as a separate category because women *did* notice the peer approach and I believe that women are alluding to power relationships in discussing this and in expressing a desire for "non-directive care".

I DECIDED TO COME HERE, primarily BECAUSE I- having worked at (PAUSE) ANOTHER FEMINIST HEALTH CENTER, believe in the mission of the feminist health centers in general. UHM TREATING the- the client, the woman as a- as a client instead of a patient there's a big difference and doctor's offices are kind of looked at as a patient. You don't know the BEST about your health. THEY KNOW MORE about your health than you do and Feminist Health Centers generally take into consideration that YOU'RE THE ONE that knows most about your health. That it is an interactive process between you and the physician.

Sally, FHC, Gyn Client

But you know what I mean. Like I never really think have a problem or anything. Like scheduling. Very ACCOMODATING and but I think they try to be. Because most people you know most doctors offices are stucky and stuff. Uhm I don't like going to the doctor's office.

Sonia, WHC, Ab + Gyn + Ab client

[the staff was] JUST, VERY GENTLE. Uhhm (PAUSE) uhmm. Almost like, like sisters type ?? NOT (Ayse: more like friends) But they're professional in that THEY DO THINGS WELL but- but the way they talk to you is like treat you like a peer. Very remarkable.

Emma, FHC, Ab + Gyn Client

Individualized care: Treated as an individual

As the staff recognized and as I discovered through the client interviews and observations, there were individual differences among the women in their knowledge, experience, what they wanted, and their physical and emotional reactions to abortion and birth control. This is why the staff at both places said there were no "typical" gyn or abortion visits. Women did enter the services with different knowledge bases coming from their experience (ranging from no experience to some experience in birth control, abortion, pregnancy, and childbirth), friends and family (mothers), internet (a quick and discrete source when more standardized information is needed), books, and doctors and Ob/Gyn providers. Women also entered the services with varying good and bad experiences in previous gyn providers. This, I predict, is why women want care tailored to their specific knowledge, experience, and needs (which also relates to "time").

[an ideal care for me] would be RESPECTING. Most important thing is just RESPECTING, WHERE THE WOMAN IS AT you know (PAUSE) (A: in terms of?) In terms of LIKE IN TERMS OF EVERYTHING LIKE, EMOTIONALLY uhm (PAUSE) physically, mentally. Just trying to ASSESS where a woman is at and then work with her. AS OPPOSED TO LIKE FORCING your own agenda on someone you know. Before the woman walks in you know some doctors think they know what's best for women "OH NO. You should definitely be on the IUD, or you should definitely DO THIS" "cause it works FOR EVERYBODY ELSE". You know. And I think the most important thing is listening to people. And LIKE TRUSTING that THEY KNOW (A: uhum. They know what's good for themselves) yeah BUT THEN I mean THERE'S A FINE LINE. Cause you also wanna- be able to- you know, give people advice and information. If somebody

came in. Somebody who doesn't know ANYTHING ABOUT ANY FORM OF birth control comes in AND IS TREATED THE SAME AS uhm someone who's WORKED AT A HEALTH CENTER, and knows a lot, (A LAUGHS: yeah) It JUST MAKES YOU FEEL kind of like they're not listening to you. You know. Or that they're not RESPECTING LIKE (A: you're not-) your knowledge you know. [] Just having a conversation with them first uh WHICH I GUESS lot of providers don't do it cause it TAKES TIME. They figure it's just easier to disperse the same information to everyone BUT UHM (A: so you think-) But I didn't feel THAT WAY HERE.

Sally, FHC, Gyn Client

well, it was interesting because I- I explained to her [to the counselor] yes I do know exactly what this is, how it works, and everything else. SHE ALMOST seemed kind of relieved didn't have to explain anything cause I've been on the depo shot for three or four years now. She did make sure that I read over the the form, that shows all these side effects. BUT AGAIN, we didn't get into it that much because I- I TOLD HER I was already familiar with it.

Crystal, FHC, Gyn Client

Bridget was very aware of individual differences of women. Shown both in the way she talked to the post abortion patient and the gyn one getting a pill. She said, some women do get used to the pill really easily, some in 3 months

WHC, Conversations with Bridget and Nel, March 21, 2002

Bridget started out by asking how she's doing now after the procedure. Bridget asked how she's doing now. Patient started saying she was worried that she didn't pass blood clots, didn't bleed as much as she heard from a friend that had an abortion two years ago. Bridget listened very attentively and then said "the range of normal is very big" Explained what the clot and cramps are for.

WHC, Abortion follow-up observation

Individualized care also meant privacy: receiving services in private and not feeling "herded". As discussed under "safety", for some women it felt good and safe to be in a place specialized to prevent pregnancy (through birth control and abortions). Some others, though, still felt the stigma of abortion and wanted more private and individualized care, as opposed to group care (which they viewed as "herding"). Seeing other women "in the same boat" as they are did not make them feel safe or in solidarity. Instead these women felt awkward and possibly judged. Being in the waiting room with other women who came for abortion (in both places), watching a

video in groups (in WHC, and previously in FHC as well), recuperating with other women in after care area (in WHC) were the activities that brought out this "herding" feeling. These women viewed abortion as a "personal" and "private" issue.

ACTUALLY THERE WAS ONE THING THAT, while I was here, that I thought was kind of- like I don't know, to SOME PEOPLE like, it would be a very personal situation, she's having an abortion. AND, everybody was here, and they do the counseling and they bring them all upstairs TOGETHER. Everyone has to sit in the room together, while they wait. I JUST THOUGHT THAT WAS ODD. FOR ME it was no problem but I just- (A: it might be) like some people in the room seemed really uncomfortable with the fact that everybody was altogether. I just picked that up.

Susan, FHC, AB + Gyn Client

UHHM the only thing I didn't like WAS THAT FIRST DAY you take- OR (PAUSE) I think it's that first day, they take everybody in TO WATCH A VIDEO. AND YOU KNOW WHAT, THAT JUST did not sit well with me. UHHM felt like, now, WE ALL KNOW WHAT WE'RE HERE FOR. We all know that we're going to the same ?? AND THAT JUST- that's gotta be ONE OF THEEE most PRIVATE ISSUES of your life. And there you're sitting in this room full of people. THAT YOU DON'T KNOW hope to God you never see them again (A LAUGHS) because then it's like "oh I know. AND YOU KNOW I know" you know what I'm saying? Everything else was INDIVIDUALIZED. But it just felt like, it ALMOST FELT LIKE they were just HERDING PEOPLE THROUGH you know. Well wait for EVERYBODY, HERD THEM THROUGH, WATCH THE VIDEO. Herd people through again. Versus, SOMETHING that is VERY INDIVIDUALIZED AND UNIQUE to each person. And IF YOU NEED ME to SEE A VIDEO, you know you're open 10 hours or 8 hours, RUN THE VIDEO EVERY HALF AN HOUR if you have to. Just for one person to (A: that's true) you know.

Nancy, WHC, Ab + Gyn

Two staff from the agencies also made references to the importance of "individualized care":

Lynn said that women watch a video in groups about the state law, then it's all individualized. Go to ultrasound first, lab work (blood for anemia and for Rh factor) then counseling. They tell women if they have any questions regarding the video, they might ask them to the counselor individually.

WHC, Conversations with Lynn, Head Counselor, March 18, 2002

And we had this video that we showed women on the day of their abortion and it was just SO NOT what people WANTED, you know not what a woman of the 90s or a woman of the millenium would want any more. SHE DOESN'T WANT this GROUP CARE. She

didn't want to watch this video that was horribly made from the 80s and scared you to think you will have all kinds of problems after abortion YOU KNOW and uh and YOU have to- I think that we- like- in the course of our changes, have grown to RESPECT WOMAN'S AUTONOMY MORE. (A: yeah and they can understand) yeah they can understand information (A: like more about the procedure itself or more) it was the procedure itself, and the risks involved, and the possible complications and how you take care of yourself afterwards. BUT IT WAS SO REDUNDANT. And it's just like (A: if you heard from the counselor) YEAH. YOU HEARD IT FROM THE COUNSELOR, YOU HEARD IT FROM THE WOMAN TAKING CARE OF YOU IN AFTER CARE, and just like kind of made it seem like "wooo, maybe I shouldn't be doing this" (A: let me just go now) yeah. (PAUSE: 3 seconds) like micro-managing every potential problem or every potential scenario that just wasn't (PAUSE) helpful, you know.

Hazel, FHC, Outreach and Education Coordinator

In the preceding quote, Hazel connects individualized care with trusting women's knowledge and autonomy, and interprets group care as lack of trust in women's capacities. Given the feminist mission of FHC and its more radical feminist orientation in the past, I doubt her interpretation and wonder whether the video shown in a group context was meant to act as a consciousness raising activity or just to decrease individual counseling time. As a contrary note to "herding", I would like to add Roxanne's quote on women bonding in the waiting room. I do not have enough observational data about waiting rooms in either center to complement it (I felt very self-conscious to make long observations), but still would like to include Roxanne's experience as an example of group care creating solidarity instead of a herd feeling.

Like you just see people coming in here (PAUSE) under the MOST like INTENSE kind of STRESS. AND OUT OF THAT, like you see people coming together and like forming these like temporary friendships and these temporary like bonds that are just SO like PURE. Like I'm- sometimes I'm- I'm- abortion clinic days, I'll be upstairs in the upstairs waiting room. Where women wait before they go in to the procedure room. And they're all you know sitting there in their gowns and everyone's nervous. I JUST PICTURE THAT being a room filled with men, EVERY ONE WOULD BE sitting there just like NOT talking (A LAUGHS: yeah) you know stressed out and sort of like embarrassed to be there and looking at their environment. WOMEN JUST TALK TO EACH OTHER and like tell their stories and they they hang out (A: wow?) wish each other good luck when they leave for the procedure room and they see each other after words and they talk about how it was and you know how they felt. (A LAUGHS) talk the things they liked and they didn't like. "OH were those shots, were they surprising?" (A LAUGHS R LAUGHS TOO) and things like that you know. (A: that's cool that they can share it) it's a hard experience but then after words like women are laughing and they're like (A: wow) you know like JUST coming together over (A: yeah) something that could have been SO

HARD and it has become I think a positive thing, I think for a lot of people. [] I think THAT IT'S SO AMAZING THAT an abortion clinic, something that people you know STIGMATIZE SO MUCH as BEING like this horrible you know house of murder (A SMIRKS) like WHATEVER it is. It's just THE MOST BEAUTIFUL things going on in here. SO MUCH like around such really hard circumstances and it's- it's SO. It's so cool. I love being here. It's so inspiring

Roxanne, FHC, health worker

Holistic care: Treated as a whole person

The last dimension of humane care refers to being recognized as a whole person. This was accomplished through having pamphlets and books on women's well-being in general (e.g. pamphlets on violence against women), through providing non-reproductive services such as general counseling in WHC and massage in FHC, and through the nurse practitioner's (in WHC) and physician's assistant's (in FHC) emphases on women's overall health.

ANY TIME I HAVE A QUESTION, they're ok with it. EVEN NON-gynecological questions that I had a urinary-tract infection. Actually came here, I think I thought something was wrong, it was my temperature, they realized and then they referred me to go to the doctor cause they don't really DO THAT. But LIKE THEY SENT ME go see a doctor. You- right like they're more of a gynecologist you know. But they were willing to see me FOR THAT, to at least tell me to go there so

Sonia, WHC, Ab + Gyn + Ab Client

Yes they do [have] pamphlets around for you to read through. And with the abuse, even WOMEN physical abuse there's they can help you get counseling that way is well. I think it's a full-round uhm you know really tailored to women

Susan, WHC, Ab + Gyn Client

I always ask about DIET cause uhm I'm up- ONE OF MY OTHER THING IS anorexia and bulimia that I kind of focus on. AND JUST SIMPLY ASKING somebody about their diet, how many meals do they eat, if they are on a special diet you can pick up a lot. I've been doing it a long time so I kind of pick up on people (LAUGHS) UHM and get a good sense sometimes about where they're coming from. SO uhm (PAUSE) you know I kind of- you know because I did family practice I kind of steer them in whatever direction based on the response that I am getting but I do do uh uhm a complete history over time they come in. IN PAST THEY WEREN'T DOING THAT. But I think that's the family practice part of me

Sally, FHC, Physician's assistant

Women's desires for holistic care had their limits. After the first three interviews in the field (with data collection starting at FHC), due to a fear that I was not "getting at" empowerment, I added, what qualitative researchers call "a magic wand question" to the end of the client interviews. I asked them how *women themselves* envisioned an ideal service to be. My aim was to find out visions of women and how these related to empowerment (whether they wanted power and, if so, how they conceptualized it). In their ideal services, most women separated obstetrical/gynecological and abortion services.

Ayse: WHAT WOULD BE YOUR IDEAL service- and this could be gynecological or abortion OR OBSTETRICS whatever, so the whole reproductive service- IF YOU WERE gonna DESIGN ONE (S: ok) what would it be like?

Sheryll: UHHHM. I PROBABLY WOULDN'T HAVE (PAUSE) the clinic like FHC with the same place as someone having a baby cause I think that- and ACTUALLY I WAS A little nervous about bringing my daughter in. BECAUSE for the OTHER WOMEN because I'm sure you know they're ?? and if someone for the very first time. A TEENAGER OR A NEW MOM you know or- it it would be very difficult for them TO SEE (A: sure) you know uhm, like this little girl going around, (A: sure) and wandering. "oh what am I doing?" you know.

Sheryll, FHC, Medical Ab client

Ayse: if you have this power to design a service for women, reproductive service and you can include anything you can put them together gyn, abortion, could be childbirth whatever, how would you do it? With space and people?

Keri: but I think if they were, all gonna be together, (PAUSE) they would, definitely have to be APART in a way because you couldn't have women coming in to have an abortion and see women that were pregnant and have to give birth and coming in to the same room and uh.

Keri, WHC, Ab patient

One woman, though, did envision integrated services and included a midwife in her ideal services.

I would do one for all. I would create one for all services. I would have it all [doctors, nurses, nurse practitioners]. And I like it- I'm not sure if she's STILL THERE, there was even one doing for mid-wife. Midwifery. And that's what is like I would have that as an option also. It's a certain. It depends on what morals you believe in. That's nice if you are you have it. If not, you still have an emergency place to go to have it DONE. If they wanna go through with it, they have the ?? choice, if they want the abortion, you have the choice there. So have it all. Midwife, it'll be you can have the abortion or have the child.

Veronica, WHC, Ab + Gyn patient

Research Question 2: What are the factors that mediate women's experience of empowerment?

As mentioned before, the theory that is reached at the end of the analysis is that *the current generation of women experience (and define) empowerment in relation to safe and humane care, as mediated by agency and community factors and by the politics of reproduction at the societal level*. I found that the women's experience of empowerment (which was seeking safe and humane care) was affected by community, agency, and societal factors.

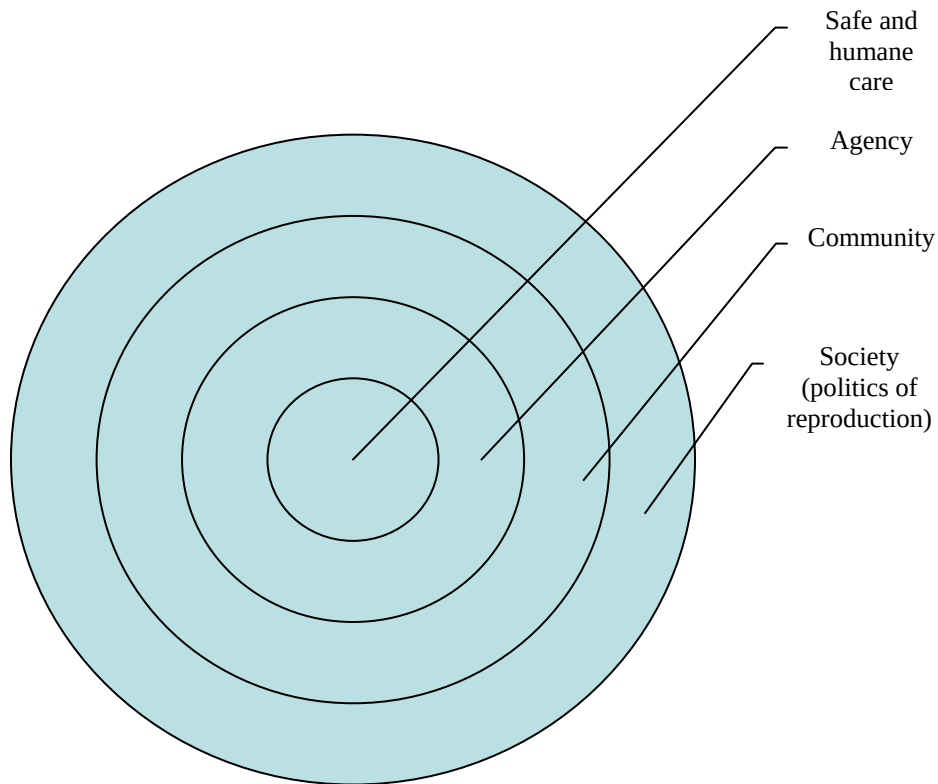


Figure 6: Safe and humane care as mediated by agency, community, and societal forces

Agency factors that affected “safe and humane care” were the agency atmosphere (security measures and homey atmosphere), staff characteristics (age, gender, race, and childbearing status), staff beliefs and motivations, the medicalization and psychologizing of services, and the business aspects. Community factors refer mainly to the interactions between the agency and community (people, schools, churches, other providers, feminist organizations, hospitals and individual doctors) that occurred in an anti-choice climate, and reflected the isolation and integration of the centers in their respective communities. Social factors refer to the norms and institutions that influence reproductive services. I will call these factors the “politics of reproduction.”

Even though the immediate effect on “safe and humane care” comes from agency factors, I will start the discussion with the community factors to foster an understanding of the two communities in which both the women and the agencies were located.

COMMUNITY FACTORS:

ALIENATION AND ALLIANCES IN ANTI-CHOICE COMMUNITIES

Both centers were established in the 1970s with the main mission of providing low-cost abortion alternatives to women in their communities, where the options were limited to local hospitals and a few doctors in each area. The first director of WHC, who was "associated with the fight to make abortions readily available since 1971" (through founding the local Abortion Rights Association and forming a voluntary operation called Abortion Information Service), expressed this mission. In the local newspaper (September 8, 1978), she is cited as quoting Allen Guttmacher Institute's estimates of "5000 women in the region seeking abortions each year" while "only 28% of the need is met." In another local newspaper report (September 8, 1978) she emphasizes that "some doctors have been providing services and a few hospitals in the area accepted medical assistance patients", yet they have been unable to "keep abreast of the work load." While praising the work of the local hospitals, she differentiates the new clinic's care from them in terms of "extensive counseling" provided before abortions and the low cost services - "providing abortion for all women regardless of their ability to pay."

As reported in an article Hazel wrote in her college's newsletter, FHC was also established by a group of twelve to fifteen women who recognized "the need for improved access to abortion services" in the area. They also emphasized that most abortions, which were provided at hospitals, were "cost prohibitive" and involved "little exchange between a woman and her doctor." Thus, the mission seems to be similar to WHC (providing low cost abortions where more

information is provided to women). The main difference was in FHC's explicit connections to the women's movement with emphasis on women's taking charge of their bodies in a clinic "run by and for women." In the quarterly publication of FHC (Fall, 1994), in an article on the 20th anniversary of the center, it is stated that "many of the ideals and much of the energy that fueled [their] formative days and early years can be linked to the self-help and empowerment movements that flowered in the 1960's and 1970's." It is further stated that the health center's efforts from the beginning "have been clearly focused on the work of educating and empowering women to take charge of their own bodies."

Despite their differences, due to their missions in providing abortion services, both centers faced resistance in their respective communities. The resistance ranged from protests and pressuring for the repeal of zoning permits (in WHC) to violent attacks at the centers (fire and a stink bomb in FHC, blockades, occupations), and targeting the doctors working at the centers. Even though both centers extended their services to include full gynecological care, both were still known in their communities as abortion clinics, which the anti-choice movement turned into abortion "mills". It is interesting that, in the local newspapers I reviewed, WHC has been referred to as the "abortion clinic" since the beginning. In a letter to the editor in a local newspaper (September 14, 1978) entitled "what's in a name", a couple question WHC's calling itself a "women's health center" instead of "[city name] abortion clinic" if, these abortions are "therapeutic abortions" or "innocent medical procedures" and if the staff are proud of their work.

As abortion providers, both centers felt alienated and unsupported by the community at large (including factions in the medical community), even by their friends/neighbors, the pro-choice community, and their own clients.

I THINK THAT YOU KNOW THAT THERE ARE- I MEAN I THINK that THERE ARE- what I notice is that there's TWO TYPES OF pro-choice supporters. There's ONE THAT supports N.A.R.A.L. Which is the political arm of the abortion movement. They feel like IT'S SOMEHOW SAFER. I mean FOR LACK OF A BETTER you know ANALOGY, it's like NARAL doesn't have blood on their hands. You know they're not

DIRECTLY providing abortions. Their building for most part is not gonna get BOMBED. They don't have you know (A: (safe pro-choice?) TEENAGE LOOKING POOR WOMEN walking in and out of their building. THEY DON'T HAVE YOU KNOW, I don't know (PAUSE) maybe the type of psyche that some of our donors- I'm sure even if you're pro-choice you know you're pro-choice to certain levels. And maybe I- I KNOW PEOPLE THAT ARE PRO-CHOICE that I'm sure wonder WHY I would do this for a career everyday. (A LAUGHS A LITTLE) Women who are on the EXAM TABLE have said to procedure room support people "WHY DO YOU DO THIS? I can't believe you do this". And I mean you know, what an (upfront? Affront?) what an INSULTING THING for somebody opening their heart up. Their heart and their you know HOME IN A LOT OF WAYS. This is like my home in a lot of ways. [] SO you got THE REAL- the people that really CARE ABOUT ACCESS, really care about the individual, really care about the clinics and the you know struggles that they go through. And then they have there're people that care about LAWS. I FEEL LIKE (PAUSE) OK, know THIS WOMAN who is running for governor, that has BEEN OUR MAYOR knew her daughter in high school, she KNOWS ME, she comes to pro-choice events. And she's very supportive of NARAL but have NEVER GIVEN A DIME TO US (A: yeah so what does that say?) and YET there are so many people like that. [] THE COMMUNITY SOMETIMES (A: you see) is not as supportive as I wish they would be. It's LIKE WHERE ARE IF- you know X AMOUNT OF WOMEN have an abortion every year, WHERE ARE THEY? (A LAUGHS) you know WHERE ARE THEY? They- THEY'VE BEEN SHAMED INTO SILENCE. And they've been you know TOLD that they're supposed to hide. YOU KNOW that they're pro-choice and has to hide their experience AND SO you know I TRIED TO START a a mailing list of clients see if people would respect their privacy around YOU KNOW RETURN ADDRESS or if they would wanna be on our MAILING LIST. And few people would and most people weren't comfortable with that and THE ONES THAT DID did NEVER REALLY RESPONDED. We have very few client supporters you know. OUR HEART you know is LIKE COMPLETELY OPEN and that makes us accessible to them. You now WE'RE HERE because of them. there is that and I think the anti-choice COMMUNITY HAASS been very successful at (PAUSE) turning us into what they would like to you know, LABEL US, which is an ABORTION MILL you know. It's like you feel very insular when then you go from like- since I've been working here, you go from times where uhm your blinds are open. You have Iris going up to every single blind you know and shutting.

Linda, FHC, Executive Director

AT LARGE, it's still an abortion center. AND PEOPLE I THINK stay away from the political issue UNLESS, SOMETHING (PAUSE) PERSONAL, triggers a type of response. YOU SEE TWO EXTREMES of the spectrum. You see some people who are just PHENOMENAL SUPPORTERS, because they've gone through either an abortion themselves or SOMEONE close to them has gone through an abortion. And they REALLY FEEL vehemently they need to support that. And people on the other hand, feel vehemently against it AND MOST OF THE PEOPLE IN BETWEEN

Bridget, WHC, Nurse Practitioner

when people ask what I do for a living, I say I work in the Women's Health Center, I get two responses I get. Ohhh really " so it's- work at a women's shelter" they think it's- They don't know anything about this place or I get (A: what are the other?) "ooohhh" and then people won't talk to me anymore. You know they go. (A: abortion ??) yeah yeah. You know so it's it's- you get either response

Lynn, WHC, Head Counselor

Uhm, the ONLY OPINION I have on that is when I speak with other people WHO ARE IN MY COMMUNITY. You know like my neighbors, my family. And it's just not discussed. A lot of times I just don't talk about my work. JUST, People are not, either not pro-choice or not comfortable talking about it. SO I just don't talk about it at all. IN THE (MEDICAL?) COMMUNITY, I think we are respected. I think we ?? medical career. Doctors, they come to our medical committee because of the fact they respect the care, they respect the physicians and the staff here so uh. (A: good) WHICH IS VERY- YES it's VERY GOOD that the medical community thinks that way.

Chipper, WHC, Medical Services Coordinator

I think there are so many places that is ?? ?? at gynecologists in this area, WHOO WAS ACTUALLY be quoted in the newspaper saying he would LIE to women about how far pregnant they were, so that they would NOT MAKE A DECISION TO ABORT. IF he thought they might make a decision to abort. Annd (A: how ethical) I think that is very frightening. And I think there is also places that women are PUNISHED for their decision.

Bridget, WHC, Nurse Practitioner

I think all of the physicians that are providing ob/Gyn care, I've heard it at least once come out of their minds. THAT YOU WOMEN are doing an incredible service to those other physicians that like would not know what to do with their patients and would not provide this THEMSELVES. Ron [one of the three doctors providing abortions at FHC], when I first met him said "WHY DON'T YOU DO A MAILING to ALL THE OB and family practice doctors up at the H Hospital. And just SEE WHAT HAPPENS " We got Dr. G. That's how we got P [the female doctor providing abortions at FHC]. (A- LAUGHS: cool yeah) So it WAS REAL you know IT WAS A WONDERFUL IDEA. BUT VERY FEW RESPONDED with donations (A: hmmm) when you know we talked about it, it was like "you know how many REFERRALS those doctors have to make to you?" you know like. That's just SO INTERESTING THAT they (A: they won't ??) STILL WON'T EVEN (own? Honor?) that we're here providing not only great service to women but it's a great service to the medical community and that we should be RESPECTED and and LET INTO THAT you know. But you're not really LET INTO THAT- that SUP-ULTRAPROFESSIONAL BOYS' CLUB kind of

Linda, FHC, Director

According to the staff, community support was higher during crises (fire or blockade).

For this reason, the staff sometimes referred to their communities as "quietly pro-choice."

I think [the community support] is really mixed. Uhm I think that uhm (PAUSE) I'd s- I only know from my (A: sure) interactions with people like personal life, SOME OF THE BUSINESSES are (PAUSE) (SIGHS) I DON'T- SOMETIMES think we're all that supported. I think we're pretty alienated and in a sense maybe we're- (PAUSE) BUT YEAH when we had our fire, there were all kinds of ?? (A: that's good) SO I guess when it came down to it, we all supported by people in the community. But other than that, we don't hear from anybody you know.

Felicia, FHC, full-time health worker

AND AS A MATTER OF FACT, there is ever a concern, IF WE WERE TO BE PICKETED, or there's a problem- AT ONE POINT, long time ago, they had uh picketers blocking the front door, I mean people volunteered to help, uhm, patients in. I will be there no matter what you want, I will help you out. I- YEAH IT IS (A: makes you just) It makes you feel good.

Bridget, WHC, nurse practitioner

The anti-choice climate (as revealed by the alienation felt by the centers) affected women's feelings of safety and dignity. As discussed before, the protests and attacks made women clients feel physically vulnerable (seeking physical safety), whereas the judgment of abortion providers and users (which was internalized by some clients as well) made them feel emotionally unsafe, and led them to seek non-judgmental, confidential care where their decisions were validated. The anti-choice climate in the community also led to the scarcity of abortion providing doctors in the area through making it difficult to find doctors to work there. The scarcity in turn increased the doctor's power at the centers.

coming back about ten years ago they were a few times they were (A: so, that was in the 70s) yeah yeah. Then, a few times they were really short. They couldn't find anybody, so they called me, and I go down on one-time basis or something just to help them out. AND uhm then something this last time I think it was 7-8-9-10 years I believe that they ?? me, they REALLY (worked?) they REALLY NEEDED SOMEBODY.

Duncan, FHC, Doctor and Medical Director

While I was here, uhhh, three doctors did procedures, were S, R, and Sam.. that was about it. Uhh, and I REALLY- I admire- I admire ANY DOCTOR who performs this procedure because.. God knows I mean there were situations doctors were shot because yeah. Uhm, I read an article that there're fewer uhm students in medical schools, that are electing to even learn how to do abortion procedures.

Eileen, WHC, Gyn + Ab patient

well, the clinician that they had, LEFT. They [WHC] used to have a midwife who would see post-abortion care. And it was basically just post-abortion care. And she moved away. And they were having a great deal of trouble, trying to get someone to come in. It's very hard to get somebody, A CLINICIAN, to work here. Because of the political dynamics that go on

Bridget, WHC, Nurse Practitioner

Against the alienation they felt, both centers built alliances with the local and national feminist organizations and other abortion providers, doctors, schools, and hospitals in the area. These alliances both helped decrease the alienation of the center and affected safe humane care. The alliances affect the safety component (safe care) through enabling referrals to the centers, providing back up mechanisms for abortion complications and acting as sources for birth control services that were not performed at the center (such as tubal ligations and hysterectomies).

SOME WOMEN who also ?? services, so we keep referring women to the hospital. We have PRETTY COMPREHENSIVE except that we just don't do major surgeries. If she wanted a hysterectomy, that wouldn't be DONE HERE. (A: uhummm. Would they be referred?) Sure. And we have a GREAT NETWORK of physicians that are supportive of the center and we can refer to and they'll send us information BACK, with lab ??. It'S GREAT! (A: that's really great) IT IS, IT IS.

Bridget, WHC, Nurse Practitioner

IF SOMEBODY GETS INTO TROUBLE, if the woman gets into trouble with complications, and they end up going to an emergency room where you know it's HOT you know HOW kind of COLD ON ABORTIONS, you know sometimes women have a HARD TIME so I think one of the things I it's not necessarily that I'm DIRECTOR BUT that I AM doing the procedures in town, that I have a connection with the hospital and if there are people, if they have problems, I CAN take care of them yes. (A: so BE THEIR

PHYSICIAN) I just feel- I really feel very responsible for these women and so I feel comfortable caring for them.

Duncan, FHC, Doctor and Medical Director

I know they had back up. And we have agreements with with hospitals if we get into trouble and we have agreements with GOOD HOSPITALS. We have agreement with S Hospital and you know and we try to reciprocate by TRAINING THE RESIDENTS THAT wish to come here. IT ALWAYS AMAZES ME HOW FEW of the residents want trainings they- they don't wanna get their hands dirty. They're afraid of the hassle

Sam, WHC, Doctor and Medical Director

[for abortion] we've got referrals from DOCTOR'S offices, Planned Parenthood

Iris, FHC, Full time health worker

uhumm yeah. We have referral sources (in?) like all the college health centers uhm. And there're PROBABLY FOUR OR FIVE Planned Parenthoods in Northeast [State]. So they tend to refer here. ALTHOUGH, a clinic opened up in R in 2000 I guess or 99. SO uhm some of the B county patients that we were seeing, (PAUSE) are now going there.

Janet, WHC, Executive Director

we collaborate with a lot of different organizations within this community. LIKE N.A.R.A.L., the [state name] netwo- the [state name] affiliate for the National Abortion Action, Abortion Action League. Uhh the Women's Lobby of [state name], [State name] Women's Fund, [state name] Fund for Choice WHICH FUNDS abortion uhm THERE'S ALSO, I mean there's a long list. W, which is a women's counseling center that WE STARTED ACTUALLY. That was seed money with a grant from the health center. And then the Coalition Against Sexual and Domestic Violence, the P Feminist Health Center uhm [state name] Family Planning Counsel. There's a LONG LIST OF coalition partners that we- that WE HAVE. People that we work with FOR DIFFERENT PROJECTS at different times. And then of course national affiliations as well. Like the National Abortion Federation or the Independent Provider Representative ORGANIZATION that the national coalition of abortion providers uhm the Feminist Majority Foundation we work with so (A: soo, all that related) RIGHT, exactly. Boston's Women Health Book Collective. I mean there's a long list yeeah. We have a great- a great you know rich history. We've been around a long time. So working here just feels like I- I just get to reap THE BENEFITS of (A LAUGHS) years and years of CONNECTING YOU KNOW.

Linda, FHC, Director

As mentioned in Sam's quote above, both centers trained residents and interns. Both centers also did or were planning to do outreach activities targeting local schools and the medical community. These two activities helped decrease the alienation of the centers (by establishing them as resource centers in the community) as well as affected "safe humane care" by normalizing and demystifying birth control and abortion services. As can be seen from the quotes below, the success of this outreach was mixed (in schools and in the medical community) due to varying acceptance in the community and the activities being limited by scarce funds and small staff size.

Janet: one of my goals is to uhm REALLY, REACH OUT to the other physicians in the community. The other doctors and help- HELP THEM UNDERSTAND WHAT WE DO HERE. So that they're not, THINKING THAT WE'RE you know uh (PAUSE) SO THAT WHEN THERE'S COMPLICATIONS, PATIENTS get TREATED WITH RESPECT. And that they UNDERSTAND WHAT AN ABORTION IS. And uhm how to DO IT how to TREAT the complications and how to talk to their patients about decisions uhm. I THINK- I think we've done a lot with that.

Ayse: how do you do that? the outreach to the doctors?

Janet: I would write letters usually. Uhm SOMETIMES just through conversations. UHM if I HAD more time, I would physically GO OUT THERE BUT I'VE DONE THAT LOCALLY anyway. I have gone out locally. I've done grand rounds of hospitals our phys- our medical director's joined me in that cause we expanded to offer medical abortions with the mifeprex. So uhm so we did a lot of teaching about that. So wherever we can find opportunities to do that and you know how we train residents they usually send them here. Because they know that we know what we're doing. Sooo THAT'S- that's a big goal to keep that going. And uhm JUST BEING APPROACHABLE and a resource and to do more outreach LIKE IN SCHOOLS

Ayse: are the schools, accepting?

Janet: NOT REALLY. BUT DEPENDS. There are different- you know I think SOME AREAS ARE more religious than others. THIS AREA is, kind of QUIETLY PRO-CHOICE (A LAUGHS: yeah) you know. But they don't they're not activists or anything. Yeah kind of when it comes to THEIR CHILDREN, you know, THEIR CHILDREN ARE OK, so don't know THEY JUST DON'T SEE THE NEED. ALTHOUGH (LAUGHS) we went to a middle-school in center city. They were really, "Please help us" (A LAUGHS: they?) THE KIDS. They knew everything but they knew nothing. You know. But so we had a really good positive experience there, uhm doing some sexuality

education, but we don't have any FUNDING FOR THIS (LAUGHS) either. SO WE'RE ALL, we run with just patient fees.

Janet, WHC, Executive Director

Linda: Ron [one of the three doctors providing abortions at FHC], when I first met him said "WHY DON'T YOU DO A MAILING to ALL THE OB and family practice doctors up at the H Hospital. And just SEE WHAT HAPPENS" We got Dr. G. That's how we got P [the female doctor providing abortions at FHC]. So it WAS REAL you know IT WAS A WONDERFUL IDEA BUT VERY FEW RESPONDED with donations when you know we talked about it, it was like "you know how many REFERRALS those doctors have to make to you?" you know like. That's just SO INTERESTING THAT they (A: they won't ??) STILL WON'T EVEN (own? Honor?) that we're here providing not only great service to women but it's a great service to the medical community and that we should be RESPECTED and and LET INTO THAT you know. But you're not really LET INTO THAT- that SUP-ULTRAPROFESSIONAL BOYS' CLUB kind of

Ayse: Is anybody pushing any of that? Training or anything [targeting the medical community]?

Linda: YEEAH. But I DON'T REALLY KNOW HOW given the fact that we do juggle too many jobs here. There sure could be somebody who's going out to the community and having luncheon meetings up at H Hospital, to EXPLAIN ABORTION, to EXPLAIN new methods, and explain who WE ARE. You know there really should be someone OUT THERE throwing down like rolodex cards and business cards and brochures and really DEMYSTIFYING what goes on behind these locked doors and give a face TO the name [feminist center].

Linda, FHC, Director

Hazel told me that she and Sally plan to do more community outreach education programs in Fall/Winter (in the summer, people are not around) about anorexia and other more HOLISTIC issues.

Conversations with Hazel, FHC, July 2, 2001

Hazel and I talked about doing more kind of community based work or (A: She was just telling me about that) yeah, getting community more involved, maybe going to schools uhmm (PAUSE) and doing some kind of outreach there OR uhmm workshops, having workshops here uhmm so that you know people from the community can come in and learn about various things uhmm just kind of establishing our clinic as a more common OR more KNOWN Resource in this city, (year-around?), (A: for the community) yeah, for young girls and stuff and NOT having it be this scary building where (A LAUGHS) they (only?) do abortion

Marcie, FHC, Full-time Health Worker

A more unusual outreach effort was performed by Duncan, the Medical Director of FHC, who talked about abortion to church groups with which he was involved. Duncan was a Republican and a religious person and he called himself a feminist. Having treated women who had illegal abortions, Duncan believed in women's abortion rights, though as can be seen below, he also sees his role as "ministering" to women some of whom are "soul sick." In these ways, his fit with the feminist mission of FHC is problematic. At the same time, Duncan gave legitimacy to the center through his prominent position in the community, and he brought out the abortion issue to the Republican Party (from which he ran as a candidate) and to church groups, both of which are places FHC would not otherwise have had access to.

I say this is AS MUCH A MINISTRY FOR ME as it is being a physician and it REALLY IS you know I feel- I feel a lot we had a we had these young young kids- 12, 13 years old. Some of them are impregnated by their step-fathers yeah yeah. SO THEY THEY COME IN THERE and they are SOUL SICK you know IF I- I could have an option of just BEING COLD, and and NASTY and stuff, but I don't do that. Cause I've really I'm really very kind of peripheral about it and I want them to be as comfortable as they can and I want them to THINK- I THINK IT'S IMPORTANT FOR THEM TO KNOW, that I FEEL COMFORTABLE with what I'm doing, that it's NOTHING TO BE ASHAMED about AND and they're not to be ashamed of IT. And this abortion thing has just been kind of a fun (A: LAUGHS twist) twist that is serious and controversial (LAUGHS) and cause I talk I talk to church groups about abortion (A: how do they, take it?) WELL, it depends on WHO THE AUDIENCE IS. BUT I- I TALK them just personally like I talked to you. I tell them you know that and I AM VERY ACTIVE IN THE CHURCH. I probably- I do more ministry at the feminist health center than I do any other place. YOU DO. Lot of people need ministering to (A: yeah. so more spiritual connection yeah) OK!

Duncan, FHC, Doctor and Medical Director

Figure 7 below is a visual summary of the community factors that influence safe and humane care. The medical community, anti-abortion groups, and their interactions affect physical and emotional safety through increasing women's sense of emotional and physical vulnerability and being judged for using birth control and abortion services. The anti-abortion influences on the medical community also lead to the scarcity of abortion providers in the community which relates both to physical safety (safe abortion care) and emotional safety (judgments). Client support is

both directly and indirectly related to safe and humane care. The lack of support reflects the internalized judgments of women on abortion and the success of the anti-abortion groups in silencing women. The agency staff's goal to increase client support is again an attempt to increase women's feelings of safety (especially non-judgmental care) through demystification of abortion.

Figure 7 also depicts the alliances FHC and WHC had with the medical community, abortion providers, schools, feminist organizations, and churches. These alliances provided physical safety (safe abortion care through alliances with doctors and hospitals) and decreased the agencies' alienation. They were also attempts at demystifying and normalizing abortion and birth control services in the community. Demystification and normalization of abortion and birth control services in the community relates to the "safety" dimension in the women's emphasis on non-judgmental care.

The differences between the two agencies in terms of community factors are identified in the figure by having the agency's initials next to the category. The differences were in WHC's increased level of integration into the medical community, FHC's alliances with local and national feminist organizations as opposed to WHC's alliances with other abortion providers, and in FHC's alliances with churches through the individual efforts of its medical director.

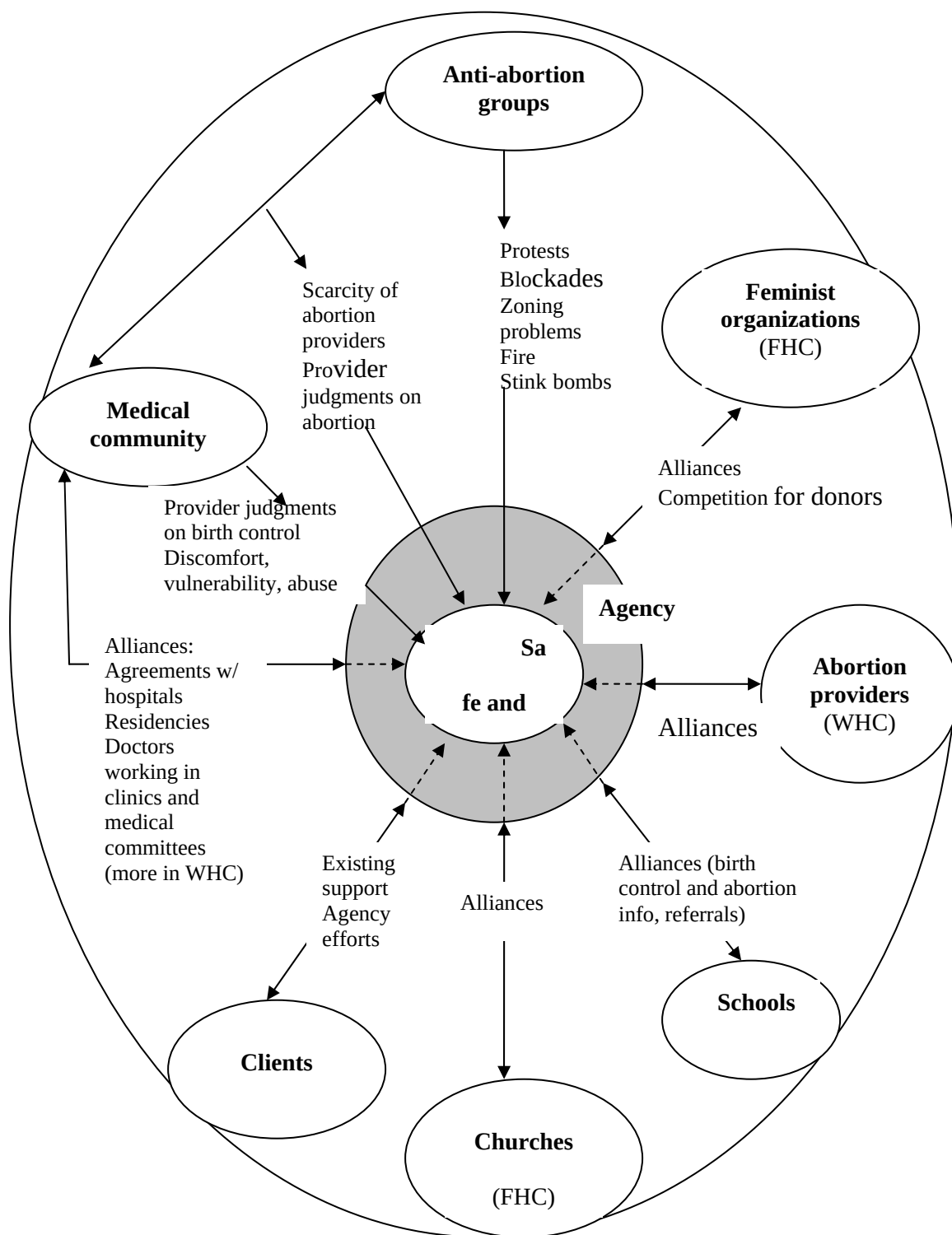


Figure 7: Community factors that interact with safe humane care (alliances and alienation)

AGENCY FACTORS

Agency factors that interact with the core category are agency atmosphere (such as the homey atmosphere and increased security measures which were discussed previously under the core category), staff characteristics, medicalization and psychologizing of services, staff beliefs and motivations, and the business aspect of the services.

Staff characteristics: Gender, age, and childbearing status

Women's visions of ideal reproductive care revealed that women felt more comfortable and safe (referring to "comforting" dimension of "safety") with female providers for gynecological services in general, and for abortion services in particular. Female providers were believed to be more empathetic, compassionate, friendlier, and to take more time with the client, the latter of which refers to the "time" dimension of "humane care". (Please see Figure 9 below for a summary of the effects of staff characteristics on safe and humane care)

For myself, I LIKE WOMEN you know dealing with other women. Just because I never had a male doctor. So you know. I don't know if I'd be comfortable with that but yeah usually like women just they're more like you know TELLING YOU WHAT THEY'RE DOING and stuff like that and gentle and they understand that like they put like covers on the stirrups and stuff like that (A LAUGHS: yeah) YEAH JUST like knowing stuff like that. Because they've been in the situation themselves it seems. Just friendlier

Andrea, FHC, Gyn Client

I DON'T MIND HAVING A MALE DOCTOR But I know, MY SISTER IN LAW, who's going to be having a child, SHE PREFERS only WOMEN. I think they think women are more compassionate too (A: yeah LAUGHS: I guess so) Either they have been PREGNANT BEFORE or, (PAUSE) (A: or had an abortion or used contraceptives) something

Susan, FHC, Ab + Gyn Client

UHHM MY GYNE- GYNECOLOGIST IS A MAN. SO and I- I do feel comfortable with that aspect for him to- to cause both I had men you know deliver my kids so I don't have a problem with that BUT GOING THROUGH WHAT WENT THROUGH [meaning abortion] a woman would UNDERSTAND MORE I think, THAN A MAN WOULD. And being IN THE CLINIC, IN THERE, it was nice to see women in THERE.

Sheryl, FHC, Medical Ab Client

Oh it would definitely be nurses and nurse-practitioners [in my ideal care] yeah. UHHM nurse practitioners take more time than a doctor does. NO OFFENSE. ?? But nurse practitioners HAVE A- mostly females and we love to gab.

Nancy, WHC, Ab + Gyn Client

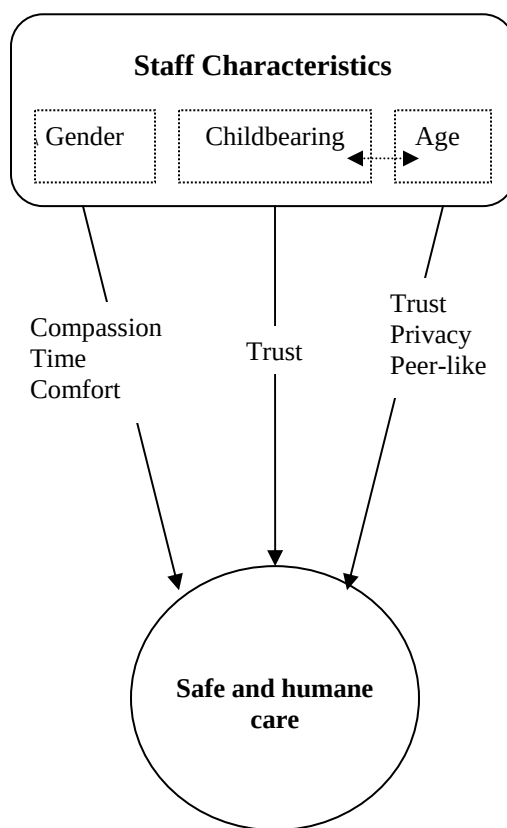


Figure 8: Effects of the staff characteristics on safe and humane care (for both centers)

In addition to beliefs about female providers (that they are more compassionate), gender preference also seemed to be mediated by women's previous experiences with male providers, types of service received (abortion versus gynecological services), and homophobia.

it was- it was nervous [seeing a female nurse practitioner] cause like if you're not used to having a a FEMALE, and knowing that knowing only of a MALE DOCTORS, THAT'S QUITE A SHOCK. TO ME that was the biggest part (A LAUGHS) I guess cause it's like- that's when it started with the gays, lesbians, like (A LAUGHS) oh my god! You know then having a- then I heard of other girls talk they would never go to a MALE DOCTOR (A: yeah) for the downstairs but that's ALL I KNEW OF. Not having a- ME HAVING A FEMALE GOING DOWN THERE, "yeah right" YOU KNOW. (BOTH LAUGH) it's honestly true. It's honestly true. IF YOU DON'T KNOW OF ANY OTHER WAY.

Veronica, WHC, Ab + Gyn client

Even though most women preferred female providers (especially for abortion), as client and staff interviews showed, female ob/gyn's could be insensitive and demeaning as well.

MY FIRST EVER was was with uhm a doctor that MY MOM- she didn't even KNOW who she would take me to she doesn't even go to regular exams, so she wasn't sure (A LAUGHS) so she took me to someone that my grandmother had known. And I did not like the woman at all. Was very ?? I think I was probably 16. 17 at the time. I was really young AND THEN UHM, when I was 17, I WAS STILL AT HIGH SCHOOL AT THAT TIME. oh SHE WAS HORRIBLE! It- It was PAINFUL to begin with. That was painful and I did not like it at all. And then she was like- NOT REALLY CONCERNED- like she was talking about my weight and stuff like that. I was 16 years old. I had WEIGHT ISSUES at the time you don't say that to someone. AND SHE- it wasn't like she was concerned about with like BEING HEALTHY AT ALL. She was just like (A: just had a problem with this) YEAH (A: herself) yeah. SO, she was- It was not good at all.

Andrea, FHC, Gyn Client

I guess I remember NOT REALLY FEELING COMFORTABLE with- with one of the practitioners I saw and I felt like it was- it was just kind of the personality. It was- She was like she was just very abrupt and and very like kind of like NOT VERY approachable you know you didn't feel comfortable asking a lot of questions and she did kind SCARED ME A LITTLE BIT (A LAUGHS) you know. It was like. (A LAUGHS) Uhm. And she said, you know, I THINK IT WAS something like maybe I asked her a question and she really made me feel kind of stupid EITHER I SHOULD KNOW THAT OR YOU KNOW. (A: putting you down. yeah) foolish for me to be thinking like that.

Sally, FHC, Gyn Client

YEAH. I think women just prefer that yeah. And and again that all has to do with two of the personalities of the peop- you know. MOST PEOPLE feel they rather have a women physician but YOU KNOW they can be- some we had them here in the past that we just haven't felt comfortable with whomever it was and you know. Way prefer Dr. Duncan. He's very gentle. He's KIND you know. BUT you know SOMETIMES they get set in THEIR WAYS and (A LAUGHS) don't want to change either.

Deedee, FHC, full-time health worker

Having said that female providers could be demeaning as well, the quote below still raises the gender issue: how women interpret patronizing and sexualized comments by male versus female providers.

I went to the regular DOCTOR for for my my annual check up and I got my my birth control pills, and IT WAS A GUY and that was probably the last time that I ever voluntarily went to SEE A MALE, FEMALE DOCTOR (A: LAUGHS yeah). Because I didn't LIKE HIM. Uhhm, at at the time I was living down in Florida and Florida had a little nude beach. [] So I- I had no tan lines that summer, when I went to the doctor. And the one thing that I'll always remember and this is years ago. Of course you put on this stupid one size doesn't fit anybody paper gown and you sit there and wait for him. And HE ACTUALLY HAD THE BALLS to make a comment "Does your mother know you don't wear bathing suit?" woosh, I felt like smacking him. I really DID I mean What could I say? (A: What is it to you?) Yeah, it's none of your damn business! [] I was so flustered so flustered that I couldn't think of anything appropriate to say back to him. But I never WENT BACK. (A: don't blame you) Found another doctor. Cause I just- IT WAS UNCALLED FOR. And I'm sorry to- here here you are, you're most vulnerable person possible you're sitting there in a paper napkin and a string and have somebody say something that has no bearing on anything

Crystal, FHC, Gyn Client

In addition to gender, age of the providers (counselors and support persons only) also seemed to affect "safe humane care" through the goodness of the fit between staff and clients. Staff who worked as counselors and support persons at both centers expressed feeling more confident and comfortable working with women of certain age groups and recounted experiences of women who felt more comfortable with them.

I particularly enjoy counseling THE YOUNGER WOMEN uhm TEENAGERS. I feel VERY uhm I FEEL VERY GOOD and I feel like I'm very connected to them I (PAUSE) I do very- I do- I have to say I do a good job of that UHM (PAUSE) I'm often times INTIMIDATED BY women that are older than myself (LAUGHS) they come here for services. For some reason I feel I had a lot of- the whole idea of wisdom and age, it's really I don't wanna, I feel nervous about possibly uhm (PAUSE) talking down- I don't want them to think that I'm talking down to them and I- AND I DON'T TALK DOWN TO THE TEENAGERS EITHER but I feel more even, maybe it's cause I look YOUNG, you know (A LAUGHS) IMMATURE (LAUGHS) or something but sometimes I feel like my problem with counseling is (PAUSE) feeling sometimes I'm invading their privacy. I get VERY CAUTIOUS

Felicia, FHC, full-time health worker

[being a support person is] this REALLY LIKE amazing opportunity because you're really interacting with these TOTAL STRANGERS WHO, OUTSIDE OF THIS SETTING, probably would never KNOW you might not even like ever YOU KNOW ever cross paths with, but it's just like YOU GAIN like ACCESS TO this extremely private moment in their lives, it's just like, you almost, LIKE I I HAD FEELINGS LIKE I almost had no business being here you know like oh my God. (LAUGHS) Like these women are 40 years old I'm like a 17 year-old punk with (A LAUGHS) no training and I don't know (LAUGHS) what I'm doing here. [] like I felt really grateful I think just being trusted to (A: do that) TO uhm (PAUSE) be in that position of support to somebody who probably had a lot longer sexual experience than me maybe has had kids like. [] (A: how do they react, how do these women feel about the support person?) I think a lot of women respond pretty positively to me. UHM (A: I mean not to you but) well women in that position. Uhm THERE WERE TIMES when definitely women are just like "SHUT UP" like- like you know like "don't touch me" but I don't think that IT'S HARD TO TAKE IT- ANYTHING PERSONALLY anyway.

Roxanne, FHC, part-time health worker

well I am YOUNG. I can RELATE BETTER to a teenager, as opposed to someone who's older. I may feel intimidated by an older woman you know. (A: older than?) I would say in their thirties. Thirties and above. I don't know if it's because, typically they see that I am much younger than they are and they don't want to voice as much to me. OR if it's just personal STYLE. A LOT OF TIMES I FEEL THAT they don't think that I'm competent because I AM SO YOUNG. [] I work THE BEST, with uhm women in their EARLY TWENTIES ??. BECAUSE I can relate to the FIRTHAND. I do work best with the younger 20s and that is good cause our peak age is 20 to 24. (A: there you go. LAUGHS). I KNOW, FOR A FACT, our head counselor Lynn works best with OLDER WOMEN. Because she is OLDER. SHE HAS the experience of HAVING CHILDREN. She knows what child birth- you know CHILDBIRTH IS LIKE. She can relate to a client THAT HAS CHILDREN. [] TWO OF OUR OTHER COUNSELORS ARE later in their

twenties. And I'm sure they WORK BEST with OLDER because, you know around that age (A: everyone has their) because they have (A: comfort) RIGHT (A: zone) SO I think it's good we're all spread out in age.

Sarah, WHC, Intern Counselor

All three staff discuss age as an indicator of experience and knowledge (including childbearing experience and knowledge). The lack of fit in age suggests not being "trusted in one's knowledge", "talking down" (to an older person), and "invading privacy" (it is interesting though that the privacy issue is brought up in conjunction with working with older women, rising alongside of feelings of incompetence). As such, they are mirroring women's needs to feel safe and comfortable through not being judged and trusted in privacy (confidentiality and "individualized care"). "Talking down" is also alluding to the "peer approach" of humane care. "Trusted in one's knowledge" relates to the "information" component of humane care, though in this sense it emphasizes not the information received but the trust in the messenger's knowledge.

Medicalization and psychologizing of services

Both centers were founded at the height of the Women's Health Movement whose main aim was to deinstitutionalize medical authority in women's health services. In my aim to revisit the legacy of the Women's Health Movement in the 21st century, I asked questions on and observed how medical authority was negotiated at each center. I found that medical authority was negotiated through the division of labor (specialization), division of knowledge (information gap), emphasis on medical and invasive versus alternative methods, and through the relationship between provider and client.

Division of labor

Division of labor refers to the use of professionals, paraprofessionals, and lay workers in services, which follows from (and reflects) the hierarchical structure of and specialization in each agency. Both centers were women-run centers, however, WHC had a hierarchical structure, where labor was divided along professional lines, reflected in the division of departments: administrative, medical, counseling, and front office (reception/phones) and in spatial arrangements (as back and front office). Doctors and nurses worked at the back area on abortion and recovery room services, counselors (usually with or working towards counseling or psychology degrees) did counseling at the front area, and nurse practitioners were located in-between the two delivered gynecological and abortion follow-up care. Even though lay workers were allowed to train for medical services (such as lab, ultrasound, and being a tech support to the doctor during abortion), only two of the staff had been trained to do so. Lay workers were also not very much utilized in counseling services. The lack of lay workers in counseling paired with the high counseling emphasis of the agency leads to what I call "psychologizing of services", making abortion a psychological event.

There was some level of job rotation and cross training for jobs (where counselors, director, and lab director took appointments, and did cleaning, and reception work). Job rotation decreased the hierarchy among the non-medical staff (especially with the director's visibility in daily routines) and cross training provided continuity in patient care in an understaffed agency. However, these were done mainly out of staff shortage. Otherwise the staff preferred specialization over job rotation.

That goes along with the shortage, if I didn't have to deal so much with doing jobs that I'm really not scheduled for I really I shouldn't be scheduled for any jobs in specific. I should just be what they called FLOAT. I have to go fill out where it's necessary.

Chipper, WHC, Medical Services Director

WHAT WOULD MAKE my job easier I mean if I didn't have to work HERE, IN THE OFFICE, that would make it easier. Cause it's constant distractions. Constant! And someone called out on Saturday. And I was here. And I had to take payments in the front desk, and check- check patients in, process their payments, doing ??, something that someone else (A: yeah) BUT AGAIN, you know I don't really complain about it because the job. And it was, you know a valid reason which she couldn't come in.

Janet, WHC, Executive Director

Job rotation also did not change the hierarchy between the medical and non-medical staff, because the medical personnel (doctors, nurses, and nurse practitioners) were exempt from job rotation.

most of us are asked to like take APPOINTMENTS, or you know or do clean the lounge. Which may be a function of the female environment. It's HIERARCHICAL, But it's NOT AS hierarchical as. And I had a hard time seeing like a medical practice where it's ALL MEN, where someone does janitorial cleans the fridge. You know higher people don't DO THAT. BUT WE'RE MORE WILLING TO, you know the person AT THE TOP IS WILLING TO DO the laundry. You know cause it's just- just SHARING the responsibility. (A: the doctors?) NOT THE DOCTORS (A: see) ARE YOU CRAZY? Not even female doctors. That's a whole- that's a class system. (BOTH LAUGH)

Sharon, WHC, counselor

Within this specialized system (with little job rotation and division of labor made across professional lines), medical personnel had considerable power in the agency as demonstrated by their positions in the hierarchy, their exemption from job rotation and decision-making power. In terms of their positions in the hierarchy, Mary described doctors as "hired hands" and Sam, the Medical Director, described himself as a technician.

THE DOCTORS are essentially hired hands here. The doctors HAVE THEIR own MEDICAL COMMITTEE MEETINGS with our executive director and a couple of our our nursing or medical staff. SO, WE DON'T- it's not like some offices where you have to run everything to the doctor, the doctor has to do this. OUR DOCTORS come in, we have the patients ready for them, if there's an unusual question or something like that must be answered BY A PHYSICIAN, we do have that lined up, give them the information. THEY'RE HERE TO DO THE ABORTIONS. This is not their PRIVATE OFFICE, they don't RUN THIS OFFICE. THEY SET POLICY for the office. But essentially the staff of women that runs this place. The doctors are contracted. None of them owns the clinic. None of them are you know, MORE POWERFUL than another.

We have an executive director- a MEDICAL DIRECTOR and we have a laboratory director who are NOT THE SAME PERSON. But essentially the docs come in and see the patients. And uh we have great guidelines established, great protocols established by the medical doc- medical physician committee so. It's not like some offices WHERE EVERY DECISION has to be made by the doctor. They, our physicians give us GREAT LIBERTY TO UH KNOW what's appropriate TO BRING TO THEM and they give us liberty to handle quite a bit on our own.

Mary, WHC, Lab Director

I I don't see them [patients] till after counseling. And and I'm sort of a TECHNICIAN that does the (A: The last ?? yeah) yeah. And you know it's a very BRIEF ENCOUNTER And you try to make it as painless as as THE LEAST UNPLEASANT that we can. They see the counselors. They go through the billing and all that. And they come back and then I'll talk to them briefly just to make sure, that this is what they really wanna do. And I also talk to the ones who who- need medication sign up ?? and then and then if they have problems, I will see them and do ultrasounds, and things of that sort and make decision- MEDICAL DECISIONS as to whether we should do it here or if they're having trouble and need additional medication, things of that sort.

Sam, WHC, Medical Director

As described by Mary and Sam, doctors' power were not the same as in a private office or hospital setting, but it was not as little as a "technician" status either. The Medical Director position was at the top of the organizational chart. He worked directly with the Executive Director on overseeing all medical staff (physicians, nurses and nurse practitioners) and determining medical protocols in the medical committee consisted of Executive Director, Medical Director, nurse practitioners, and physicians in the community.

I call the board just corporate management. Then then I'm next in line and the medical director works with me. I work with him ON medical decisions basically. Guidelines each year we evaluate the guidelines. We HAVE A medical committee made up of physicians in the community as well as physicians that work here and our nurse practitioners and we meet twice a year and discuss changes in policies and procedures. Uhm we just meet to discuss COMPLICATIONS, management and complications that kind of thing.

Janet, WHC, Executive Director

According to Sam, though, Janet had important input into these decisions on policies.

And I have to sign policy changes and THINGS LIKE THAT. Nothing major. Janet does all the work and I just- (A LAUGHS: you just sign?) yes yes. UH. With with MEDICAL changes, we HAVE A (PAUSE) twice a year full-team medical committee meetings and

that's what where part of our medical policy changes are made. But she brings input and research things in so we can make hopefully make informative decisions.

Sam, WHC, Medical Director

Other indicators of doctors' power were the individual doctors ability to determine the gestation limit they would work with, medical directors' blocking of the use of the manual vacuum aspirator that Bridget (nurse practitioner) advocated for women whose uteri clotted after abortion, administration of the medical abortion pill by the doctors and not the nurse practitioners, and the divide between the medical and counseling staff.

The divide between the medical and counseling staff were in terms of time, assignment of risk and the focus on medical versus emotional safety.

It's actually very good. I feel very comfortable with the doctors. And all of the nurse staff. The nurse staff is very helpful. Uhm basically and they're extremely busy in the back, making sure that everything flows quickly FOR THE PHYSICIANS. For the physicians have very limited time working here, so they relieve the pressure on them.

Sherry, WHC, part time counselor

I do what's called traffic [float]. it's patient traffic, to make sure the flow is going. You know. Because we have doctors that are WORKING like workworkworkworkwork. They wanna GET DONE and you know. SO we have to make sure that- And not the doctors are. Actually they're MUCH BETTER. We had other physicians who are much tougher on them. But now- they slowed down a bit (A LAUGHS, They relaxed?), they've taken a step back to the whole picture. If the whole staff works like that and THEY DON'T, I think they take notice. You know, why are you acting this way we're trying to take care of the patient. Rushing them through ?? create a problem so.

Chipper, WHC, Medical Services Director

THE ONLY REAL schism I see is sometimes between MEDICAL STAFF and the counseling staff. Because they have DIFFERENT AGENDAS. UHM you know, the nurse, the anesthesiologist is interested in making sure that the patient has no MEDICAL PROBLEMS, and gets out of here safely AND THE COUNSELOR uhm, WANTS HER TO BE OK EMOTIONALLY and get what she needs- and sometimes a woman will come in and she'll say (PAUSE) "I smoked marijuana last night" NOW, she can't have an abortion at that point. It had to be 24 hours. Even though I KNOW, AND THE DOCTOR KNOWS, and EVERYONE ELSE KNOWS that smoking a little bit of marijuana is not, going to make this a dangerous, it doesn't invalidate her competency.

So I mean THAT IS really no cutting corners if like something she had an aspirin yesterday. Then the counselor's back there with the nurse, saying "BUT YOU KNOW SHE'S GOING TO BE FINE" and you know, she drove three hours to get here, give her the abortion you know. AND SHE CALLED IN, she's gonna get fired if she takes another day off work. And the nurse if like "NO! Because the medical protocol." And people DO ACCOMMODATE EACH OTHER. It's not completely it's not this stark dichotomy. BUT I think there's some friction. Uhm, JUST BECAUSE we have DIFFERENT AGENDAS. We're responsible for one thing, they're responsible for something else. (Ayse LAUGHS) And sometimes the two don't exactly JIVE. (Ayse: yeah. How is it resolved?) UHH WELL, usually MEDICINE TRUMPS PSYCHOLOGY (LAUGHS) [] BUT IT'S- PEOPLE ARE ACCOMODATING, and THEY WILL listen to the counselor and I have changed minds and had the woman be seen for surgery WHEN INITIALLY she said NO. They're not completely (PAUSE) unapproachable about this. Uhm they err on the side with PHYSICAL SAFETY. SO what if they have to drive another six hours ON SATURDAY, she COULD DIE, OR she could be at risk for this or that. EVEN IF IT'S REMOTE, DO YOU WANNA BE THE PERSON that's responsible for that? NO!

Sharon, WHC, part time counselor

As mentioned before in "settings", the Feminist Center was initially run with an external board of directors and hierarchical relations between lay and professional health workers. However, through increased contact with other feminist organizations, FHC changed its structure in 1977 into a worker-controlled one with an internal board of directors and a decision-making model based on consensus where all workers (except medical staff) were given the job title *health worker* and were reimbursed under the same pay scale. At the time of the study, all workers (except the medical staff) were still called health workers, there was no external or internal board and a person was assigned as the "director" for legal purposes.

The main differences of FHC from WHC in the division of labor were in the use of lay workers and the level of rotation. In FHC, lay workers (women without any medical background) answered the phones, performed pre-abortion and birth control counseling, did lab work, identified fetal tissue, and acted as the support person for the client or as the technician for the doctor during an abortion. And health workers rotated on daily jobs and on teams. The use of lay workers and job rotation followed from the feminist ideology of breaking down the hierarchy

between staff and administration, and between medical and non-medical staff, and in turn, demystifying medicine (and medical authority) for women workers and clients

It's also cool THAT EVERYBODY HERE has had probably NO medical training before coming here with the exception of a few people. Our nurse practitioner and uhm a few other women work here are nurses or have went to nursing school or have worked in other like medical related things but a lot of people LIKE ME, lot of the part-time staff worked out of college or out of high school and we came and DIDN'T HAVE ANY EXPERIENCE and WE LEARNED SO MUCH. Like the stuff that I know about LIKE birth control and reproductive health is just like amazing to me at MY AGE and uhm the fact that you know like we're teching in the procedure room like and doing things that you know and WE'RE TOTALLY CAPABLE OF IT TOO TOU KNOW (LAUGHS) It's great. IT'S- empowering in that sense as well. You've learned it here enough that you CAN DO THINGS LIKE THAT. Like identify tissue and you know like it's just the doctor and the surgery in essence THAT'S JUST AMAZING. I think that (PAUSE) you know it breaks down the hier- hierarchy

Roxanne, FHC, full-time health worker

in terms of the way that we RUN the health center, we DID uhm (PAUSE) for many years have uhm a rotation system where you know people would spend a certain amount of time couple of years on a team and then they would have to move on to ANOTHER TEAM and learn new skills and so that. IN THE SEVENTIES, one I think one of the values of the 70s when this place was SET UP WAS uhm for- WAS THAT, WELL ONE OF THE BELIEFS was THAT (PAUSE) WE'RE ALL capable of acquiring information and applying that information uhm and acquiring skills in different areas THAT uhm there was sort of an anti-expertise kind of mindset that (PAUSE) nobody was to be put up on a pedestal because they knew they had special knowledge in a certain area. We wanted to believe that we all could have that knowledge and that that expertise. Uhm and so sort of cross-training has been a real norm of this place.

Iris, FHC, full-time health worker

It's just SHOCKING TO PEOPLE that we would be TOUCHING even touching A SYRINGE without going- having gone to medical- nursing school you know so THAT I THINK IS FEMINIST in working you know like a lay health worker you know. [] THERE ARE CERTAIN WOMEN WHOOO expect to see white lab coats.

Linda, FHC, full-time health worker and director

As admitted by the staff, the use of lay workers in medical procedures decreased from before due to increased state scrutiny and insurance reimbursement policies. Job rotation also

decreased (and specialization increased), partly due to business pressures (e.g. efficiency). These caused FHC to swing a little back to the medical model with job specialization.

Dr. K was very progressive and he he did TRAIN and ALLOW US TO TRAIN EACH OTHER TO DO a number of things like we had- we had health workers doing a prescreening exam before women went in for the abortion, THEY WOULD DO pelvic exam to size the uterus, they would do the Pap Smear those things would be done by a health worker and Dr. K TRAINED THEM to do that. And we also had health workers uhmm when we we sort of (PAUSE) were instrumental in reintroducing the cervical cap, we had we USED TO HAVE cap fitting GROUPS where women would come in that were interested in having the cap in and there would be a health worker who would TEACH about the cervical cap and then do a fitting. SO HE was very progressive BUT uhm AT A CERTAIN POINT when REALLY THE STATE DID NOT uhm I think they didn't inspect us even until you know left us alone for a number of years but then uhmm they started scrutinizing us more and I think you know his medical license was covering us and so I think he kind of backed off and became a little more conservative a little more aware of the state looking over his shoulder and our shoulder We were REALLY involved in the direct provision of health care in ways that they aren't NOW that we just we just don't do anymore. WE KIND OF SWUNG a little bit back toward the medical model and rely on our PRACTITIONER FOR (PAUSE) A LOT that we relied on ourselves for back in the seventies and early eighties.

Iris, FHC, full-time health worker

The longest time the lay health workers did the pelvic exams, uhm (PAUSE) you know. I MEAN THEY'RE- they're- we lost SOME OF THAT CONTROL because of insurance. Insurance, what they will pay for. They won't PAY for a lay health worker to do pelvic exam. You can't get reimbursed. It wasn't like that before HMOs became the common thing now with HMOs, it's- it's- profit driven you know. It's not based on HOW you know. BUT YET that's why you know we can't anyone doing ultrasound. It has to be a practitioner. We can't have just anyone do a pelvic exam. IT HAS TO BE- and that wasn't true until probably the late mid-80s. That's when things started changing.

Felicia, FHC, full-time health workers

YEAH. We- We we still ROTATE (PAUSE) the clinical jobs. Basically everybody who's full-time knows how to do every clinical job. We've been all TRAINED TO DO every clinical job. NOW AGAIN we kind of sort of fallen into this thing where Hazel's ALWAYS TECH because she LIKES the TECH she's GOOD AT TECH. You know she's willing to TECH (A LAUGHS yeah) and there are other people you know we'll do it because we have to because we need to keep up our skills and it provides a supply of you know if Hazel's OUT, somebody else could step IN NO PROBLEM uhm SO We- I think we need to maintain cross training in the clinical work but in the running of the health center the organizational work people could be more put kind of into their (niche?) and stay there if they're happy.

Iris, FHC, full time health worker

As mentioned above, lay workers and job rotation helped decrease medicalization. Other measures such as introducing all providers (including the physician's assistant and doctors) by their first names, giving doctors no voting power in the running of the agency, and encouraging staff to challenge doctors (and other medical staff) if they felt it necessary also served to decrease medical authority. However, doctors (especially the Medical Director) followed by the physician's assistant, still had power in the agency, as demonstrated by their role in making the medical protocols, and in the medical director's blocking the training of mid-level professionals for abortion. The Medical director blocked the training of mid-level professionals because of the differences in his versus the feminist staff's assignment of risk.

Uhm. You know OUR MEDICAL director DUNCAN, is very conservative in a lot of ways. He- He's He's very old fashioned in a lot of ways and he's always not until late people like doing like VERY RESISTANT to mid-level practitioners uhm such as Sally or nurse-practitioners doing being trained to do abortions. And he feels that they shouldn't be doing it. That's a dangerous medicine.

Felicia, FHC, full time health worker

In terms of the assignment of risk, a difference between FHC and WHC was that in FHC, the physician's assistant (Sally) was able to deliver the medical abortion pill, whereas in WHC, only the doctors were allowed to do so. The strategy of challenging the doctor in FHC also had problems due to the scarcity of doctors available in the community.

we're- we're EQUALS with our doctors in the sense that we call them by the doctor's name we uh we can tell them if we don't like what they're doing. It's not always easy to do. But we're we're SUPPOSED TO DO THAT, that's part of our, if we don't do that, we'll get- If SOMETHING WENT ON, this is- this is a perfect example. Uhm one time there was woman who wants to see her tissue. SHE WANTED TO SEE the fetus. UHM I think SHE she was 13. 12 or 13. I don't really remember like she was far along those ABSOLUTELY. EVERYTHING WAS THERE. You know and and uh our policy is WE ALWAYS SHOW THAT TO THEM. if they wanted to but DR. DUNCAN SAID ABSOLUTELY NOT. We can't show her the tissue. And the health worker said "OK". Alright, I won't show it to them. And told her "sorry I can't show the tissue to you" and then it came out and that staff member, the health worker GOT NAILED. For not having confronted physician and should have stood out to him. But there is this thing. One of the ?? that I SENSE HERE (A: yeah) is that we we how can we replace that doctor? how many doctors is there willing to be abortion provider. So we have to kind of BE

CAREFUL in HOW WE CONFRONT THEM because you don't wanna have him say "see you. I don't need this place" "It's not like I need that money", NOT THAT THEY NEED THE MONEY you know. SO THAT'S- you know that it's a bit of FEAR THERE.

Felicia, FHC, full time health worker

Despite his power in the agency, as the medical director of WHC did, the medical director of FHC (Duncan) also saw himself as a technician (even though he alludes to a more minstrel role as well).

they've been counseled and everything. So, when they get to me the decision is made, I feel like I AM A TECHNICIAN down there [at the center]. BUT AT THE SAME TIME, it's a great opportunity FOR ME to be as KIND AS I CAN BE to somebody who is in terrible distress. And I really. SO THEY THEY COME IN THERE and they are SOUL SICK you know IF I- I could have an option of just BEING COLD, and and NASTY and stuff, but I don't do that. Cause I've really I'm really very kind of peripheral about it and I want them to be as comfortable as they can and I want them to THINK- I THINK IT'S IMPORTANT FOR THEM TO KNOW, that I FEEL COMFORTABLE with what I'm doing that it's NOTHING TO BE ASHAMED about AND and they're not to be ashamed of IT.

Duncan, FHC, doctor and medical director

Division of knowledge

Division of knowledge refers to the information gap between the medical and non-medical staff and between the staff and clients, which indicates the providers' (especially medical providers) monopoly over reproductive knowledge. As discussed previously under the "being informed" dimension of the core category and under staff beliefs, the staff of both agencies believed in and shared information with the clients on birth control and abortion. The only exceptions to providing information to women and trusting in their knowledge and decision-making capacity came from the medical staff in each agency:

I know doctors, doctors are well in our office for instance, I think there is a philosophy sometimes you can tell them too much and I subscribe to that. I think that sometimes they tell the clients too much and I think on the other hand, I think that we don't tell them

nothing I think it usually could be a SIN to to- you have to- ONE THING YOU HAVE TO LET THEM UNDERSTAND IS THAT what they're doing is NOT AN INSIGNIFICANT thing. BUT AT THE SAME TIME, (PAUSE) you don't wanna scare them either, you don't wanna DETER THEM by you know by saying you're killing the baby so it's a- I THINK it's it's tricky, it's very tricky

Duncan, FHC, medical director

I introduced myself to more of the people. A nurse and two students doing PA and nursing degrees. The nurse told me about laminaria. The Indian doctor will use it 13-14 weeks and after 15, might do a 2 day operation. Dr. Sam will not do abortions after 14 weeks. She said she wouldn't feel comfortable working at some of these clinics that provide abortion beyond 14 weeks. I asked why. She said more complications, more anesthesia needed etc. She said she diverges from the pro-choice people here, that if women are given 15 weeks, they may make their decision, if 21 weeks, they will wait till 21. I said not the teenagers who don't even KNOW the legal limits. She said once they've been in the situation, they do.

Field notes, WHC, March 2003

As different from WHC, FHC had also utilized self-help techniques in the past such as workshops and a quarterly publication to decrease the information gap between women and providers. These efforts, though, were discontinued.

In terms of the division of knowledge among the staff (between medical and non-medical staff and between doctors and physician's assistant or nurse practitioners), in WHC, nurse practitioners were trained by the doctors in laminaria insertion, and the counselors were trained by doctors and nurses in the drugs that women can take at the day of an abortion with IV sedation. In FHC, as mentioned before under "division of labor", doctors used to train lay workers more in the past about pelvic sizing before an abortion, performing Pap Smears and cap fitting. However these were abandoned with increased state scrutiny and the lack of insurance reimbursements. At the time of the study, lay workers were trained by the doctor to be technicians during abortion, and by the physician's assistant (and other lay workers) in answering phone calls on abortion complications. Some of the physician's assistant's quotes on lay workers doing

ultrasound, and answering calls about medical abortion do reflect her existing hold on the medical knowledge:

[medical abortion is] relatively new for us, UHM (PAUSE) EVEN THOUGH I did an in-service on it, I'm the one WHO DID THE BULK OF THE READING AND RESEARCH ON IT, so the information is in my head uh I can only TRANSMIT SO MUCH AND PRETTY MUCH THE COMPLICATION RATE is like any other miscarriage SO medically that's not any different SO (PAUSE) but YEAH they're they're pretty much RELY ON ME to- to (PAUSE) to back them up (PAUSE) from the phones. IF THEY'RE UNCOMFORTABLE I told them if you're uncomfortable with all of this and it's not all fitting the right pattern, (A: so these may be complications) COMPLICATIONS UHM INFECTIONS birth control REFILLS.

I'm the only one doing [ultrasound]. UHM IT'S TECHNICALLY NOT DIFFICULT but knowing what you're seeing is what's difficult so you really have to have THE ANATOMY BACKGROUND SO UHM I was just kind of the logical person to do it.

Sally, FHC, Physician's assistant

Sally's quote on ultrasound is especially interesting, since, in WHC that had very few lay workers, Chipper, a lay worker, was trained to do the ultrasounds.

Emphasis on medical, invasive or hormonal versus alternative methods

This dimension refers to the use of medical versus alternative methods in abortion and birth control care. As discussed before under the "non-directive care" dimension of the core category, medical abortions, which are less invasive than surgical abortions, were used less in WHC, due possibly to staff beliefs that it is a risky procedure. In contrast, in FHC, medical abortions were used more and were seen as less risky. Herbal abortions were not discussed in either agency.

In terms of the birth control options offered in each agency, there was no encouragement of barrier methods over hormonal methods, despite a commitment to barrier methods by feminists in the former years of the Women's Health Movement. Lastly, in WHC, Bridget, the nurse

practitioner, used alternative methods in abortion care (in inserting laminaria and in dealing with post-abortion clotting of the uterus). These methods provided less medical and invasive, and as she puts it, more "psychosocial" care.

sometimes I put in Laminaria. On the day of their abortion. uhm they are YOU KNOW they never delivered practically or if they're a little bit farther advanced in pregnancy it's something to dilate the cervix, to make it easier for them. And I would put that I do that. Sometimes I think nurses have a little bit more gentle approach than physicians TO SOME OF THESE PROCEDURES, you know they're more PSYCHOSOCIALLY you know. PLUS WE use a LIBERAL AMOUNT OF (PAUSE) A NUMBER OF THINGS. We use a lot of (placebo?) We- we use quiet music at the background. We use aroma therapy at times with (claire?)-sage, it helps up cramping. Putting in the Laminaria is scary, can be painful. I use lot of topical anesthetic. Lot of doctors don't do that, they say "oh why do that?" but it helps a lot.

Bridget, WHC, Nurse Practitioner

There's some other techniques I've done to try to help them. uhm put a tablet of uhm Cytotech in the cervix which causes uterus contraction. Sometimes it works, and that's been working pretty well.

Bridget, WHC, Nurse Practitioner

Relationship between provider and client

In both agencies, clients' contact with the physicians were minimized. Clients in FHC had the most contact with lay workers and the physician's assistant, and in WHC, with counselors and nurse practitioners. As discussed before in "staff beliefs" and as seen in the women's responses, these relationships were based on a model of mutual participation in decision-making. To be more egalitarian (or peer like), counselors and nurse practitioners in WHC, and lay workers, physician's assistant *and the doctors* in FHC were introduced to the clients by their first names. Clients in both agencies were comfortable asking questions during counseling (to counselors or lay workers) and during gynecological exams (to nurse practitioners or physician's assistant). Except for two clients at WHC, clients overall did not ask any questions to the doctors before or during abortion, saying that their questions were answered by the counselors beforehand. It is not

clear how much of it is also due to the short-term interaction with the doctor and to women not feeling comfortable asking questions to a doctor.

Whether the strategy of minimizing the clients' time with the doctors (and assigning doctors to a technician status) was successful in decreasing the doctors' power and provide an alternative doctor-patient relationship depended on how the women interpreted the situation. While these results are not conclusive, it seemed like some women found it abrupt that the doctor was not talking to them. For others it was ok especially if there were other staff such as the nurses in WHC and support persons in FHC who utilized conversation to distract them or walk them through the process.

I found the doctor to be a real jerk (LAUGHS) just a little abrasive you know (Ayse: ohh. What did he do? or not do?) OK. He just- you know he just like, SITTING THERE for you know fifteen minutes (LAUGHS) you know WAITING FOR HIM finally he comes OK "hi, how are you?" so, and just like went to work then he would buck out you know. (A: so, you felt) yeah kind of like "Thanks!" (A LAUGHS)

Frances, FHC, Abortion and Gyn client

AND WHEN I GOT INTO THE ROOM, we actually were talking about TOM CRUISE and in the movie "Interview with the Vampire". They think he fit THAT ROLE- AND AND as they were doing that the anesthesia was going and then I WOKE UP IN ANOTHER ROOM. [] [The doctor] he was bald. and he didn't talk at all. Like literally they they were talking to me about Tom Cruise and like he was like scooting he was doing his business and I was like OK. They had two nurses and the doctor came in so like I mean. He wasn't like how you're doing today, dadada. Like you know he just was pop your feet up and he goes wham, you're out and then you wake up. (Ayse: was that OK? that he didn't talk?)YEAH. he- I mean he was like nice and stuff. I THINK- I think he did come and SEE ME like I got- I got dressed and he came in and I was like OK we're gonna bring you over and the nurse brought me over. But he wasn't mean. He was literally He GOT TO HIS JOB. ALRIGHT, I'M DOING IT (A LAUGHS) and I don't see him afterwards. The nurses were all in the other room. They were nice and they gave me antibiotics.

Sonia, WHC, Ab + Gyn + Ab client

The core category, seeking safe and humane care, is reflected in many aspects of medicalization and psychologizing of services. Figure 9 and Figure 10 below provide visual summaries of the effects of medicalization/psychologizing of services on safe and humane care for FHC and WHC respectively.

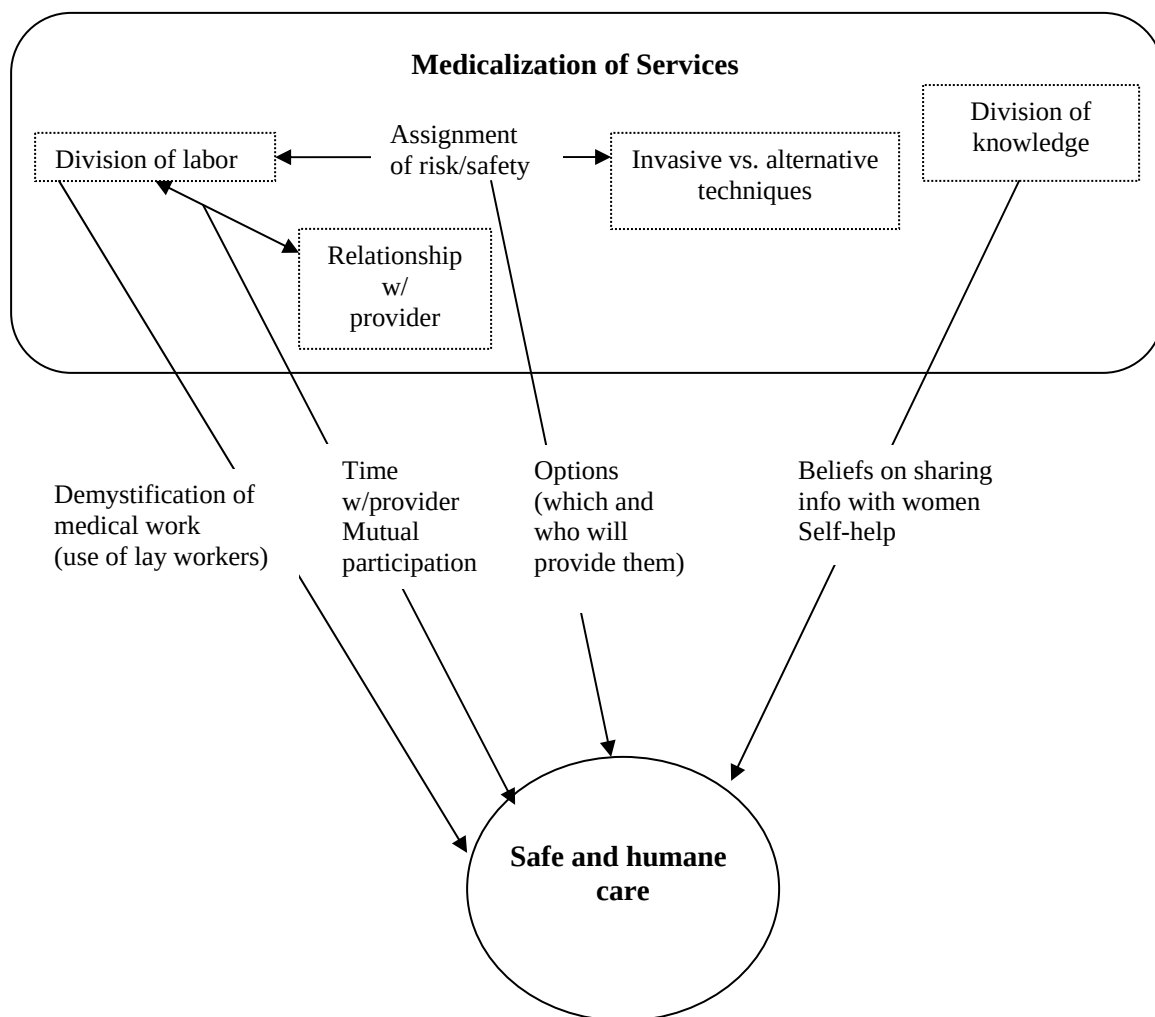


Figure 9: FHC: The effect of medicalization of services on safe and humane care

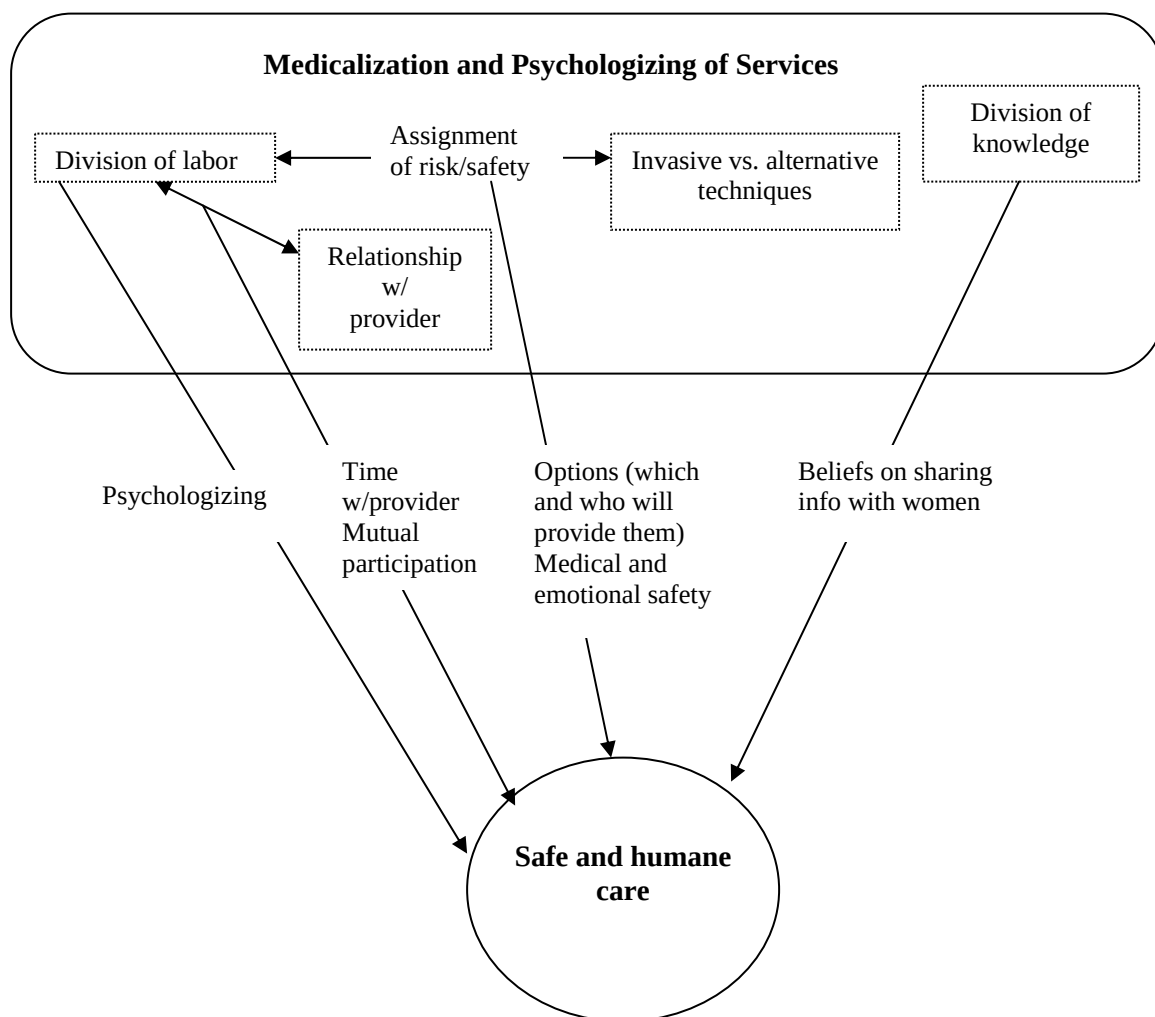


Figure 10: WHC: The effect of medicalization and psychologizing of services on safe and humane care

In terms of the division of labor, FHC used lay workers and had job rotation to demystify medical work. WHC in contrast had specialization and did not utilize lay workers. Clients in FHC, though, did not recognize the importance of lay workers. When I asked the women about the care they received from FHC and about the kind of staff they would have in an ideal reproductive care they would design, women answered that it was "ok" (and not crucial) to have lay health workers. The Women's Health Movement's vision of using health workers to demystify women's care and decrease the doctor's control over care seemed to be lost to the women. Women's preference (in FHC) for doctors or nurse practitioners depended on the information and experience these staff had and women's previous experience with physicians versus nurse practitioners. The lack of lay workers in WHC did affect the services in the area of counseling. The use of professionals and not lay women for pro-abortion counseling seemed to intensify the counseling sessions in WHC as compared to FHC. This heavy emphasis on counseling (having a counseling department, use of professionals, and having counseling at both days) was "psychologizing" abortion, which in turn acted in opposition to the agency's attempts to normalize (destigmatize) abortion. In this sense psychologizing of services relates to the "non-judgmental care" dimension of the core category.

Another way division of labor relates to the core category is through the definition and assignment of risk and safety. The hierarchy between medical and non-medical staff and within the medical staff (between doctors and nurse practitioners) affected the abortion and birth control options available to the women, the invasiveness of the options (which means an interaction between the categories of "division of labor" and "invasive versus alternative methods"), who provided the services, and in WHC whether providers focused on medical or emotional safety while providing abortion care.

In FHC, the medical directors blocked the training of mid-level practitioners. In WHC, the medical director blocked the use of manual aspirators for re-evacuation purposes. Both of

their decisions were based on assigning a high level of risk to the abortion procedure (which could only be performed by doctors and in the case of re-evacuation, with more invasive techniques such as D & C). The decreased use of medical abortion in WHC (which was administered by the doctor, not the nurse practitioner) was also possibly due to the assignment of a higher risk to that abortion option. In WHC, Sharon also mentions that the doctors emphasize medical safety while the counselors focus on emotional safety. Bridget adds that nurse practitioners are more psychosocially oriented than are doctors. As these examples show, the assignment of risk does relate to safety through determining the abortion and post-abortion (i.e., re-evacuation) options available to the women (nondirective care), who provides them (comfort), and in WHC whether the emphasis is on medical or emotional safety.

Interacting with the “relationship between the provider and client”, the division of labor relates to humane care as well. The differences in WHC between the doctors' and the counselors' approach to time relate to the "time" dimension of the core category. While for women, having time to ask questions and address concerns was an important part of humane care, doctors and counselors seemed to be pulling on opposite ends of time. Due to the doctors' power in the division of labor in both agencies, the clients' relationship (time) with the doctor was minimized. The rest of the relationships were based on a mutual participation model where the counselor, lay worker or practitioner were called by their first names and women were encouraged to participate in decision- making. The mutual participation model relates to the "egalitarian care" dimension of "humane care" where women did realize and appreciate peer services.

Lastly, the division of knowledge relates directly to "being informed" dimension of the core category that referred to the importance of providing women with all the information about reproductive issues.

Staff beliefs and motivations

In FHC, within the context of beliefs, I asked staff whether they were feminists, how they defined their feminism, and how (in their views) feminist idea(l)s of the center were translated into work. Since WHC was not a self-declared feminist agency, I asked questions on feminism only when it came up in the interview.

In FHC, the staff called themselves feminists, yet each defined it differently. There were multiple feminism(s).

Ayse: How do you think the feminist philosophy here applies kind of in practice?

Deedee: uhmm uh WELL IF- IF YOU HAD TO sit us all down in a room and ask us what feminism was you'd never get us to agree.

Ayse: and that's fine

Deedee, FHC, full-time health worker, lab manager

The different definitions of feminism(s) were all related to a basic question of feminism: what is a woman? And the definitions addressed the questions embedded in it: What is the nature of woman? What are her relationships to herself, to men, and to society at large? Duncan and Roxanne for example, believed in the inherent nurturing capacity in women that should be celebrated by women and emulated by men.

to classify L [HIS WIFE] my wife I think she's very pro-choice and very pro-woman. BUT AT THE SAME TIME I think the (PAUSE) the, her maternal stuff, I MEAN SHE'S JUST A- a wonderful mother and even a better grandmother as far as the, cause she's got those strong maternal instincts but I think that SOME WOMEN try to suppress somehow (Ayse: so you believe there's an instinct) Oh yeah I believe this. THERE'S A there's a DIFFERENCE BETWEEN MEN AND WOMEN, no question about it. (A LAUGHS: yeah) And I think that (A: sometimes) some of the best PART OF ME is my female side. As far as the nurturing side. [] And they've done a better job. Women should be PROUD OF being a woman and they shouldn't strive to be always- not not (I don't say want to say they would be like men?) but they don't have to be competing with men. I mean they should get men to compete with them for Christ's sakes.

Duncan, FHC, Doctor and Medical Director

Roxanne: But that feminism is is about being feminine just as much as it is about (PAUSE) you know fighting for equal pay and fighting for you know things like that. I STARTED GETTING INTO eco-feminism a little bit. FOR ME THIS IDEA OF OF-caring and and uhm and uhm the maternal aspect of it is really big for me. like I really think that uhm the way care about- IN THIS COUNTRY the way we care about the environment to our military to politics to our school, system, like ALL OF IT is from a very masculine point of view and TO ME it's- it's INJECTING that- that feminine point of view as much as possible in places where it's been totally banished.

Ayse: yeah. But do you see this feminine side as more uh natural to women like something natural?

Roxanne: I do. I mean and I- an I just think it's because we have babies, and (A LAUGHS) we're mommies, and we know what that's about. And it is something that I think that's more inherent in in women

Roxanne, FHC, part-time health worker

Linda's description of feminism, on the other hand, includes woman as a social being, and the nature of woman as dynamic rather than as determined by the forces of nature. Accordingly, for her, feminism means "bucking the (patriarchal) system" by personal and social action, and women making choices without an apology.

But I think FOR ME FEMINISM IS UHMM (LONG PAUSE) Ohhh god it is hard, It's PROBABLY, I'll use the term again self-determination that I AM ABLE TOO UHM (PAUSE) MAKE CHOICES without you know WITHOUT APOLOGY without- and not just choices, reproductive choices, but I'm able to make a choice to YOU KNOW UHMM, if I- If I wanna live in a cabin in the middle of the woods in AN AGE OF TECHNOLOGY. You know that could seem CRAZY, but TO ME IT SEEMS empowering and feminist to something to do outside of the NORMAL guidelines of WHAT WOMEN CAN and you know and are supposed to and able to do. SO PUSHING THE ENVELOPE on WHAT WOMEN ARE SUPPOSED TO DO. UHM You know CAN YOU (PAUSE) HAVE very close friends, that stay over night and STILL BE A HETEROSEXUAL WOMAN (A LAUGHS) [] BUCKING THE SYSTEM, pushing the envelope, saying WHATEVER YOU KNOW YOUR ARCHETYPE IS, whatever YOUR IDEA of a woman is, it's (A: doesn't exist) it's EVER EVOLVING, EVER CHANGING.

Linda, FHC, Director

Linda ties this to feminist care, to providing women with what they need without judgment.

AND- empowering and providing feminist care I guessed- I guess is JUST (PAUSE) WITHOUT saying all those things, IN THE MOMENT, whatever a woman is coming to you NEEDING, it's again, IT'S LIKE, you don't have to- you don't have to apologize for what you're needing, wanting, and thinking. UHM and giving some of the all the TOOLS

to be able to- or as many tools as you CAN. You can't certainly give someone ALL THE TOOLS I think that's SELF-ABSORBED (A LAUGHS) to think I- have ALL THE TOOLS BUT (A: to give) as many as- AS MANY AS I HAVE AS A PEER. I'm GONNA GIVE TO YOU. I'm a peer BECAUSE you're a woman and I'm a woman.

Linda, FHC, Director

In describing (their) feminism, other staff also emphasized self-determination, having "choices", making one's choices/decisions without apology, and respecting other's choices (without judgment). As can be seen in Linda's quote and in the quotes below, these feminist beliefs do relate directly to "safe humane care" in the areas of non-judgmental, non-directive care where women are equipped with knowledge, not coerced into choices, feel respected in their choices, and are treated as peers.

SO. I'd think of (PAUSE) uhm feminism as being uhm AS HAVING A CHOICE. In WHATEVER. It doesn't necessarily mean you know contraceptive choices but in general Annnnd uhm being accepting of others REGARDLESS OF what their opinions are, of VIEWS ARE. Uhm just to be totally accepting of differences UHHH (PAUSE) SO I THINK THAT the health center really does a good job of that with our clients. In that you know we- we aren't judgmental of people that COME IN HERE regardless of why they're here OR if they come back. Or then you know however many times they come back if they have. Yeah AND REALLY TRY TO GIVE people (PAUSE) a- a feeling of being open, regardless of their choices

Deedee, FHC, full-time health worker

I guess that hmmm [feminism is] you know women have a say in how to live their lives and that they they hmmm feel in control and independent and choices, their choices regarding anything aren't dictated by anyone else but themselves that they feel that feel that they can pretty much do anything they wanna do or not do anything they don't want to.

Marcie, FHC, full-time health worker

I probably drive my boyfriend really crazy. I OWN MY OWN HOME, I FIX EVERYTHING. EVEN WHEN I WAS MARRIED, I did the fixing, I did all the plumbing or REPLUMBING of the house (A: wooo LAUGHS) the only thing I really don't do is power tools. (LAUGHS) I don't really want guys opening doors for me I- YOU KNOW I'm fully capable of doing that (A LAUGHS) by myself fully capable of working and earning my own money I- I- (PAUSE) wanna do OWN CHOICES. I don't want- NOT THAT I DON'T WANNA GUY IN MY LIFE TO- TO do things WITH. But I wanna do things WITH, I don't (A: ??) I don't want someone taking care of me. You

know if I'm sick and dying he can take care of me (A LAUGHS that's allowed) UHM BUT NO. It's MY body, I wanna do what I want with my body, it's my life I'm gonna do what I want with my life. And if he chooses to be in that life with me, then that's the way it is. SO UHM I do (A: and in terms of the reproductive health issues, your beliefs?) Oh I THINK women have a right to choose (A: ?? what you said yeah) what is right for them. AND NONE OF US- I- I'VE BEEN IN A POSITION where I THOUGHT this one was making a really bad choice. But it's NOT MY DECISION. And the only thing- MY ROLE as a practitioner is to support her decision and give her the information that she needs to make that decision. THAT IS THE ONLY ROLE that I have. SO I am very clear about that UHM I HAVE BEEN IN A POSITION where I've felt VERY UNCOMFORTABLE with the decision the woman is making BUT UHM THE ONLY TIME that I WILL PUSH IT is if I think someone is making a decision and they number one don't have all the facts, or number two are being coerced into making that decision by someone else and then I will- I will tell them I think you're making their own decision because of this. I- if this is your decision, then I think this is going on. BUT everyone has the right to make their own decision.

Sally, FHC, Physician's assistant

Within the feminist beliefs of staff, there were some problematic areas that came up in the interviews. These were on connecting the personal to the political, in fighting against medical power, and serving women of other cultures and anti-choice clients.

In addition to staff beliefs, some of the motivations of staff -their goals in serving women- also related to the core category. In FHC, these were empowering the women to take control over their reproduction in particular and their lives in general, participate in their care, and to become active in normalizing abortion (through talking to other women about their abortion and participating in pro-choice rallies).

[my goals] are to make women feel (PAUSE) uhm RESPECTED for the choices. To help women to feel that THEY HAVE CONTROL over whatever situation. Like I FEEL LIKE THIS IS JUST ONE SITUATION- the abortion issue decision. You know YOU'RE COUNSELING THEM but YET (PAUSE) if you give them that control and respect them AND AND if they HAD be part of that that that can travel over other ASPECTS OF THEIR LIVES to make them feel like "WELL I AM an independent woman who is VERY (PAUSE) CAPABLE of making my own decisions REGARDLESS OF whatever- you know what that decision MAY BE" and to- to make women feel comfortable. SOMETIMES I feel concerned that how much can you do

through in a short period of time but you just HOPE THAT IF- if much of your time with them and then other person use their time, then it all adds up it's ?? ?? that it will SINK IN somewhere.

Felicia, FHC, Full time health worker

OH, DEFINITELY. I HAVE I don't have expectations but I have goals. I'D LIKE TO SEE WOMEN UHM (PAUSE) at pro-choice rallies and I'd like to see women which goes beyond what we can do here but relates to the whole stigma of abortion but I'd like to see them SPEAKIN OUT about their experience and I'd LIKE TO SEE THEM you know, show up at rallies and just talking openly. And starting you know, with themselves de-stigmatizing the procedure, you know. TELLING PEOPLE that they had abortion.

Hazel, FHC, Education and Outreach Coordinator

As these quotes show, FHC's staff aim to provide a space where women feel respected and in control of their reproductive decisions (which corresponds to non-judgmental, non-directive, dignified care, and staff feminist beliefs on women's ability to make their own reproductive decisions). The staff further hopes that this experience will carry over to decisions in other areas of a woman's life, that it does not only provide a safe space during care but empowers her to take control over her life in general (including reproductive life). The motivations also show that the staff expect the women to become active participants in removing judgments over abortion (making abortion safe and normal).

Figure 11 provides a visual summary of the effects of FHC staff's beliefs and motivations on safe and humane care. The figure also depicts the interaction between staff's beliefs and the division of labor in the agency, where the flat structure, the use of lay workers and job rotation were due to the feminist mission of the center and maintained by the feminist beliefs of the staff.

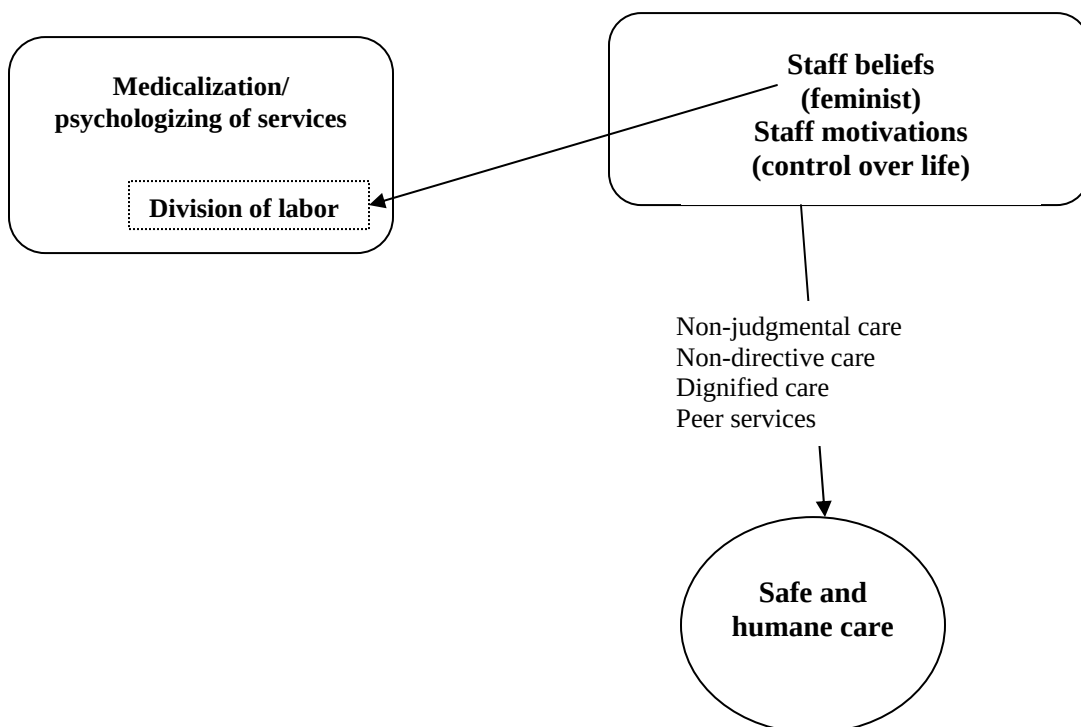


Figure 11: The interactions between FHC staff's beliefs and motivations, division of labor, and safe and humane care

In WHC, only a few staff identified themselves as feminists. Most described themselves as "pro-choice".

Ayse: So you would define yourself as a feminist?

Janet: Oh absolutely. (A LAUGHS) Absolutely. It's funny that I ASK, EVERY SINGLE one of my prospective employees that question. And no one knows how to answer it. Because everyone has a different has a different definition of what a feminist is.

Ayse: But DO THEY CALL THEMSELVES?

Janet: NOT EVERYONE DOES. YET IN MY DEFINITION, THEY ARE. See cause I- I separate feminism (A: (application?)) and activist. I'm not really an activist. But I'm I'm completely 100 percent a feminist.

Janet, WHC, Executive Director

It seems that it was not the different definitions of feminism, but the negative connotations of the word "feminist" (which FHC staff was also aware of) that prevented some of the WHC staff from identifying themselves as "feminists". For example, Bridget, the Nurse Practitioner, hesitates to call herself a feminist even though her beliefs and practices (e.g. on self-help gynecology) do, in my view, make her very much of a feminist.

I DON'T KNOW. Uhm depends on how you define feminist. You know I just believe in a woman's RIGHT TO CONTROL HER- her FERTILITY. That I do. Yeah.

After this, Bridget discussed -what I would call her very feminist- views on emergency contraception. Then, her hesitation to call herself and her daughters feminists returned.

WE'VE DONE THAT in college campuses, and we've become VERY VERY PRO-ACTIVE in that field. Everyone who leaves here, can have a prescription for emergency contraception. Just tuck away somewhere IF YOU NEED IT. And I think it's an important thing. IT EMPOWERS women to take some control. Uh save our patients from coming in. (A: yeah. sure) As far as I'm concerned, I'D LIKE TO SEE THEM, (PAUSE) TAKE, cigarettes out of the vending machines and instead put Plan B in there.
.....

And it's- IT'S AMAZING because both of my daughters have grown out to be SUCH- I don't know you know again FEMINIST IS A STRANGE WORD, BUT so very devoted

and COGNIZANT of women's health issues. And committed to maintaining you know AT LEAST, GOOD standards for women.

Bridget, WHC, Nurse Practitioner

Ayse: would you call yourself A FEMINIST?

Jill: AHHHH. We had this discussion in class the other day (A: LAUGHS oh no) UHM I would say YES. As much as a negative perception as people get with the word feminism and feminist-

Ayse: (INTERRUPTING) yeah. DO you do you have a negative perception, or negative connotation, whatever?

Jill: ahh (SIGHS) I think I do but I think that's only because everyone else does in society cause kind of pushes that ON YOU. But we took a TEST, and I'm like eighty NINE percent feminist. [] SO, as negative as the connotation as the word gets sometimes, I am a feminist. 88% (LAUGHS, A LAUGHS TOO)

Jill, WHC, intern

There were also some anti-choice beliefs among the staff:

I introduced myself to more of the people. A nurse and two students doing PA and nursing degrees. Dr. Sam will not do abortions after 14 weeks. [The nurse] said she wouldn't feel comfortable working at some of these clinics that provide abortion beyond 14 weeks. I asked why. She said more complications, more anesthesia needed etc. She said she diverges from the pro-choice people here, that if women are given 15 weeks, they may make their decision, if 21 weeks, they will wait till 21. I said not the teenagers who don't even KNOW the legal limits. She said once they've been in the situation, they do.

WHC, Observations, March 21-23, 2002

And there was an evolution in staff's -feminist or pro-choice- beliefs as well:

well I'm very much of a feminist. And I I always support. Uhm, you know, abortion on demand I actually think we should have free abortion in this country. And free birth control so maybe even further LEFT THAN lot of PEOPLE. I really have no problems about it. I the one thing I've learned FROM WORKING HERE, is just more the emotional aspect of it. Uhm I think- I don't think I ever I thought seriously about the RANGE OF RESPONSES that one might get. Cause I've had abortions. But it has just you know, it wasn't pleasant but it wasn't a traumatic emotional experience. (A: what ?? range of responses) I mean everything from complete denial of their emotions to

ACCEPTANCE, to "I'm going to burn in hell, but I HAVE NO CHOICE". Uhm and everything IN BETWEEN. But I think what I'm saying is that the issue was much more black and white for me before I was working here. Where it was just "Abortion, I'm PROCHOICE! What's the big deal". It also guess that we had to make this- you know uhm this uh you know this available to women and keep it legal. OR you know and those people are wrong. Whereas NOW, it's more ?? my views are still THE SAME VIEW same kind of- same pro-choice (A: yeah yeah. ?? all those things) But I think I've come to RESPECT uh the PRO-LIFE movement, at least saw the elements of it. And I think that their view is OK. I don't FOLLOW IT MYSELF. But I believe that many of them are very sincere and I will see them as having NO choice but to protest if THEY BELIEVE that's what's going on there is completely un- immoral. Then have a ethical obligation to pro- protest, these people logic upon, the logical argument upon which they base this fallacy. (A LAUGHS: ok. total sense out of) I think they're nuts but (A: and the consistency of the nut behavior) yeah

Sharon, WHC, Counselor

And I also like to (PAUSE) talk together pass it on, give normalcy to abortion. When I first worked here, I had a pager that if the nurse at the school needed to call me about my son, they could page me. SO I never wanted them to call, wanted nobody to know that I worked here. Now I'm not like that.

Chipper, WHC, Medical Services Coordinator

Whether they called themselves feminist or pro-choice, the beliefs of the staff converged around women's control over her body, her reproduction (meaning control over her decisions, and owning the decisions), and having equal rights with men.

uhm I believe a woman has a right to choose what SHE DOES with HER BODY

Jill, WHC, intern

I THINK THAT (PAUSE) every child a wanted child, that was the Planned Parenthood uh tagline a few years back. Raising children is hard work, it's FUN WORK, but you pretty much need to be able to wanna do it. If you don't wanna raise a child, you're ill-equipped to raise a child, if- ON- ONLY the individual that can determine whether or not she can bring the patience and the understanding to child rearing SO I think that abortion is a valuable option because (PAUSE) THIS MAY BE A ?? PREGNANCY but few years from now, her life can turn around, and she might not even have that future opportunity. IF- IF it hadn't taken place here. SO uh I THINK IT'S NONE OF MY BUSINESS what somebody else does. I can't live their life for them. I uh (PAUSE) I feel very fortunate that I live in this particular ERA, when I was able to space my children the way I wanted

them to be. Uhhh (PAUSE) I could never begin to tell somebody else, how to live their life. What the right decision for them is.

Mary, WHC, Lab Manager

Ayse: yeah yeah. IN WHAT WAY WOULD YOU call yourself a feminist?

Janet: I- I think that you know women need to be empowered, they should have the equal rights as to anyone you know uhm NOT THAT they should have more rights, but equal. And full control over their reproductive health care. That there should be no government interference with that. YOU KNOW JUST, NOT ONLY WITH the reproductive health care but just for their own LIVES. You know empowering them to make decisions in their lives and not uhm RELY ON OTHERS to do it for them.

Janet, WHC, Executive Director

Janet discusses her feminism within the context of the pro-choice movement and as a right to privacy. Sam's quote below has the same definition of women's abortion rights as freedom from government interference.

[my goal is] to give women THE CHOICE. You know I think I think the people who have stick their nose into other people's business HAVE NO RIGHT TO DO THAT. And they think their (PAUSE) their morals, their ethics, should be everybody's you know. In a multicultural society, different people are you know believe different things. IF SOME PEOPLE don't wanna have abortion, THAT'S FINE. But then don't don't TELL ME WHAT TO DO

Sam, WHC, Doctor and Medical Director

Closely related to these beliefs were staff motivations or goals in serving the women. These were providing safe, comfortable care, helping women make the best decision for themselves, and normalizing abortion, for which again (as in FHC) client participation was needed.

what are my goals working here? That's a good question. I THINK it's to INSURE THAT THIS KIND OF WORK GOES ON. That women continue to have a place that they can gooo to make- to be comfortable in their reproductive decision-making. I think there are so many places that is ?? ?? at gynecologists in this area, WHOO WAS ACTUALLY be quoted in the newspaper saying he would LIE to women about how far pregnant they were, so that they would NOT MAKE A DECISION TO ABORT. IF he thought they

might make a decision to abort. Annd (A: how ethical) I think that is very frightening. And I think there is also places that women are PUNISHED for their decision.

Bridget, WHC, Nurse Practitioner

My biggest goal is for them to have a POSITIVE EXPERIENCE. ...BUT ON THE VERY BASIC level, for them to be supported (A: sure) FEEL SUPPORTED. TO FEEL LIKE they're being listened to, AND UHM GETTING the care that they need and the services that they want. SO uhm you know at a fee that they CAN AFFORD.

Janet, WHC, Executive Director

But just always the most important thing is is patient care. There's always uhm- we wanna make sure- that this is one of the most difficult decisions anyone EVER HAS TO MAKE in their lives. And just making sure uhm for how difficult it is, we try to make it AS- I don't know if EASY is the word but, AS COMFORTABLE as possible uhm you know, they are already having such a difficult time, we don't want to make them any more difficult. SO, it's always looking out, always trying to make sure that you know, (a) this is the right thing for them. This is what they truly want to do. BUT ALSO you know getting them through the process in the best way possible. SO, THAT'S A GOAL always trying to maintain. That also safe pro-REPRODUCTIVE CARE

Lynn, WHC, Head Counselor

safe care. Uhm understanding. Helping them define (PAUSE) THE RIGHT CARE FOR THEM. Right kind of birth control. Helping them determine if this is the right procedure- RIGHT WAY for them to proceed

Mary, WHC, Lab Manager

uhm I'd like to improve- improve my ability to with my helping skills ?? AND IN GENERAL just to understand other women might go through the life altering decisions And uhm I'd like to learn more about how they deal with their situations or how they cope with others. [] Also be somebody just here to listen to them. And also someone (PAUSE) uhm to help them realize that they have the ability to take, participate in decisions that that it's so much your decision, what they wanna do with their body. THAT THEY DO HAVE the power to make their decision for themselves those three are.

Shery, WHC, Counselor

I mean this is like on a very large level, [I would like women] TO BE ABLE TO TALK ABOUT THEIR EXPERIENCES with other people. SO that it becomes destigmatized. And they can FEEL GOOD ABOUT IT.

Janet, WHC, Executive Director

Taken together, the beliefs and motivations of the WHC's staff emphasize safe, non-judgmental, non-directive care (listening to women, helping them decide). Janet, Lynn, Sherry and Sam's discussions also reflect an assumption that abortion is a psychological phenomenon, the "most difficult decision a woman has to make in her life." Seeing abortion as such contributes to what I will discuss next, psychologizing of women's reproductive care, which in turn conflicts with the staff desires to normalize abortion (to destigmatize it). In the normalization of abortion, as in FHC, there were again expectations of clients to become active participants in the process.

Figure 12 provides a visual summary of the effects of WHC staff's beliefs and motivations on safe and humane care. Similar to Figure 11, Figure 12 also depicts the interaction between staff's beliefs and the division of labor in the agency, where the staff's beliefs that abortion is a psychological event is related to the use of professionals (i.e., counselors and counseling students) instead of lay workers.

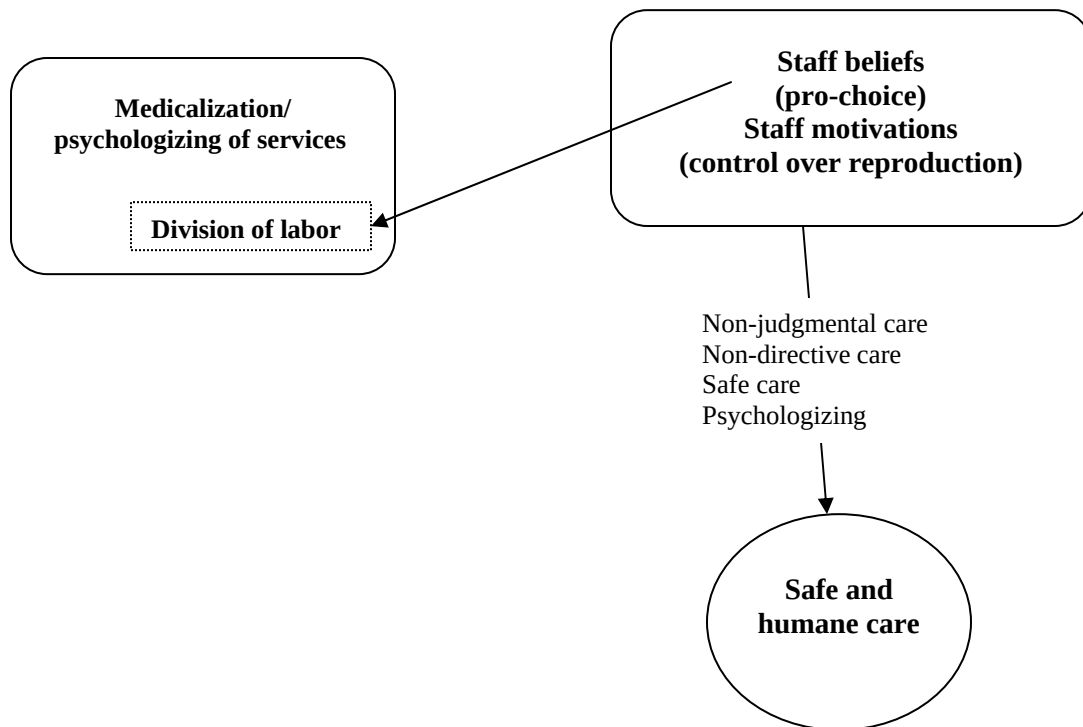


Figure 12: The interactions between WHC staff's beliefs and motivations, division of labor, and safe and humane care

Women's health business: Balancing care and business

The last agency factor that emerged in relation to the core category was business aspects of abortion and birth control services. FHC is a non-profit agency that runs with client fees and fundraising efforts. WHC is a for-profit agency that runs mainly with client fees. Both agencies had limited funds for staff salaries, benefits, and outreach activities. At both centers, staff discussed competition with other agencies that provide abortions, and the need to balance care with business.

In FHC, the competition was between FHC and Planned Parenthoods in the area.

as I'm sure some people have talked to you about the Planned Parenthood uhm issue. The difference between Planned Parenthood AND US. We have a real US VERSUS THEM mentality. Some of us do here. Because historically Planned Parenthoods have moved into communities that there are already providers, undercut their prices and put them out of business. (A: Yeah they do that) So someone, so someone- SOME CLINIC, whether it's a- you know just a private physician's office, who's JUST PUT THEIR NECK ON THE LINE, had their building bombed, you know been picketed and threatened for years and the community had a HARD TIME ACCEPTING them being there but finally they've made a place for themselves GET PUT OUT OF BUSINESS. When Planned Parenthood realizes that- that the the air is clear AND the community accepts it and we know what the risks- THE INHERENT RISKS ARE, THEY MOVE IN. So it's like basically the WALMART versus the you know (A: the local) So the concern for me is that they have three sites south of us. It's where the majority of our population comes from. Uhm NOW it's- it's such a FINE- you know TO TALK TO- such a- very SENSITIVE THING to bring up with donors cause donors for the most part are donating to the issue. THEY MAY CARE ABOUT US, and they may really believe in the- THEY MAY UNDERSTAND AND BELIVE IN the quality of care that we give and why that- that model is different than maybe from Planned Parenthood's model. But most people DON'T. they just care about WOMEN being able to access services. Abortion, reproduction, whatever reproductive rights. SO I THINK THAT uhm when we try to APPROACH PEOPLE with what kind of threat we have coming down the pipe, it's gonna be really difficult to talk about because the- THE ANSWER, you know THE RESPONSE FROM PEOPLE IS, why- we aren't the SAME THING? THE FUTURE LOOKS TO ME like WE NEED TO- it's a lot of where our building renova- FOR ME taking a risk in building renovations TAKING A RISK IN UHM getting an ultrasound. Taking a risk in hiring more staff. WE'VE GOTTEN- you know VERY- as I have said before VERY INSULAR, we weren't REACHING OUT TO THE COMMUNITY, and we weren't hiring staff. We were sort of getting by. Cause we were THE ONLY ACT IN TOWN. [] Well it's not gonna be like that anymore. It's really weird to talk about abortion and talk about market competitiveness (A LAUGHS) IT'S ALMOST LIKE you're not- like it is- (A: like you're selling) YEEEAH. Like we're doing

SOMETHING BAD being a businesswoman around decisions that you're making and and recognizing competition (WHISPERING) It's weird.

Linda, FHC, Director

As can be seen from Linda's quote, competition with Planned Parenthood agencies, combined with the donors' lack of differentiation in care (provided by feminist agencies versus Planned Parenthoods), affect care in FHC through limiting resources for building renovations, and buying an ultrasound. Building renovations and ultrasound do relate to the core category through, respectively, providing a homey space and safe care for the women. Figure 13 below depicts the interactions between business aspects, agency atmosphere, division of labor, and safe humane care.

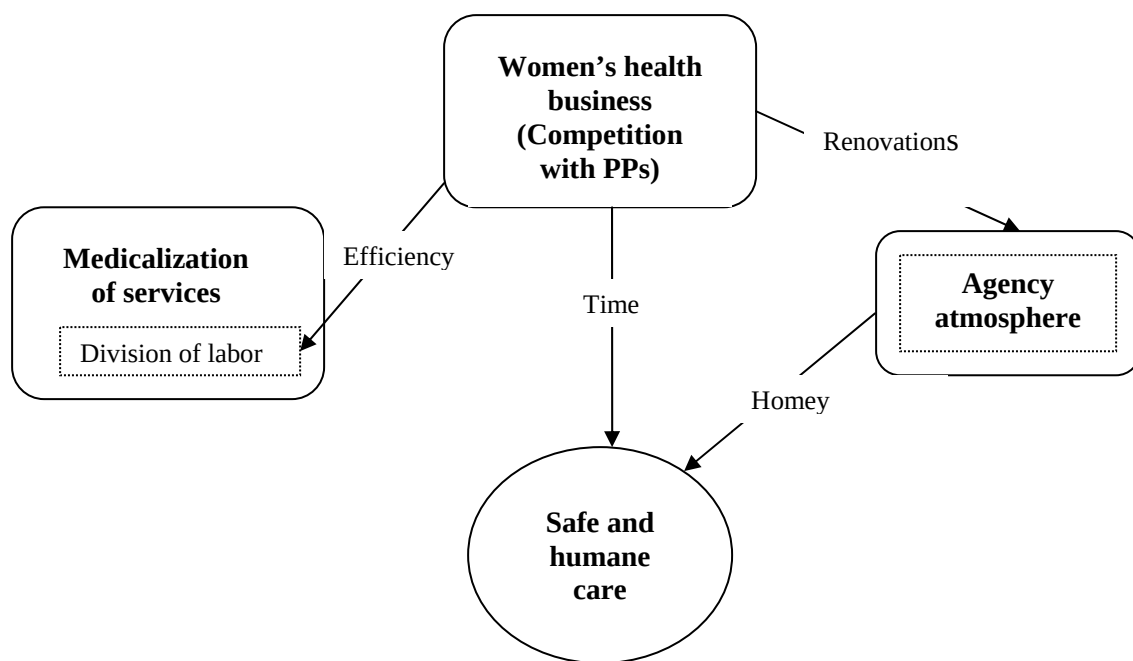


Figure 13: FHC: The interaction between women's health business, agency atmosphere, division of labor, and safe and humane care

FHC staff's recognition of the business aspect of reproductive work was also evident in their frequent references to "time" and "efficiency." These concerns combined with frustrations over the decision-making process, and for Iris, with the changing needs of women, led to significant changes in the flat collective structure of the agency. FHC replaced consensus with two-thirds majority vote:

AND I CAN'T EVEN like SAY THIS IS A FLAT STRUCTURE. WHEN YOU LOOK round. THERE ARE STILL patterns diffe- differentials of power. PART-TIME PEOPLE DON'T HAVE really decision-making power here. THEY DON'T KIND OF GET the benefits that we get. I mean it's governed by non-profit law BUT THERE IS REALLY (A: some) some IMPROVEMENTS WE COULD MAKE and going back to a place where there's more inclusiveness. But when you're talking about trying to make MAJOR DECISIONS FOR AN ORGANIZATION, with eight or nine people VERSUS 25 (A: uhum. 25?) Time is- YEEAH. AT LEAST 25 with the part-time people TIME IS MONEY. And you can just sit there in a staff meeting going round and round and round and if everybody's supposed to be HEARD. You know there used to be a TIME WHERE (A: consensus?) we made decisions by consensus, RIGHT. (A: I know. Yeah) (SIGHING) OHHH (A: LAUGHING it's not working) DID IT WORK! Even two-thirds can be tricky because people KNOW THAT not- I mean there can be MANIPULATION IN IT (A: ??) well YOU KNOW. YOU CAN COUNT YOUR support on something or you can count your opposition or you can abstain from a vote and abstaining itself will throw a vote the other way

Linda, FHC, Director

FHC was also moving towards increased specialization in roles (including specialization in medical roles) in the "interest of efficiency".

We're we-re REALLY involved in the direct provision of health care in ways that they aren't NOW that we just we just don't do anymore. WE KIND OF SWUNG a little bit back toward the medical model and rely on our PRACTITIONER FOR (PAUSE) A LOT that we relied on ourselves for back in the seventies and early eighties. (Ayse: Why do you think that happened?) I THINK it's evolution. AGAIN, that women's health movement happened at the time that it happened for a reason I DON'T think that women's needs are quite the SAME AS THEY WERE uhmm I (PAUSE) I think it's also just BEEN HARDER to have- I mean when I came here, there were twenty people on staff. It's- IT'S harder with fewer people to provide the SAME KIND OF uhmm sort of PEER services that we did before with with health workers who really becoming really educated about a lot of women's health issues, and being, spending a lot of time talking with women about those things uhmm just in the (A: that was more practical) interest of efficiency, you know I think that we gradually (LOWERING THE VOICE) sort of left a lot of things up to the practitioner.

Iris, FHC, full time health worker

Iris makes a connection between the changing times (change in women's needs and emergence of business concerns such as "efficiency") and peer services, which women clients defined as a dimension of "humane care". Increased specialization (including medicalization) was also caused by increased state scrutiny over their operations and the lack of insurance reimbursements for lay workers. These will be discussed in the next section.

At the time of my visit, FHC staff was discussing one more significant change, that of adopting an external board of directors. Duncan and Iris believed an external board would ease FHC's financial burdens, without, according to Iris, necessarily threatening the collective structure.

I mean as far as the services that they PROVIDE. And I think without a a a board of directors that who could, like they are always strapped for money and I think with a board of directors, if they have a development group that would money and do stuff like that, I think they would be far better off. AND I TALKED TO THEM BEFORE about that and they nod their heads and say yes but they never do it.

Duncan, FHC, Doctor and Medical Director

WE provided financial support for- for a spin off [feminist counseling] organization so THEY formed as a collective and uhm I don't know when it was that they got an outside board but they they have an outside board but they still function, they still run their own affairs you know day-to-day management is still done on a collective basis by the group of women who work there. So, I think their board is for long term planning uhm fundraising, uhm you know fiscal work, (A: administrative ??) fiscal management uhm and THAT'S THE KIND OF THING that I envision for US, that it will be not a not a board that will be really involved in our day-to-day affAIRS but will help us have you know VISION for the future and be able to connect us with the larger community and do fundraising and

Iris, FHC, full time health worker

Linda, in contrast, thought that, while increasing the legitimacy of FHC in the community, an external board would threaten the feminist structure.

THAT'S WHAT A BOARD IDEALLY DOES FOR YOU. That there are prominent people in the community like a physician on the board, a YOU KNOW a lawyer, a person with money, a client, this whole collective mix. I feel THAT WOULD REALLY HELP the organization move to new places but at the same time. I've seen other flat structure

organizations like us. And TALKED TO THEM ABOUT IT say "don't change, don't change" cause the- THE ENTIRE MISSION went into the hands of these people COMPLETELY OUTSIDE of the organization. Who DON'T PROVIDE DIRECT SERVICE. Who don't understand the needs of the organization (A: SO) and (A: There is a hierarchy) YEAH and they're making decisions that REALLY, in application (A: in practice) DON'T WORK yeah.

Linda, FHC, Director

WHC also faced business pressures aggravated by the laws around abortion and increased state scrutiny over their operation. The laws and policies regarding abortion (such as the 24-hour waiting period and parental consent laws) increased competition with agencies in the neighboring state without such laws, while the increased state scrutiny over their procedures led to liability concerns.

well, one of the MAJOR CHANGES, is that, we had to deal with the Abortion Control Act which is the law that was passed in 1994. That required a 24-hour waiting period. Uhm and the minor ?? law which requires minors to have parental notification or go through judicial bypass. That was A MAJOR, MAJOR CHANGE. That happened in 199, it was in 1994. Because we'd see patients in one day who didn't have any concerns. But we saw a lot more patients at that time too. There's a lot more education that's involved. There's a lot more (PAUSE) LIABILITY that's involved. Which is unfortunate because you have to- not that we've never had informed consent. But things are scrutinized a lot more than before.

.....

Well we haven't we had to figure a way. Because patients had to ?? ?? ? ???. And in [NEIGHBORING STATE] it isn't a law. SO, uhm you have to think of it now not as a patient ?? but as a business aspect. Which is unfortunate but you have to weigh that. SO trying to work it out. And also for convenience and to the benefit of the patient, not have then come twice. SO that's how we started having phone consultations where we can have a person talk on the phone and. IT JUST MADE IT MORE TIME CONSUMING. That, our our appointment process used to take five minutes now takes FIFTEEN to schedule an appointment. SO, LOT MORE, it's just a lot more TIME CONSUMING YOU KNOW. For the patients themselves like, it just made- it just made it more time consuming for them you know. As I said most of the time I think patients have made the decisions. There always gonna be patients who are unsure. And they definitely come in, speak with someone, that's not a problem but patients WHO HAVE MADE THE DECISION NOW, THEY STILL have to wait longer. Cause when someone calls, they wanna been seen yesterday. They don't wanna wait

Chipper, FHC, Medical Services Coordinator

BUT ON THE VERY BASIC level, for them to be supported (A: sure) FEEL SUPPORTED. TO FEEL LIKE they're being listened to, AND UHM GETTING the care that they need and the services that they want. SO uhm you know at a fee that they CAN AFFORD. Uhm and it's again a delicate balance. With SOME WOMEN WE FEEL like we spend so much time- like one of the women that I was dealing with this morning, who has this medical condition that makes it very difficult for us to do the procedure here YET, WE SPENT SO MUCH TIME WITH HER. And she hasn't paid us anything. You know it's like YOUR HEART GOES INTO YOUR WORK. And you you gotta balance that with you know what you deserve to be paid for that too (LAUGHS) You know, we have to value that ourselves (A: sure) But you know our hearts are always ?? what needs ?? SO providing good care and really being that- if they're calling around to different clinics, you know, being the one that sounds the nicest on the phone.

Janet, WHC, Executive Director

Chipper and Janet are discussing how competition and liability concerns (as affected by the change in abortion laws), impacted care, through the dimensions of "time": increasing number of visits to the agency and women's time on the phone and in sessions (with increased documentation for informed consent). Chipper also mentions how the new law reveals a lack of trust in women's capacity to make a decision. She touches an important aspect of empowerment, one that was brought up only by feminist clients of FHC.

WHC had a medical and hierarchical structure. The business worries and increased scrutiny helped maintain this structure, through increased use of medical personnel (instead of lay personnel).

PATIENT ADVOCACY was always first and foremost no matter what. I think that THEME (A: went ??) YEAH. I don't think that's changed very much. Our (position?) is always about always meeting THE patients' needs BUT WE ALSO HAVE TO BALANCE THAT with medical safety. And not doing anything that's gonna put us AT, RISK. Uhm to open us up to EITHER LAW SUIT or YOU KNOW PROBLEMS. BAD CARE. SO we're very concerned about that. Which is why we use RNs. We have medical assistance too but there's always an RN in the procedure area and in the recovery room.

Janet, WHC, Executive Director

Figure 14 below summarizes the interaction between women's health business, division of labor, and safe and humane care.

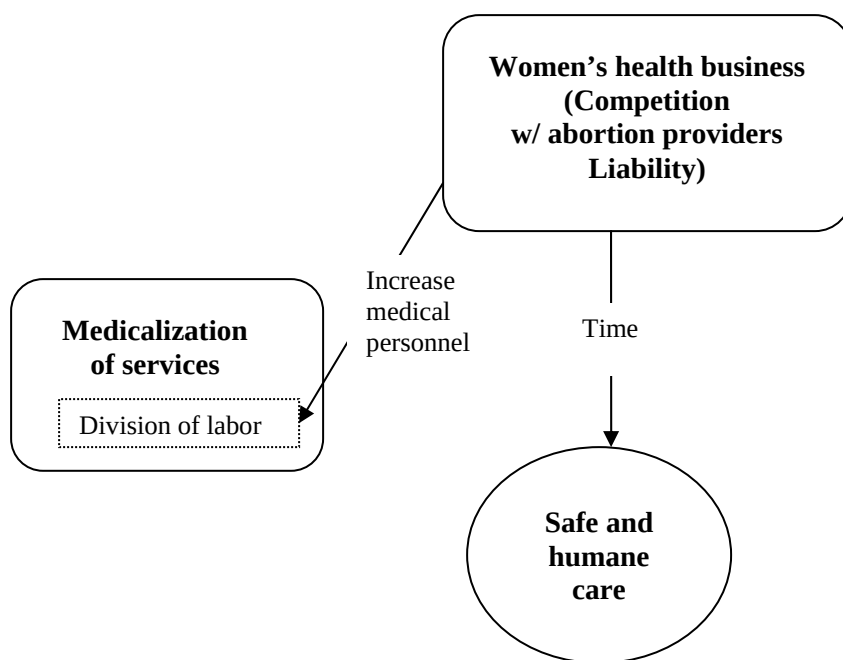


Figure 14: WHC: The interaction between women's health business, division of labor, and safe and humane care

SOCIETAL FACTORS: POLITICS OF REPRODUCTION

Politics of reproduction refers here mainly to the extent to which reproduction is "normalized" (birth control and abortion are recognized as normal life events and as rights of women) versus stigmatized and criminalized. Politics of reproduction affected the core category directly as well as indirectly. The indirect effect was mediated through the workings of legal, economic, and medical systems as well as women's awareness of these, and the agencies' navigation of these systems.

The direct effect of politics of reproduction on the core category can be seen in the emergence of "safety" as a category for both clients and staff. Affected by stigmatization of and violence around abortion, both groups talked about feeling vulnerable and judged (for providing or receiving abortions) and emphasized the importance of physical and emotional safety. For the clients, the stigmatization of abortion is seen most clearly in the "non-judgmental care" and "individualized care" dimensions. Women's conflicting feelings around abortion (including statements such as "I never thought this would happen to me"), women's feelings of being judged by the society, family, and even by their own Ob/Gyns, and seeking, in turn, validation, confidentiality, privacy (individualized care) and a space specialized for preventing pregnancy, all show the awareness of the shame and stigma associated with abortion in the society at large.

WELL I MEAN, it's- THINK IT'S IT'S AN an issue that is just SO NOT SPOKEN ABOUT (A: true it's HUSH HUSH). And so totally needs to be yet not been through it's not the days of the June Beaver or Carol Donna Reed or whatever their names. You know it's not the 50s any more and it is time that women understand. [] I think it can NASTY CONNOTATIONS. In the minds you picture all these clinics you SEE ON THE NEWS, all the picketers and the rioters and it's. I think it's such an EMOTIONAL EVENT. EVERY TIME YOU SEE it ON THE NEWS, or any time you hear the word abortion, that's usually what it is, it's some big news thing plastered on the TV and the papers uhh but REALLY, uh I wish more people would look at it and just understand abortion is just a choice. It's a choice you make.

Claire, FHC, Medical Ab client

I think more people, IF PEOPLE- if people knew more women have them, they might be more understanding. Like they think, you know, (Ayse: birth control?) oh, you know, and abortion like, you know it's an immoral woman. But if they just knew it! And I know a lot of woman who have had'em that you would not think have had them cause people keep it quiet but (Ayse: yeah they do) yeah (Ayse: it keeps us all quiet) yeah. AND IT'S NOT REALLY anything to be quiet for because there's so many people that need help and they can't get it cause nobody. You just see people protesting and then you hear this huge controversy about abortion and men getting involved but they don't know how it feels you know and they should just keep their mouths shut. [] You know if there was somebody like a role model this country looked up to, like maybe Hillary Clinton, somebody who had an abortion and spoke about it or something people would shut up about it and maybe realize like you know, IT HAPPENS.

April, WHC, Gyn and Ab client

These women exemplify women's awareness of the stigma over abortion, which silences and shames women and prevents them from seeking abortion services. These two women further offer ways to "normalize" abortion, by talking about it, by naming it. In relation to this, it is interesting to note here that in FHC, the room where abortions were performed was called the "procedure room", and in WHC, abortion was called "termination", showing the staff's inability to overcome this stigma either. I have to confess that, sensing this silence over it, I called abortion the "procedure" in some of my interviews as well. April and Claire's comments also coincide with the staff goals of having more women talk about abortion.

There were other women, though, who were aware of but also had internalized the stigma of abortion and judged themselves and other women for the abortion decision. This was seen in the feelings of guilt, seeing abortion as a "lesson", and in women's allusions to who deserves abortion.

Jana: I think it was A VERY IMPORTANT thing for me to to- to go through it all. And I wouldn't change anything because TO ME IT KIND OF (A: hmmm ??) TO LET ME KNOW what's about (A: ?? yeah) it's something that you- you- I think EVERY WOMAN SHOULD GO THROUGH. If it's their decision you know. Instead of being put to sleep they should go through this [local anesthesia] (Ayse: I see) You're awake, you know, what's going on

Ayse: hmmm, BUT DO YOU MEAN, MORE LIKE (LAUGHS) A PUNISHMENT OR? Or just to KNOW?

Jana: I THINK, (PAUSE) YES. TO ME, it was kind of a lesson. I don't know for other woman but to me it was kind of a lesson. BECAUSE, I- my grandmother always told me you know, childhood (stops? or is not for?) getting pregnant but it was a mistake that the condom would break whatever. (A: and it happens yeah) BUT it was a lesson because of the relationship I was in I I should have known that HE WASN'T- I don't know maybe he ? going through ?? I'm going through it. But to me it was a lesson. And hard to explain

Jana, FHC, Ab client

Because it's one thing you know when you're young, and you don't have money and you're not in a stable relationship, and it's almost like for situational reasons, that almost gives you the for lack of a better word, a better excuse. You know ?? ??of course you know I wouldn't you know emotionally or financially be ready to care for a child at this point in my life. And uhm, I think sometimes, and I- I, even speaking from my own experience with it, sometimes the perception, of a woman who IS MORE MATURE, maybe more financially stable, it's almost like more of a what she should do, she is selfish kind of thing. AND I CAN REMEMBER EVEN making those judgement calls myself, EVEN THOUGH I'M PRO-CHOICE, just thinking of myself, NOT REALLY JUDGING the woman BUT just thinking she could do this if she really wanted to you know. It doesn't matter why you don't wanna be a parent why you don't wanna be a parent. If you don't wanna be a parent, THANK GOD places like this exist. You can have abortion and it's safe and it's legal. Good care for you. Both for your physical and emotional needs [] WE WERE BACK AND FORTH about what we thought we wanted to do. Had I gone through with my FIRST, GUT FEELING, WAS, and this is exactly what I said to myself, well you know you are 35 years old, you should be able to handle this. That was my first, AND I WAS JUDGING MYSELF, REALLY but.

Eileen, WHC, Gyn and Ab client

While discussing abortion decision or the protesters, some women made comments about who deserved abortion (rape victims, and women who had "accidents" in birth control) and who did not (promiscuous women and women with multiple abortions).

We were sitting in the abortion clinic and there are these girls in there talking about this is their FOURTH ABORTION, and WHAT ARE YOU DOING? Like my heart just breaks for them. BECAUSE (PAUSE) JUST WHAT'RE YOU DOING? WHY are you getting pregnant FOUR TIMES? And you just think it's that easy, that you can get- WHY IS IT SO EASY FOR YOU that you can get rid of your children? (Ayse: do you think it's easy for them?) IT MUST BE if you're getting knocked up time after time. That's how I feel like. It HAS TO BE. OK, ONE TIME, TWO TIMES. Everybody's entitled to make a mistake. BUT, three and four times, THAT'S YOUR FAULT. THAT IS YOUR, YOUR there's just to me there's no EXCUSE FOR THAT. There's so many options of protection.

And I can say yeah I didn't use protection but I knew the consequences. And they fell back on me and I had that option. I would NEVER PUT MYSELF THROUGH THIS again. If I got pregnant, there is no way I would abort another child. There's just no way I could DO IT BUT, FOR SOMEBODY TO SIT THERE AND THINK "oh this is my first abortion. Hehehe" WHAT IS FUNNY ABOUT THAT? TO ME there is nothing funny. YOU KNOW, BE RESPONSIBLE, GROW UP. If you're growing up to spread your legs and have sex, THEN USE A PROTECTION. Cause I'm sure you didn't have four abortions OF THE SAME GUY.

Christa, WHC, Ab patient

Uhhh you know, I never saw myself in that predicament but you can't predict your future. You know I mean you can- WE TOOK all the safe- (A: precautions) WE DID EVERYTHING that we should HAVE DONE uhh uggh (SIGHS) so it's not as if a guilt of "well. You know I slept with six guys. On one weekend, I've never seen them again" You know what I mean, it was just a A FLUKE

Nancy, WHC, Ab and Gyn client

The politics of reproduction also had indirect influences on the core category, through the workings of the legal, economic, and medical systems, women's awareness of these systems, and the strategies used by the two agencies to navigate these systems.

In the legal sphere, the politics of abortion was reflected in the laws surrounding abortion and birth control that normalized or further stigmatized these services (relating to "non-judgmental care"). Figure 15 and Figure 16 depict the direct and the indirect effects of the legal sphere on the core category, where the indirect effects are mediated by community and agency factors

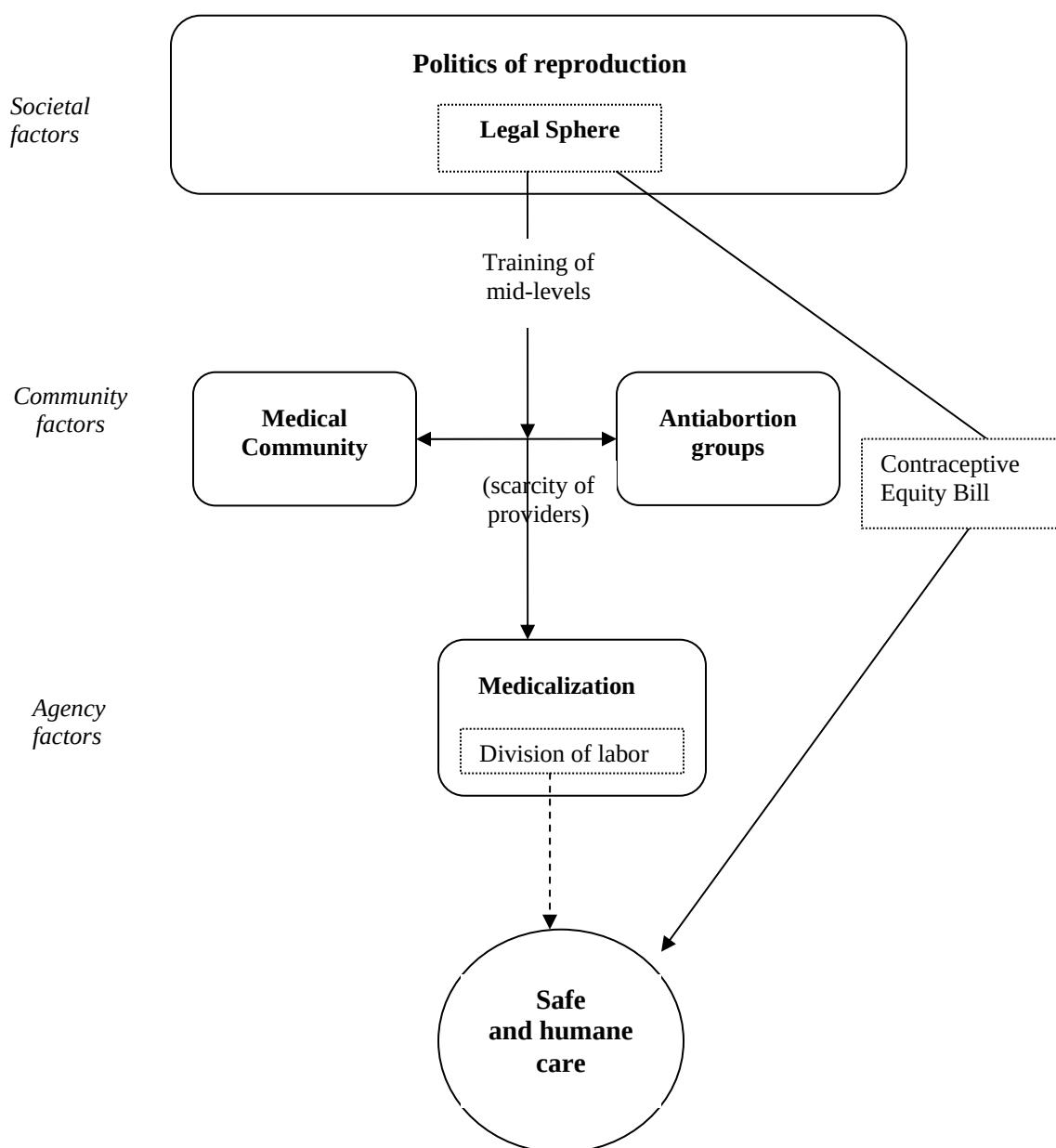


Figure 15: FHC: The direct and indirect effects of the legal sphere on safe and humane care

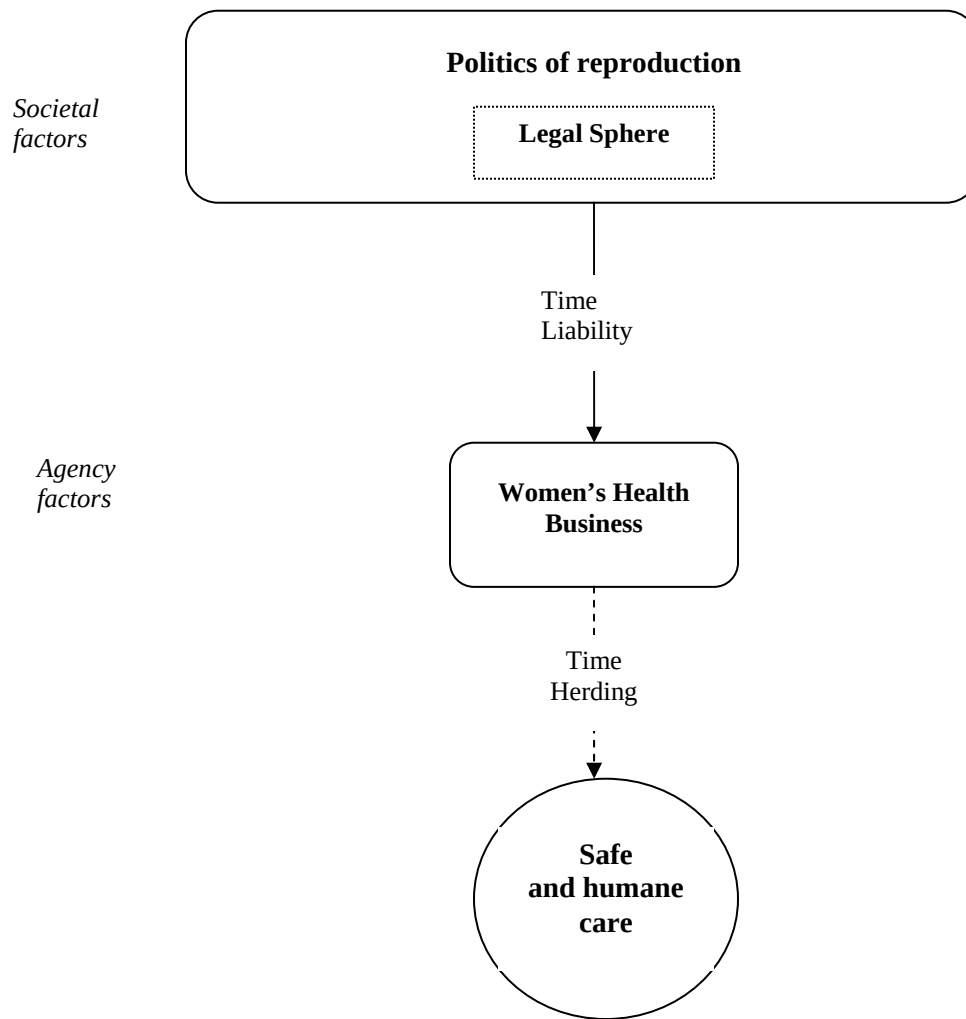


Figure 16: WHC: The direct and indirect effects of the legal sphere on safe and humane care

The state where WHC was located had a 24 hour waiting period and parental consent laws, which affected the core category mainly through the dimension of "time" and "individualized care". The laws increased number of visits to the agency to which WHC responded by adding phone consultations. WHC also chose to give the state information through a group video, which decreased time in visits, but gave the women a sense of "being herded" (a dimension of "individualized care"). Lastly, the laws, combined with liability concerns over increased state scrutiny, led to increased documentation in consents, procedures, etc., which again

increased "time" in sessions. As discussed in the "women's health business" section, the laws also aggravated competition with other agencies in neighboring states with no such laws, and affected financial support of the staff.

The state where FHC was located did not have a waiting period or parental consent laws, and even had a loophole that allowed training of mid-level practitioners for abortion (which would increase abortion providers and decrease doctors control over the procedure). FHC wanted to use this legal opportunity to train mid-level practitioners; however, the medical director blocked the process. FHC's state also had passed a "contraceptive equity bill" which normalized contraceptive care. The success, though, as discussed below, was mediated through insurance policies (economic factors).

In the economic sphere, the politics of abortion was reflected in the insurance coverage of abortion and birth control services and in insurance reimbursements for lay workers working on gynecological care. Figure 17 and Figure 18 depict the direct and indirect effects of the economic sphere on the core category.

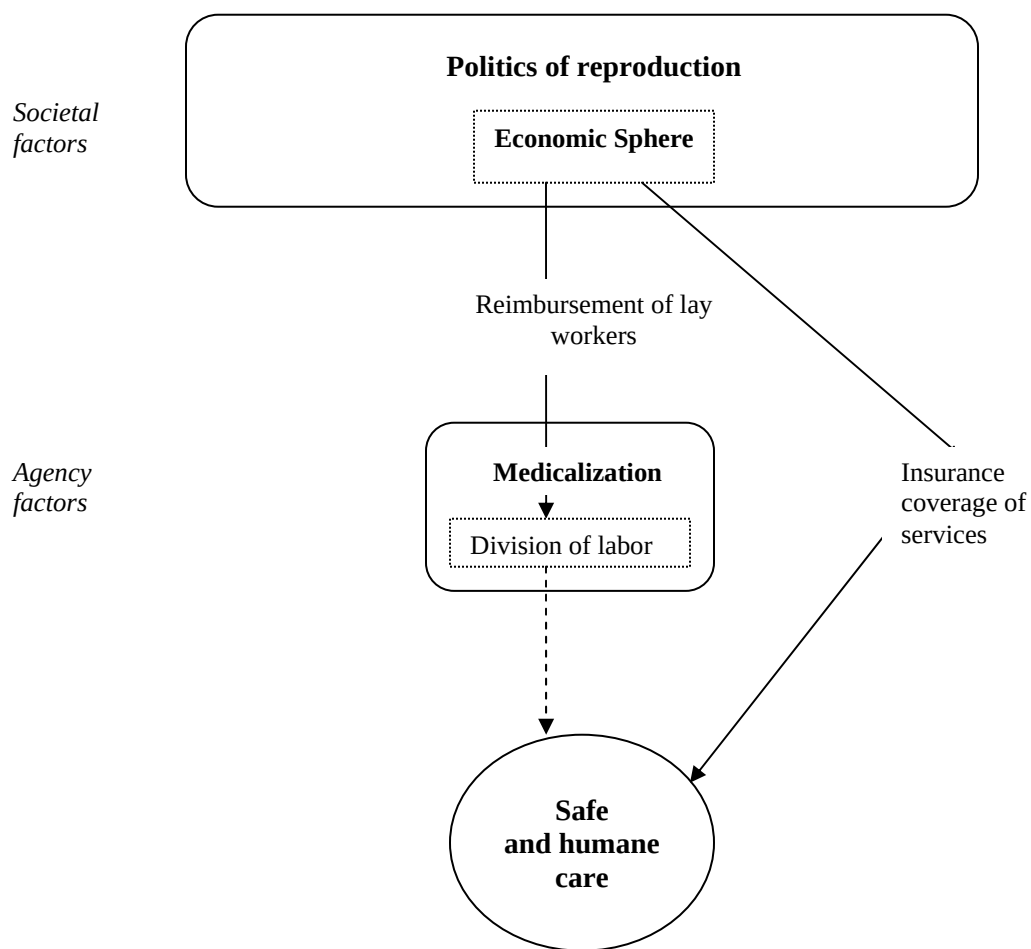


Figure 17: FHC: Direct and indirect effects of the economic sphere on safe and humane care

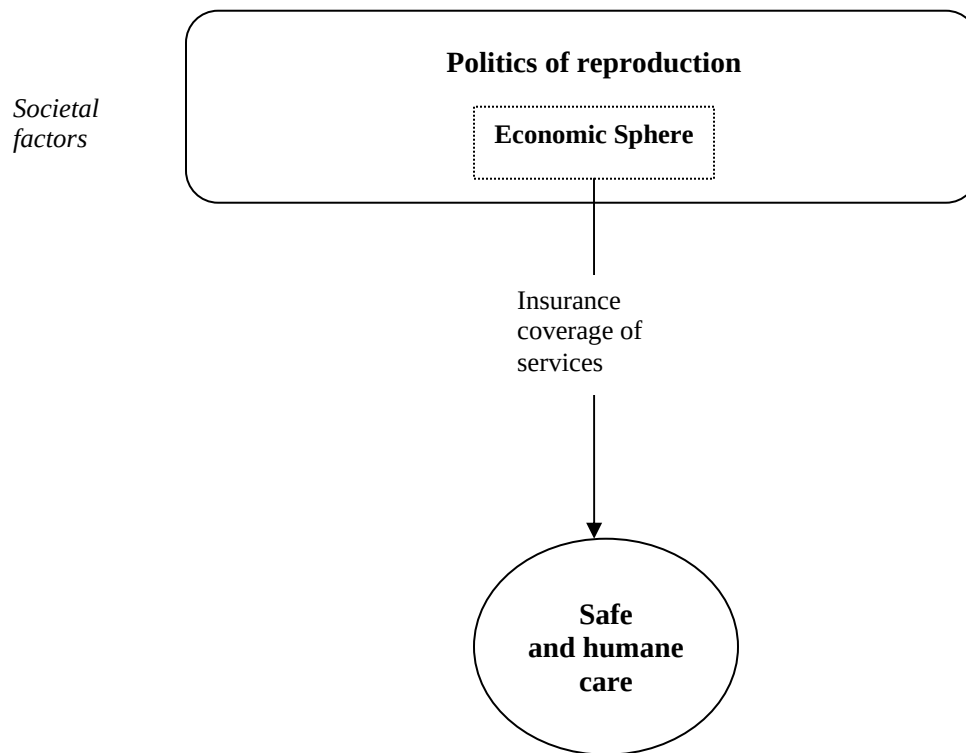


Figure 18: WHC: Direct and indirect effects of the economic sphere on safe and humane care

Staff of both agencies discussed increased insurance coverage for abortion and birth control services (FHC's state had passed a "contraceptive equity bill"). The success of these in normalizing abortion was mediated by the policy limitations as well as women's awareness of their insurance coverage, of the limitations over coverage (and its contradictions), and their willingness to use their insurance for abortion or birth control.

It's like I REALIZED that the plan I had working for the health center, WOULD COVER ABORTION. When I first started working here, it covered 450 dollars procedure. But it wouldn't cover a 50 dollar diaphragm. (PAUSE) You know and that was PRIOR of course to the contraceptive equity bill that was passed last year in this state. WHICH WAS REALLY IMPORTANT. So that ALL FDA APPROVED BIRTH CONTROL METHODS HAVE TO BE covered by the HMOs. IT PASSED a couple years ago but went into effect January of this last year so will be a- it's a year old in January UhM UNFORTUNATELY it's problematic in a lot of different ways in that (PAUSE) WOMEN HAVE CO-PAYMENTS, pharmacies have, have PHARMACEUTICAL CO-

PAYMENTS and there are PREFERRED drugs and THERE ARE NONPREFERRED DRUGS. And so if you're on the PREFERRED PILL WHICH might be a cheaper pill (A: I see), they'll cover you IN FULL. And they'll cover you at a good co-payment, a 5 dollar co-payment instead of 25 dollar co-payment. BUT IF ORTHO-TRICYCLEN works for you, it's not in the formal areas preferred, you're gonna be paying CLOSE TO what PAYING OUT OF POCKET might be ANYHOW. SOO THEY MAKE DECISIONS around what's preferred PLUS IF YOUU HAVE (PAUSE) like say [] SO IF THE LIFE OF A METHOD, like the IUD IS TEN YEARS WHAT GOOD (PAUSE) is paying a co-payment, every month over ten years. YOU'RE NOT- (LAUGHS) yeah you're not gonna do that. You're gonna cough up the 400 dollars for the IUDs. SO I think that, in terms of birth control, it's STILL A LONG WAY TO GO with insurance companies. And private carriers aren't REQUIRED, AT THIS POINT, you know, to provide EQUAL COVERAGE FOR for women as for men. Uhm so like something like Walmart who is notorious for their policies around coverage yeah. Won't provide emergency contraception TO WOMEN out of their pharmacies, bringing prescriptions in. Or ANY CONTRACEPTIVE COVERAGE TO THEIR FEMALE EMPLOYEES. BUT THEIR MALE EMPLOYEES HAVE FULL BENEFITS (A: interesting) all the way- all the way to VIAGRA. (A: discrimination, viagra. I'm amazed by that yeah) yeah RIGHT. BUT MOST MAJOR HMO- major HMOs have UHM have been covering abortion. SO (A: so ???) so private carriers IT DEPENDS THOUGH on where you- where you work. Because like if you work at X Hospital and the carrier is XXX. GENERALLY most people's plans ALLOW that. BUT a CATHOLIC you know CHARITY IS GONNA put an exclusion provider on that policy that says abortion is excluded

Linda, FHC, Director

My interviews with the clients showed an awareness of birth control and abortion coverage as well as awareness of the limitations of the system and its sexism.

yeah I'm stuck, I have to pay cash because the way the insurance works. My insurance won't cover it and I can't afford to get insurance that WILL cover. (A: yeah. cause it's expensive) but honestly and truthfully for my entire life of having to pay for such expenses it's never been covered by insurance. Just this state happens to be one of the ONLY places I ever heard of THAT COVERS IT. (A: this is the annual exam or the?) ANY OF IT. Well annual exam MAY BE COVERED under (A: it should) under regular physicals but any form of birth control or preventing or anything along those lines IS NOT COVERED by any other insurance. None of the ones that I've been on, either not the pill, or the shot or anything. (A SIGHS) Cause I I called AND ASKED. The company that we're still with for the next couple of weeks. And no I'm sorry we don't cover.

Crystal, FHC, Gyn client

Ayse: how do you usually pay for your visits?

Sonia: (LOWER VOICE) cash

Ayse: ok. all of them?

Sonia: yes yes. Insurance policies actually don't cover- like for some odd reason, you can get Viagra so you can have sex but you can't you know- do nothing to PREVENT (A: exactly) something from happening.

Sonia, WHC, Ab + Gyn + Ab Client

Ayse: How do you pay for the visits?

Elizabeth: I pay by cash.

Ayse: ok. the insurance?

Elizabeth: no, my insurance didn't cover it. They're anti (A: aggh! ANGRILY) yeah.

Elizabeth, WHC, Ab patient

There were still some women who were not aware of their abortion coverage and were surprised that their policies covered abortion.

And believe it or not different, my insurance- the different insurance I had covered it. (Ayse: yeah, they do) yeah was surprising. Cause I said I don't know if it will or won't you know so it's like it did covers it so.

Veronica, WHC, Ab + Gyn client

don't believe how many women when we'll say "oh what kind of insurance do you have?" an I say ?? abortion they'll say "my insurance will pay for this" like it's shock women.

Felicia, FHC, full time health worker

INSURANCE- WOMEN HAVE BECOME MORE AND MORE AMAZED- I mean women are- women are amazed that more and more insurance companies are covering ABORTION. And it's stands to REASON. It's like I REALIZED that the plan I had working for the health center, WOULD COVER ABORTION. When I first started working here 450 dollars procedure. But it wouldn't cover a 50 dollar diaphragm. (PAUSE) You know and that was PRIOR of course to the contraceptive equity bill

Linda, FHC, Director

There were also fewer women (two at WHC) who were not aware of their insurance coverage of contraceptives.

Ayse: And do you have insurance to pay, for the visits?

Nancy: UHMMM. NO (A: hmmm) I- I- I HAVE INSURANCE. But- but I don't think the insurance covers the depo.

Ayse: It might cover. Did you check with them?

Nancy: I NEVER REALLY CHECKED

Nancy, WHC, Ab + Gyn client

since insurance switched. They're taking the Blue Cross Blue Shield. I DON'T KNOW how it really works. I've been paying it all always out of pocket. Let's leave it like that. I was always paying out of pocket. It's taxed- it's a tax write off for me at the end of the year.

Veronica, WHC, Ab + Gyn client

Even when women were aware of their insurance coverage of abortion and birth control, not all women were willing to use insurance.

I HAVE INSURANCE well I HAVE health insurance THAT TOOO, pay for the check ups but for my birth control, I didn't want my parents to know so I always paid for it myself (Ayse: cause they-) BUT NOW I have insurance pays for it as I'm older. I felt weird at the time. But the abortion I paid cash even though my insurance will cover it cause I don't want my parents to get a paper back

April, WHC, Gyn + Ab patient

April is twenty-one years old. She had her birth control visit when she was nineteen and the abortion visit when she was twenty-one. Her unwillingness to use her parents' insurance for birth control is a good example of the control over young women's sexuality by family and fear of judgment (crystallized in young women's choice of centers for specialized care in preventing pregnancy and in seeking "non-judgmental care").

The last factor in the economic sphere is the impact of the restructuring of the health care system (around HMOs) on medicalization of services through decreased use of lay workers in reproductive care:

The longest time the lay health workers did the pelvic exams, uhm (PAUSE) you know. I MEAN THEY'RE- they're- we lost SOME OF THAT CONTROL because of insurance. Insurance, what they will pay for. They won't PAY for a lay health worker to do pelvic exam. You can't get reimbursed. A LOT OF- a lot of (A: was it always like that or did they change?) YEAH. It wasn't like that before HMOs became the common thing now with HMOs, it's- it's- profit driven you know. It's not based on HOW you know (A: ??) IT CERTAINLY we can't completely dis- DISREGARD you know medical- medical stuff, you know good decision-making BUT YET that's why you know we can't have anyone doing ultrasound. It has to be a practitioner. We can't have just anyone do a pelvic exam. IT HAS TO BE- and that wasn't true until probably the late mid-80s. That's when things started changing.

Felicia, FHC, full time health worker

In the medical system, the politics of reproduction is reflected in the limited number of ob/gyns who provide abortion services and the decreased training of medical students for abortion (Please Figure 19 below for a depiction of the direct and indirect effects of the medical sphere on the core category for both centers).

I mean there were situations where doctors were shot because yeah. Uhm, I read an article that there're fewer uhm students in medical schools that are electing to even learn how to do abortion procedures. They don't want to ?? be providers.

Eileen, WHC, Gyn + Ab patient

Sam: And we have agreements with with hospitals if we get into trouble and we have agreements with GOOD HOSPITALS. And you know and we try to reciprocate by TRAINING THE RESIDENTS THAT wish to come here. IT ALWAYS AMAZES ME HOW FEW of the residents want trainings they- they don't wanna get their hands dirty. They're afraid of the hassle

Ayse: yeah yeah. It's not man- mandatory is- right? (Sam: no. no) the abortion training?

Sam: no. IT SHOULD BE. Because it is an intricate part of of the specialty. You know IF EVERYBODY- if everybody was willing to DO THEM (PAUSE) uhhh there wouldn't be A NEED FOR clinics like this.

Sam, WHC, Doctor and Medical director

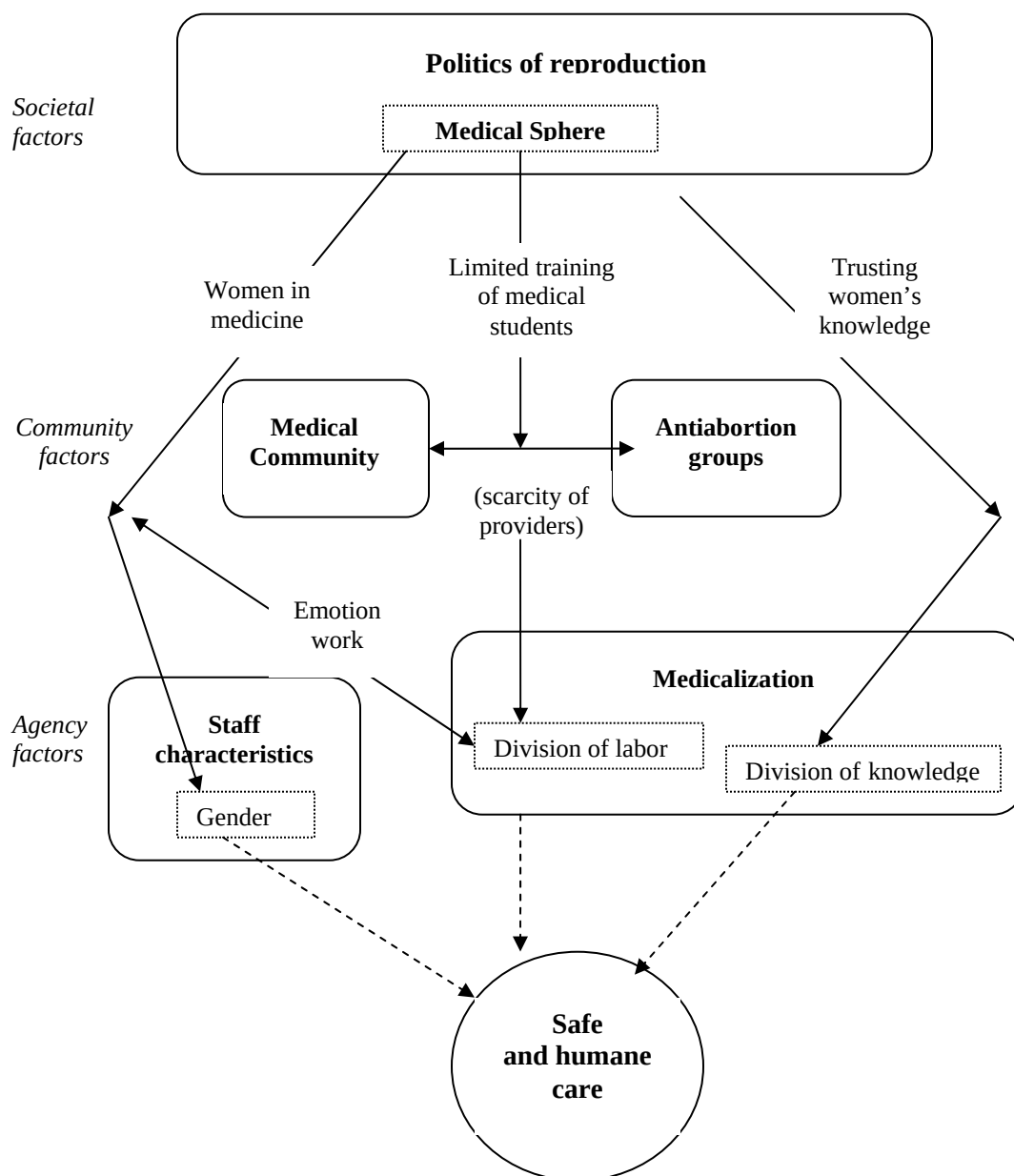


Figure 19: The direct and indirect effects of the medical sphere on safe and humane care for both centers

Eileen and Sam are discussing the connection between stigmatization of and violence over abortion and decrease in providers. As Sam alludes to it, not providing abortion training in obstetrical/gynecological education itself reveals a judgment and blocks normalization of these services that would be achieved through inclusion in the regular curriculum and widespread provision.

The politics of reproduction is also seen in the treatment of women in medicine.

To Nel I asked if in her education she encountered any sexism. She said not really, but she said she noticed a difference between male and female practitioners especially in Obs where the male doctors only take care of the technical parts and leave the nurturing (care) to female nurses, who have to follow up with the women after delivery, take care of her before delivery, be involved in the grieving process, if lost a child. Nel said the nurses in these situations would get upset and tell the doctor the patient saw them before and would want to see them after delivery as well too. She said they discussed this sexism issue in class too, discussing whether it is a male/female or doctor/nurse thing. I said probably both. She said yes.

Conversation with Nel, WHC, March 21, 2002

sometimes I put in Laminaria. On the day of their abortion. Uhm they are YOU KNOW they never delivered practically or if they're a little bit farther advanced in pregnancy it's something to dilate the cervix, to make it easier for them. And I would put that I do that. Sometimes I think nurses have a little bit more gentle approach than physicians TO SOME OF THESE PROCEDURES, you know (B LAUGHS, A LAUGHS: yeah) they're more PSYCHOSOCIALLY you know, oriented (A LAUGHS: capable) yeah. A little bit more sensitive on some of these issues.

Bridget, WHC, Nurse Practitioner

Both Nel and Bridget are referring to a division of medical labor among nurses and doctors, which ran along gender lines (where the *female* nurses are doing emotional work and *male* doctors are doing more technical work). In WHC, this was mirrored in the division between the medical and counseling staff (where the counseling staff was all women). These relate to "gender" under "staff characteristics" where women preferred female providers for compassion and empathy. These quotes show that it is not merely gender but its interaction with medical hierarchy that determines how compassionate a provider is.

In addition to caring, the gendered nature of the politics of reproduction was also revealed in beliefs in medicine on the sharing of information with women and trust in women's knowledge and capacity.

Ayse: You said THE ONE GOOD THING is that they prepare the client till then [till they come to you] SO- (D: yes they do, they do a good job) YEAH YEAH do you think the DOCTORS could do that (LAUGHS) ever in the future

Duncan : uhuh (A: why not doctors, I know doctors, doctors are) well in our office [means his private practice] for instance, I think there is a philosophy sometimes you can tell them too much and I subscribe to that. I think that sometimes they tell the clients too much and I think on the other hand, I think that we don't tell them nothing I think it usually could be a SIN to to- you have to- ONE THING YOU HAVE TO LET THEM UNDERSTAND IS THAT what they're doing is NOT AN INSIGNIFICANT thing. BUT AT THE SAME TIME, (PAUSE) you don't wanna scare them either, you don't wanna DETER THEM by you know by saying you're killing the baby so it's a- I THINK it's it's tricky, it's very tricky just the whole scene is very tricky.

Duncan, FHC, Doctor and Medical Director

being here is that WE DO EVERYTHING TO INFORM WOMEN about anything that's going on with them. You know and like we SHOW THEM THEIR CHART you know like I've been to doctors (A: not hide it from them). They hide it, they won't let you to look at your own medical chart and it's like you know like we'll show them exactly what we've written down about them.

Roxanne, FHC, part time health worker

YOU KNOW I- I HAVE A CERTAIN PHILOSOPHY with the women is that I GIVE THEM THE INFORMATION AND THAT WE PARTICIPATE TOGETHER IN in choosing what's best for them based on the information that I can give them. I'VE ALWAYS PRACTICED LIKE THAT, it's not ANYTHING NEW FOR ME. Uhm uhm, I'VE ALWAYS BEEN ONE OF THOSE PEOPLE WHO really STRESSED patient UHM information, EDUCATION, (LOWERING THE VOICE) uhm, and my patients know where they stand SO uhm HASN'T ALWAYS LIKE THAT IN MEDICINE UHM AND SOMETIMES I got BUCKED FOR BEING LIKE THAT, "oh the patient doesn't need to all that stuff" YES THEY DO. IN MY OPINION (?? Must needed to know that?) that's the way I practiced and MAYBE THAT'S BECAUSE THE WAY I WANTED TO BE TREATED MYSELF being a practitioner that's just the way I wanted it to be. SO and NOW it's kind of the STANDARD that you inform your patients of any decision SO

Sally, FHC, Physician's assistant

I DECIDED TO COME HERE, primarily BECAUSE I- having worked at (PAUSE) ANOTHER FEMINIST HEALTH CENTER, believe in the mission of the feminist health centers in general SO uhm WAS FAMILIAR WITH the feminist health center mission so (IN A LOWER VOICE) that's primarily why (PAUSE) decided to come (A: what do you think the mission to be?) IT'S REALLY just- I always believed that a feminist health center mission AS (PAUSE) UHM TREATING the- the client the woman as a- as a client instead of a patient there's a big difference and doctor's offices are kind of looked at as a patient. You don't know the BEST about your health. THEY KNOW MORE about your health than you do and Feminist Health Centers generally take into consideration that YOU'RE THE ONE that knows most about your health. That it is an interactive process between you and the physician

Sally, FHC, Gyn client

These quotes, mainly from FHC, show how doctors still hold a monopoly over knowledge in traditional medicine by keeping knowledge from women and not trusting their knowledge and decision-making capacity. This relates directly to the core category dimensions of "informed" (client's wishes to be informed on all their options) and "non-directive care" (client's wishes to be provided information without persuasion).

Research Question 3: How do the two agencies differ in enabling empowerment?

In this section, I will discuss the differences in the two agencies in enabling (and restricting) empowerment. To this end, I revisited the core category and the related categories (community, agency, and societal factors).

DIFFERENCES IN SEEKING SAFE AND HUMANE CARE

In terms of the core category, which reflects the meaning and experience of empowerment, the main differences between the two agencies are in two domains of emotional safety: non-judgmental care and non-directive care. Regarding non-judgmental care, going through abortion in a safe space where one felt validated changed or helped question anti-abortion views of women in both agencies. However, among those women who still found the decision hard to make, as discussed before under the section on “validation”, it was mainly the clients of FHC who viewed abortion as an empowering experience and as one that made them more aware of their rights to abortion.

Regarding non-directive care, which meant receiving all options in abortion and birth control and being allowed to make one's decision without being cajoled into a choice, the differences were in the options provided by each agency. In terms of abortion options, both agencies offered surgical and medical abortions. WHC provided surgical abortions with local or full anesthesia, whereas only local anesthesia was offered in FHC. This was due to the feminist mission of having women fully aware during and active participants in services, and due to the possible side effects of IV sedation such as short-term memory loss. In terms of the abortion options, as mentioned before, medical abortion was defined as more risky in WHC, which might have indirectly led women to choose surgical abortions. And herbal abortion was not an option in either agency. Other differences in options were in the offering of options counseling (which was used more in WHC), active encouragement of emergency contraception use for women who did not want to use birth control after an abortion (which I only observed in WHC), and in allowing the use of birth control methods beyond the manufacturer's criteria. Regarding the latter, the physician's assistant in FHC did insert IUDs for women who did not have any children and were

of childbearing age, both of which are manufacturers' criteria that other providers use to disqualify women for IUD use.

DIFFERENCES IN COMMUNITY FACTORS

As discussed before, both agencies were known in their communities mainly for their abortion services, and were tagged as "abortion clinics." Both clinics felt alienated due to the anti-abortion violence and a lack of active support from the community (including their clients). In addition to their identity as an abortion provider, FHC also had a feminist identity that led to more alienation in the community.

He is a predominant, you know HIGHLY RESPECTED INDIVIDUAL in the community. Who has given US legitimacy YOU KNOW. WE WERE JUST THE RUN-DOWN CRAZY FEMS probably before Dr. Duncan CAME and NOW, WE'RE SOMETHING like I said MORE LEGITIMATE because of HIM.

Linda, FHC, Director

On a contrary note, though, three women (all gynecological clients) chose FHC for its feminist identity.

In order to fight this alienation, both agencies formed alliances at the local and national levels and reached out to schools, the medical community (individual physicians and hospitals), and other abortion providers. The differences in these alliances were that FHC had additional alliances with feminist organizations (e.g. Feminist Majority League) and with collectives (e.g. Boston's Women's Health Book Collective), and WHC was more integrated into the local medical community through referrals and especially through the medical committee.

We just don't do major surgeries. If she wanted a hysterectomy, that wouldn't be DONE HERE. (Ayse: Would they be referred?) Sure. And we have a GREAT NETWORK of physicians that are supportive of the center and we can refer to and they'll send us information BACK, with lab ??. It'S GREAT!

Bridget, WHC, Nurse Practitioner

IN THE (MEDICAL?) COMMUNITY, I think we are respected. I think we ?? medical career. Doctors, they come to our medical committee because of the fact they respect the care, they respect the physicians and the staff here so uh. WHICH IS VERY- YES it's VERY GOOD that the medical community thinks that way.

Chipper, WHC, Medical Services Coordinator

Although the staff of both agencies mentioned the scarcity of doctors who provided abortions (due to the widespread anti-abortion views, the scare of violence, and lack of training in abortion), at the time of the study at least, WHC had less difficulty finding doctors to work there.

I probably have MORE DOCTORS THAN most clinics do. A LOT MORE.
SO we feel PRETTY LUCKY.

Janet, WHC, Executive Director

DIFFERENCES IN AGENCY FACTORS

In terms of the agency level factors that enable empowerment, the differences between the two centers occurred in the domains of staff beliefs/motivations, medicalization and psychologizing of services, and business aspects.

Staff beliefs and motivations

As discussed before, the staff of FHC defined themselves as feminists while those of WHC identified more with pro-choice beliefs. Under both beliefs, a woman's control over her

body and reproduction was emphasized. However, FHC staff's feminism also included making choices without an apology and "bucking the (patriarchal) system" as a woman personally and through work. Another difference was in the WHC staff's belief that abortion was a psychological as well as a medical event, which led to the psychologizing of services.

In terms of staff motivations in providing the services, staff of both agencies aimed to have the active support of clients to normalize (destigmatize) abortion through talking about it and participating in pro-choice rallies. The difference in motivations, which relates to feminist vs. pro-choice views, is the mention in FHC of empowering women to take control not only of their reproductive life, but their lives in general.

[My goal is] to help women to feel that THEY HAVE CONTROL over whatever situation. Like I FEEL LIKE THIS IS JUST ONE SITUATION- the abortion issue decision. You know YOU'RE COUNSELING THEM but YET if you give them that control and respect them AND AND if they HAD be part of that that that can travel over other ASPECTS OF THEIR LIVES to make them feel like "WELL I AM an independent woman who is VERY CAPABLE of making my own decisions REGARDLESS OF whatever- you know what that decision MAY BE." [] SOMETIMES I feel concerned that how much can you do through in a short period of time but you just HOPE THAT IF- if much of your time with them and then other person use their time, then it all adds up it's ?? ?? that it will SINK IN somewhere.

Felicia, FHC, full time health worker

Medicalization and psychologizing of services

As discussed previously, doctors had the most power in both agencies while the nurse practitioners and physician's assistants were situated, in the power structure, between the doctors and lay staff (or counselors in WHC). Both agencies were women-controlled and minimized the women's time with doctors as a strategy to decrease doctors' power. FHC employed further strategies such as calling doctors by their first names, use of lay workers, excluding the doctors from voting in agency matters, and requiring workers to confront doctors when necessary. The

main differences in the division of labor between the agencies were in the use of lay workers (for counseling, lab work, and as technicians helping the doctor) and the increased use of job rotation in FHC. The lack of lay worker and the emphasis on job rotation, accompanied by the doctors' and counselors' significant roles in the organizational structure of WHC, signify the medical *and* psychological model of care used in WHC.

To decrease the (medical) monopoly over reproductive knowledge, the staff of both agencies believed in and provided full information to women on birth control and abortion. In the past, FHC had also employed more self-help activities such as community workshops, cervical cap fitting groups, and a newsletter.

In terms of use of alternative and less invasive methods, which was related to the division of labor (through the doctors' power in assigning and defining risk and safety), medical abortion - a less invasive abortion technique- was defined as less risky in FHC, manual re-evacuation and abortion by mid-level practitioners were defined as risky procedures by the medical directors of WHC and FHC respectively, the nurse practitioner in WHC used alternative methods in laminaria insertion or complications after abortion.

Lastly, in terms of the provider-client relationships, in both agencies, the client's relationship with lay workers, counselors, nurse practitioners, and the physician's assistant were more interactive and mutual than their relationships with doctors. There were exceptions such as doctors who "walked the client through" the abortions; however, these were not as consistently mentioned by women as their encounters with the other staff. In FHC, as mentioned before, the lay workers had a feminist duty to confront the physician to advocate for the client, but the actual use of this depended on the feminist consciousness of the lay worker and the scarcity of abortion providers in the area.

Business aspects

Although FHC was a non-profit and WHC was a for-profit agency, they were both small budgeted agencies running mainly with client fees (and foundation grants in the case of FHC). As such both were affected by business pressures. In FHC, it was the competition with Planned Parenthood and in WHC, competition with agencies in neighboring states without restrictive laws (such as a waiting period and parental consent for minors) and the liability concerns that aggravated existing business pressures.

In FHC, the business pressures affected the feminist collective structure of the agency through providing the impetus to transition from a consensus model of decisions-making into a 2/3 majority vote, to increased specialization and to spend less time in peer education. All of these changes were done in the name of "efficiency." Debates over adopting an external board were also related to business pressures, since the board was viewed as responsible for fiscal management (through increased ties to the community).

there is another organization that actually started from here. That's a counseling uhm a counseling -feminist counseling service. THEY formed as a collective and uhm I don't know when it was that they got an outside board but they they have an outside board but they still function, they still run their own affairs you know day-to-day management is still done on a collective basis by the group of women who work there. So, I think their board is for long term planning uhm fundraising, uhm you know fiscal work, fiscal management uhm and THAT'S THE KIND OF THING that I envision for US, that it will be not a not a board that will be really involved in our day-to-day affAIRS but will help us have you know VISION for the future and be able to connect us with the larger community and do fund raising.

Iris, FHC, Full time health worker

Business pressures of FHC also threatened staff salaries and pensions (thus staff financial support), building renovations (thus non-medical atmosphere of the agency), and technological improvements such as purchasing an ultrasound.

In WHC, the business pressures also affected the agency structure. Liability concerns led to hiring of more Registered Nurses to work during abortion and in the after-care area, which strengthened the medical model of the agency. Business pressures also affected "time" spent in visits (which relates to "humane care"), against which the agency adopted measures such as phone consultation and the use of a group video. Lastly, similar to the FHC's director's comments, WHC's Executive Director also mentioned the effect of the pressure on staff salaries (thus again staff financial support), which she resolved by balancing care and business.

[My goal for the women is for them to] FEEL SUPPORTED. TO FEEL LIKE they're being listened to, AND UHM GETTING the care that they need and the services that they want. SO uhm you know at a fee that they CAN AFFORD. And it's again a delicate balance. With SOME WOMEN WE FEEL like we spend so much time- like one of the women that I was dealing with this morning, who has this medical condition that makes it very difficult for us to do the procedure here. YET, WE SPENT SO MUCH TIME WITH HER. And she hasn't paid us anything. You know it's like YOUR HEART GOES INTO YOUR WORK. And you you gotta balance that with you know what you deserve to be paid for that too (LAUGHS). You know, we have to value that ourselves. SO providing good care and really being that- if they're calling around to different clinics, you know, being the one that sounds the nicest on the phone. And you know from the phone call to recovery everyone is a counselor here.

Janet, WHC, Executive Director

DIFFERENCES IN SOCIETAL FACTORS

The differences in the enabling of empowerment also occurred at the legal and economic spheres. In the legal sphere, WHC was operating in a state with restrictive laws for abortion that required a 24-hour waiting period and parental consent for minors. FHC, in contrast, was located in a state with laws that did not restrict the provision of abortion to physicians only, but allowed the training of mid-level practitioners for abortion. The state also had passed a Contraceptive Equity Bill that required HMOs to cover all FDA-approved methods of birth control. Although these laws enabled empowering care, the training of mid-level practitioners was blocked by the

medical director and the effect of the equity bill was mediated through insurance policies that had preferred methods and unreasonable payment options. Moreover, private carriers were not required to provide equal coverage. This situation demonstrates the way the legal (state) forces interact with medical and economic power to decrease woman's control in reproductive services.

Another example of how legal and economic spheres differentially affected the two agencies was in the effects of state scrutiny and insurance reimbursement policies on the collective structure of FHC. In FHC, increased state scrutiny and lack of reimbursements for lay workers had decreased the use of lay health workers in "medical procedures" such as Pap Smears, cervical cap fittings, uterus sizing before abortion, etc. This decrease meant an increase in the division of labor where medical personnel held monopoly over medical procedures.

CHAPTER 6

DISCUSSION

In this chapter I will discuss the findings of this study in relation to the concept of empowerment and within the context of the Women's Health Movement (its history, aims, and legacy), as discussed in chapter two.

Meaning of empowerment: Control versus safety and respect

As discussed in the second part of the literature review, the definition of empowerment as borrowed from community psychology, nursing, and health involved having control (over one's life and decisions), having choices, having a voice, and holding self-efficacy beliefs (Rappaport, 1981; Robertson & Minkler, 1994; Shields, 1995). In the context of human services, this translated into providing the conditions that enable people to take control over their lives (and health). Having control was also emphasized by the Women's Health Movement. The main aim of the WHM was to increase women's control over their bodies and health (over the decisions and actions affecting their bodies and health).

The main finding of the present study is that women define empowerment (in reproductive services), not so much as control, but as safety and respect. The only three aspects of the core category that allude to power and control are receiving non-directive care without being cajoled into a decision in birth control and abortion services, the sense of empowerment that came from making the abortion decision and going through with it in a safe, validating environment, and being treated as a peer. Even these three potential indicators of control were discussed by the women within the contexts of safety and respect. There was no direct mention of a sense of control. This was accompanied by women's references to physical and emotional safety (e.g.

feeling vulnerable to anti-abortion violence, vulnerable in uncomfortable or abusive interactions with providers, and feelings of being judged for receiving abortion and birth control services and for asking questions of providers). The lack of a direct mention of a sense of control was also accompanied by women's references to being treated as a human being (e.g. being given time, information, and not being treated as a number in a mass produced setting). These references and the lack of direct mentions of control mean that after 30 years of struggle by the WHM's advocates, women still do not feel in control of their bodies and health in mainstream medicine. They instead feel vulnerable and judged, unsafe, and not respected by their providers, which show the continuing authority of medicine and medical practitioners over women. The need for physical safety -from violence- and fear of judgments on the other hand, shows the success of the anti-abortion movement in stigmatizing and criminalizing abortion.

One of the few studies that documents women's current lack of control and their sense of vulnerability in reproductive services in relation to the WHM is Griffith's (1997) work. Interviewing female college students at SUNY Geneseo about their interactions with their gynecologists, Griffith found that women did not challenge the medical authority of their gynecologists, felt vulnerable and adopted a passive role in the interaction. The women who saw themselves as active participants (asking questions or demanding more time with the doctor) attributed these to personal strength rather than recognizing the power imbalance in the situation and exercising their (collective) right to challenge the doctor's power. This, Griffith thinks, shows the failure of the WHM to reach the young women of the current generation.

Griffith found that the vulnerability women experienced derived from feeling "physically and psychologically exposed" to the gynecologist, caused by the nakedness and the powerless position (laying down with one's feet on stirrups and not being on an eye-level with the doctor). Women's feelings of vulnerability were exacerbated by the fact that examination room was the first place they met the doctor while they were already naked and usually in a prone position.

In the findings of the present study, one of the components of "emotional safety" is "comfortable/comforting care" that address the vulnerability women felt in abortion and gynecological procedures, which they perceived as uncomfortable, anxiety provoking, and sometimes abusive. At both of the centers, the homey atmosphere, the little extra touches such as tea and crackers in after-care, empowering messages on the walls, nice gowns (instead of paper gowns) for gynecological exams, and the behavior of the staff (checking with them through a procedure, supporting them, and chit chatting with them before and during care) were strategies that alleviated the sense of vulnerability - the discomfort, anxiety, and nakedness. At both centers, women who received gynecological exams for routine care or for abortion follow-up care also saw the provider (physician's assistant or nurse practitioner) first dressed up. This sensitivity, though, was not applied to the abortion procedure. At both places, women were in the gowns (so half-naked) when they saw the physicians providing abortions for the first time.

In the present study, the strategies that alleviated the sense of vulnerability also related to the "humane care" dimension of the core category in making women feel respected as human beings and not treated as numbers or medical objects. The relationship between vulnerability and respect is supported by Thomas' (2000) study of 14 feminist health centers, where she found that providing colorful gowns, mittens on stirrups, and allowing clients to be dressed up when first meeting the provider, constitute an important dimension of empowering care, which is treating all women with "respect and dignity."

A second reason for the women clients' foregrounding of safety and humane care instead of control might be that safety and respect are perhaps the *conditions* of empowerment, which takes place over time (where women reach "a sense of control" after repeated exposure to safe and respectful settings). In her study of 14 feminist health clinics, Thomas (2000) found that the centers conceptualized empowerment as a process "that takes place over time through the mutual sharing of information, knowledge, and skills", and "culminates in a woman's active control of

her health care" (p. 144). In the present study, staff motivations (staff's goals in serving women) at both FHC and WHC included empowering women to take control of their reproduction (control over her decisions and participating in her care). Empowerment and control were also explicitly written in FHC's intake form that each client filled out. It reads:

You may be wondering what we mean by "Feminist" in our name. Feminism means something different to each woman who works here, but we all agree that one important aspect of feminism is self-empowerment. This means:

- Taking responsibility and control of our health as women
- Regarding our own experience and that of other women with respect and using this experience to further our growth and that of the women we serve
- Challenging restrictions and injustices that narrow our choices and those of all women.

FHC, intake form, p. 3

There was also a mention in the FHC staff interviews that empowerment happened over time. In addition to conceptualizing empowerment as a process that takes time, there was further an understanding in FHC that empowerment was a cumulative process, a cumulative effect of the whole system of "feminist care" from the non-medical environment to the information provided, to the use of lay workers (peer services).

Even though, due to their feminist ideology, empowerment and control are mentioned more explicitly in FHC, I believe that what both centers are doing is providing the *conditions* to enable women to be empowered, to take control of their reproductive lives. Through the non-medical homey environments, the relationships with providers (health workers, counselors, nurse practitioners, and physician's assistants) that involve mutual interactions, time, and respect, the use of lay workers (in FHC), the centers are providing a safe and humane environment, as different from women's mainstream providers. And in doing so, they are modeling an alternative form of care (as Iris from FHC says, "planting the seeds" of empowerment), where the women, they hoped, would in time feel empowered to take control.

This interpretation fits with Rappaport's (1985) definition of empowerment. He states that "what those that have power and want to share it can do is to provide the conditions and the language and beliefs that make it possible to be taken by those who are in need of it" (p. 18). It is also in line with Sherwin's (1998) concept of "relational autonomy", which she states, goes beyond informed choice (or the presence or absence of being offered a choice) and requires that the person have the opportunity to develop the skills necessary for making choices. The components of safety and humane care, i.e., safe, non-judgmental, non-directive, dignified, individualized, egalitarian, and holistic care, represent the conditions provided by both centers to enable empowerment. The difference between the two centers, though, is that these conditions have an ideological basis in FHC and thus are provided intentionally, constituting together "feminist care", where non-judgmental care and a demedicalizing approach (especially through the use of lay workers) were emphasized.

In WHC, the staff and clients described the care as "patient centered care" which referred to having patients' needs as the main focus in care, and spending as much time as necessary with each woman (and her partner or family). As different from "feminist care", patient-centered care did not have an explicit ideological basis and was also based within a more medical (and psychological) model. This is best evident in the following quote from the mission statement of WHC:

WHC is committed to maintaining the highest standards of the medical field while providing medical care and emotional support to women coping with problem pregnancies.

WHC, Personnel Policy Manual

Meaning of empowerment in relation to the empowerment models

In chapter two, I discussed empowerment models borrowed from the fields of reproductive health care and health care ethics, from which I deduced three dimensions of empowerment. These dimensions were *access to services*, *service-delivery characteristics*, and *ethics of care*.

Access to services

The access dimension refers to distance (accessibility), cost (affordability), and time (time in services, waiting time, and management of waiting time). In the findings of this study, among these three components of access, "time" was the main one to emerge as an important aspect -indicator- of empowerment for women clients. Time was described as having the time to listen to women's concerns, answer questions, and going through the counseling, abortion, and gynecological procedures at a comfortable pace. This seems to describe time in services. Time also meant respecting women's time through accommodating women's schedules in scheduling appointments for them, decreasing waiting time, and returning women's calls promptly. This includes but goes beyond waiting time. The main finding here is that, taken as a whole, time in services and respecting women's time signified "dignified care" for the women (and for the staff). Thus, a dimension of empowerment, which in the literature is defined as an indicator of "access" or even in Thomas' (2000) feminist conception as "breaking down institutional barriers", is defined by women as an indicator of respect, care, and dignity; being given time means being cared for and respected.

Within the "time" dimension of access, Ruzek (1978) stated that, as compared to traditional settings, feminist centers would have more time spent in services, have less waiting time, and utilize the existing waiting time to educate and build rapport with the women. The

latter, Ruzek referred to as the "management of time." Both FHC and WHC had acceptable waiting times, where women were able to schedule their gynecological or abortion appointments within a week. This might be one of the reasons why "time" was interpreted more as respect than access (because access was not an issue in terms of "waiting time"). As discussed above, there was also more time spent in services in both centers as compared to women's other providers. However, except for the brochures and books in the waiting rooms, counseling rooms, and exam rooms, there was no indication that the time was used in either setting, to educate the women more actively or build rapport with them.

Findings of the present study also show how "time", whether experienced by clients as an indicator of "access" (in the literature) or "respect" (as in this study), is affected by agency and societal forces. In WHC, the state laws surrounding abortion (such as the 24-hour waiting period) increased "time" in services through increasing visits from one to two visits. The state scrutiny over the center's operations also increased "time" in services due to increased documentation. WHC, in return, adopted strategies such as phone counseling and group video showings of the state information to decrease visiting time to make it more convenient for the women as well as to be able to compete with abortion centers that resided in neighboring states without such laws. Thus, in WHC, clients' experience of "time" was affected by legal and economic forces and the agency's response to them. In FHC, "time" in services was affected mainly by the economic forces. However, the "time" that was decreased (as compared to the past) was the time in "peer services" with lay workers, which I will refer to as "peer time." As Iris stated, with increasing business pressures, "in the name of efficiency" (and with the changing needs of women), there was less time spent with lay workers and more time with the physician's assistant.

FHC's experience with "time" brings out the importance of differentiating "time in services" further into time spent with specific providers and the different effects each has on empowerment. When women clients in this study discussed "time in services", they were mainly

referring to time spent with lay workers (FHC), counselors (WHC), nurse practitioners (WHC), physician's assistant (FHC), and nurses (WHC) at the centers and comparing these with their time with other providers, mainly physicians (e.g. family practitioners, dermatologists, abortion providers). Women rarely referred to "time in services" as time with the physicians at the centers. The main reason for this is that at both centers women's time with the physicians was minimized. At both centers, in abortion services, women spent more time with lay health workers (FHC), counselors (WHC), nurses (in both), nurse practitioners (WHC), and physician's assistants (FHC), all of whom were female.

In FHC, doctors were seen as "hired hands" contracted to perform abortions and were to share their power with lay workers who owned and operated the business. In WHC, there was also a similar mention by Mary the lab manager, of doctors as hired hands. The two physicians I interviewed at FHC and WHC (who were the medical directors of the centers) also saw themselves as "technicians" who had brief encounters with the women.

This minimization of the time with doctors, according to Ruzek (1978), is one of the characteristics of feminist settings that differentiate them from traditional settings. By minimizing women's interactions (women's time) with the doctors through the division of labor, feminists aimed to change "dominant role relationship between provider and client" from one of power to mutual participation. As discussed within the empowerment models, under "ideal types of health care worlds", she states that in traditional feminist settings, female paraprofessionals provide most of the actual care, thus reducing opportunities for physician dominance over women clients. In these settings, physicians diagnosed, offered advice, or performed medical procedures only after other workers have seen the patient. Closeness and communication between provider and client were also facilitated by the existence of an all-female paraprofessional (and preferably professional) staff. In radical feminist settings, patients are encouraged to assume major responsibility for their own care and perform basic health services for themselves (with the

assistance of lay women). Whenever present, physicians are delegated to technician status, hired to do the jobs restricted by laws, only after lay persons have defined what needs to be done.

According to Ruzek's (1978) definitions, both centers are feminist settings, where physician's time with women are minimized and restricted to care after female paraprofessionals or lay workers have seen the women. FHC seems to be a hybrid of radical and traditional feminist settings, because they use lay workers but lay workers do not assist clients in performing services (e.g. pelvic exam, taking blood pressure) for themselves. WHC, on the other hand, seems to be a hybrid of a traditional feminist setting and traditional-egalitarian setting because they use female workers but the doctors' expert status is still protected through medical committees, medical staff's authority over counselors, etc. WHC also differs from FHC and Ruzek's categories in employing what I would call professionals (instead of paraprofessionals or lay workers) in counseling.

The present findings call into question the belief that the "dominant role relationship between provider and client" (especially between the doctor and the woman) can be changed by minimizing "time" with physicians. I raise two questions based on my findings. First I ask whether minimizing women's time with physicians without changing the nature of physician's interaction with the women (by having physicians who are in line with the idea of empowerment - sharing power with the women) is effective in altering the "dominant role relationship between provider and client." Secondly, whether minimizing time with doctors without changing the doctors' power within the agency (through division of labor) is effective in again altering the "dominant role relationship between the provider and client."

The first question brings out the importance of what happens in the brief encounter between women and physicians during abortion, how women perceive the "time", and which factors affect it. As discussed in the previous chapter, when women first met the doctors, they were not dressed up, they did not ask questions to the doctors (partly because their questions were

answered by the counselors or lay workers beforehand), not all the doctors talked to the women, and other female staff in the room (nurses and support persons) mediated the relationship between the doctor and the women, relieving the doctors from the emotional work.

When the doctors did not talk to the women, some women found it abrupt. Other women thought it was ok, especially because of their wish to "get done with it". Yet, for others, it was important that the doctor interacted with them. They found it comforting. The doctors' interaction seemed to gain even more importance for women who have had abusive gynecological experiences, been raped or for whom abortion was their first gynecological interaction.

In FHC, the staff stated that their female physician was the one who had the best interactions with the women. This was seen as partly due to her being the physician who was most in line with the feminist ideology of demedicalization (trusting women's knowledge, taking her time, and working to decrease the distance between the doctor and client).

These findings on the women's interactions with the doctors show that however kind, gentle, and dedicated to abortion work all the doctors in WHC and FHC were, whether women's "time" with the physicians influences the traditional "dominant relationship between provider and client" depends not on the length of time but the nature of the interaction during that time. The nature of the interaction itself was determined partly by the doctor's beliefs on sharing power.

The second question the findings in "time" brought out is on the effectiveness of minimizing time with doctors without changing the doctors' power within the agency (his/her place in the division of labor). As Ruzek (1978) stated, the "dominant role relationship between provider and client" constitutes only one of the six dimensions to differentiate between traditional and feminist settings (in the levels of autonomy and responsibilities given to women and providers). Another important dimension emphasized by Ruzek (1978) and supported in the findings of this study is the "division of labor" within an agency.

Ruzek (1978) states that in traditional-authoritarian and traditional-egalitarian settings, there exists a rigid division of labor between patients and workers based on formal training and certification, where physicians reserve all medical tasks for themselves. Traditional-feminist and radical-feminist settings, in contrast, have a less hierarchical division of labor with job rotation, where physicians' actions and responsibilities are observed and evaluated by lay women. WHC had a rigid division of labor where physicians, nurses, and nurse practitioners performed all the medical tasks. Lay workers were not used in medical (or counseling) tasks. In Ruzek's (1978) terms, these make WHC a traditional setting. The effect of this division of labor on "time" and "dominant role relationship between provider and client" was seen in WHC, on the staff's effort to make "everything flow for the doctor", revealing the importance of doctor's time.

In WHC, the use of certified counselors or counseling or psychology students added a further layer of professionalization (specialization), which brings out the issue of psychologizing of services. In WHC, women's time with the physician was minimized, which might have decreased medical power (physicians' dominance over women). While decreasing women's time with one type of professional (physician), the agency though increased their time with another (psychologists or counselors), and thus contributing to expert dominance over women and undermining ideas of self-empowerment and demystification -and normalization- of women's health, specifically abortion in another manner.

In FHC, there was less specialization and more job rotation and physicians' (and all medical staff's) actions were supposed to be evaluated by the lay staff. However, in practice, the challenging of the physician's actions depended on the feminist consciousness of the staff and the staff's fears of losing the physician (in a time of growing scarcity of abortion providers).

Within the relationship between the "division of labor", "time", and "dominant role relationship between provider and client", there is also the question of how women interpreted

spending more time with lay workers or counselors than with doctors. Did they experience it as empowering?

The findings suggest that most women were not aware of the significance of having non-medical staff (especially lay workers) provide most of their care and did not interpret it as demystifying health services for them or as decreasing the doctor's power over their health. Thomas (2000) found that most feminist centers that had empowering care used lay workers to reinforce the belief that women can learn about their health care from each other. So did FHC. This vision of the Women's Health Movement, though, was lost to the current generation of women.

These findings on "time" reveal the multidimensional nature of empowerment at interpersonal, agency (medicalization), and societal (laws and economic pressures) that is crucial for a better understanding of the concept. The findings also show the importance of going beyond "waiting time" and "time in services" and looking at who the "time" is spent with most, how it is spent, which agency and societal factors affect "time", and how women interpret these.

Another component of "access" as discussed in the literature review was distance. Five of the twelve women interviewed in FHC and three of the twelve women interviewed in WHC chose to go to the centers because they were closeby. Even though they did not choose the centers because of proximity, five additional women in WHC and five additional women in FHC also found the centers to be easily accessible. Even when the centers were not easily accessible, some women still preferred to go there because of safety, anonymity, and the high level of care; three aspects of safe and humane care.

As in the case of "time", the findings on "distance" also show that "distance", which is designated in the literature as a dimension of "access", has to be researched in the context of other components of empowerment, in this case "respect" and "safety". Women's negotiations of

which center to choose and how empowered they felt in them depended on more than mere "access" or "distance" to the center.

Service delivery characteristics

The second dimension of empowerment I deduced from the empowerment models was "service delivery characteristics." The components of this dimension were: providing correct and adequate information, the inclusion of information on alternative treatments and encouragement of self-help, the way the information is presented, where interactive, nonjudgmental, peer-oriented styles used by feminist clinics are expected to lead to empowerment, choice of methods offered on a reliable basis and their variability across subgroups of women, preferences for barrier methods over hormonal ones, the dominant relationship between provider and client, the division of labor in the agency, follow-up mechanisms, management of space, assignment of risk, and staff training and support. All of these components emerged in the findings of this study, within the core category as well as within the agency level factors and their interactions with the core category.

In terms of the core category, which revealed the meaning (and experience) of empowerment for women clients, women emphasized the importance of being informed and the way the information was provided. "Being informed" meant receiving information on all options of birth control and abortion and all procedures in an interactive and individualized manner (tailored to the individual needs of the women). Women interpreted "being informed" as an indicator of "humane care", of being "treated with dignity." In this sense, the findings provide support for the "ethics of care" models, where Kols et al. (1999) and Sherwin (1998) interpret provision of information as an ethical issue. Kols et al. states that "respect for autonomy" requires that a client be provided full and correct information and respected in her decision-making ability

and decisions. In this study, though, "being respected in decision-making ability and decisions" were discussed within the context of safety (under "non-directive care") rather than respect.

In the provision of information, in her model of empowering care used by feminist clinics, Thomas' (2000) emphasized interactive, non-judgmental and peer-oriented styles. Interactive and peer-oriented styles also emerged in the findings of this study in the forms of "non-directive care" and "egalitarian care" respectively. "Non-judgmental care" in this study, though, referred not to judgment in providing information but judgments for women's use of abortion and birth control services, which in turn, implied judgments for (especially young) women's sexual activity, choices, and decisions.

Petchesky (1990) noted this relationship between reproductive services (especially abortion) and women's sexuality. She argues that "abortion is the fulcrum of a much broader ideological struggle in which the very meanings of the family, the state, motherhood, and young women's sexuality are contested" (xi). She discusses how the 1970s and 80s with their sexual revolution brought changes in the "signs of white female teenage sexuality", where the sexuality of the young, white, single woman became visible through the local abortion clinic. Petchesky says that the "clinic symbolically threatens white patriarchal control over 'their' young women's sexual 'purity'", explaining why 'more effective contraception' is a failing argument to use with anti-abortionists (p. xviii).

In the present study, the relationship between women's sexuality and reproductive services came was most clearly evident in the young women's experiences in gynecological services. They described feeling judged (by the people in the community) for going to Planned Parenthood, and experiences of being judged by their gynecologists for being sexually active as teenagers.

Women's sexuality was also contested in abortion services through the regulation of women's sexuality by the family and Ob/Gyns. In terms of the family, some women said that their

parents (especially the mothers) would never know of their abortions, mainly due to a fear of judgment or the regulation of their sexuality by the family, where the parents wanted grandchildren or had forced the young woman (who was living at home) to have an abortion.

Women's sexuality was also regulated by Ob/Gyn providers and family practitioners. As discussed in the previous chapter, most women did not trust their Ob/Gyn providers on protecting their confidentiality and chose to go to the centers for anonymity. Women further felt that these ob/gyns were judging them for having an abortion rather than having a child. As Frances, an abortion and gyn client in FHC put it, "it was one thing to go into the doctor to have a baby, whole other thing for other services."

This judgment by Ob/Gyn providers and family practitioners was the reason behind women's preference for a place "specialized in pregnancy prevention". Women turned to health centers for comfort and (emotional) safety.

Zimmerman (2000) states that "routine care for women's common health problems is divided in the organization of medical education and practice between gynecological/obstetrical and other health services" based on specialization and turf interests rather than on women's health care needs (Zimmerman, 2000, p. 129). The findings on judgmental care show how women's health services, already divided between obstetrics/gynecology, internal medicine, and family practice, are further fragmented within reproductive services (into pregnancy prevention and obstetrical services). This fragmentation, though, is not based on turf interests but on the sexist social ideologies on women's sexuality (especially on motherhood) that are reproduced in medicine. The organization of services in prenatal, fertility, or birth-control and abortion services reinforce the patriarchal division in women's sexuality between women as mothers and women as sexual beings.

Ethics of care

The third and last dimension of empowerment I deduced from the empowerment models was "ethics of care." Within this dimension, certain aspects of the previous two dimensions of empowerment (access and service delivery characteristics) are interpreted as ethical issues. As exemplified above in the discussion of "time" and "being informed", the findings of this study support this assumption of the ethical approaches to empowerment. Women clients in this study did interpret certain aspects of "access" (e.g. time), and "service delivery characteristics" (e.g. being informed, being provided choices, individualized care, and peer services) as indicators of dignified, individualized, and egalitarian care, thus as ethical issues.

Kols et al. (1999) state that being treated with respect required that a client be provided with full and correct information, courtesy, confidentiality, and privacy. Women clients in this study discussed information, courtesy, and privacy within the domain of humane care (respect). However, a subcategory of safety, "confidentiality: no one will ever know" also emerged. Confidentiality was seen more as a safety strategy to guarantee "non-judgmental care" and "emotional safety" than as a requirement of respect.

Within the dimensions of "access", Kols et al. (1999) and Thomas (2000) further discuss "cost" as an issue of justice. Kols et al. state that the principle of justice demands that risks and benefits be equally distributed in a society and that everyone has access to services. Thomas refers to this as the "dignity and respect" dimension that derived from the feminist centers' mission of serving all women regardless of their income status. What Kols et al. and Thomas are touching upon, is also one of the aims of the WHM, a commitment to health care as a right, including guaranteeing access to services regardless of financial or insurance status.

Although "cost" (or affordable care) did not emerge as a component of the core category, as revealed by the staff interviews, both centers took extra measures not to turn away any women for abortion services. FHC's strategies to guarantee this were deferred payments and referring

women (who, though, had to be at least 9 weeks pregnant) to a pro-choice organization to provide one-third of the cost. WHC also allowed deferred payments (though only after very strict assessments) and had a "WHC Pro-choice Fund" of their own, where \$5 from every payment was set aside to donate to pro-choice organizations, activities, legal defense, or to use in helping women who could not pay for abortion services. WHC further offered reduced fees for cash-paying patients, medical assistance patients, and students. Both agencies also accepted major insurance plans of their respective states. As discussed in the findings, under "social factors" that affected "safe and humane care", though, the effect of insurance on reducing the cost of services depended on the coverage of services and the limitation clauses included in these policies. It further depended on *women's awareness* of their birth control and abortion coverage and their *willingness to use* their insurance for these services (for fear of family or other providers' knowledge of their contraceptive use or abortion history).

I believe that the most important implication of the present study in relation to empowerment models is the support the findings provide for Sherwin's (1998) concept of "relational autonomy" (as opposed to individualistic models of autonomy) and feminist ethics. Sherwin (1998) argues that within biomedical ethics, autonomy (as well as its opposite paternalism) is conceptualized as an issue of control of medical decision-making at the moment of treatment between an individual doctor and a patient. This model of health care ethics neglects the fact that the range of options available to both parties at the time of treatment has been significantly reduced by prior decisions on research agendas, allocation and accessibility of health care resources, and by the power of the dominant medical tradition. Sherwin states that feminist ethics requires that these "prior layers of decision-making" be exposed and evaluated and "justice" and "autonomy" be redefined as socially situated terms. The findings of the present study do expose these prior layers of decision-making, namely the agency factors and societal factors that affect women's feelings of autonomy, which in this study emerged as feeling safe and

respected. The findings situate "autonomy" or "empowerment" in its sociopolitical context, where an agency's mission and operation, and the politics of reproduction in which it resides (the legal, medical, and economic factors) interact with individual women's needs to enable or restrict her autonomy in reproductive services. The specific effect of each societal factor will be discussed in detail in the following section.

Findings within the context of the Women's Health Movement

Feminist Health Center and Women's Health Center as movement organizations

As mentioned in the literature review, Ferree and Martin (1995) define feminist organizations as "the places in which and the means through which the work of the women's movement is done" (p.13). They further state that the relationship between feminist organizations and the women's movement is dynamic and reciprocal. The movement gives the organizations "their broad purpose, and specific agenda, and supply of activists", while it draws from them "a set of practices, political and material resources, and a supportive context within which activists can carry on their lives while struggling for change" (p. 7). Thus, the movement and the organizations continually redefine and transform each other.

Ferree and Martin (1995) are referring to the women's movement in general and all types of feminist organizations that emerged out of it; however the same phenomenon applies to the Women's *Health* Movement and its organizations. As Ruzek (1978) states, within the WHM, feminist health organizations involving health activism at different levels have proliferated since 1969. These were clinics, groups such as "Jane" that provided illegal abortions and abortion referrals, counseling centers, rape control organizations, and national associations. Among these various feminist health organizations, Morgen (2002) emphasizes the women-controlled clinics, established on the eve of or immediately after *Roe v. Wade*, as the vanguard organizations that

translated feminist principles into health care, formulating alternative models and practices of women's health care. According to Morgen, what made these clinics "feminist" and movement organizations were: (1) the concept of control by women (owned and operated by women with non-medical backgrounds, where physicians do not have a monopoly over reproductive knowledge and female providers -ranging from lay workers to nurse practitioners- are preferred), (2) emphasis on self-help, (3) value placed on egalitarian relationships, (4) value attached to providing low-cost care, (5) feminist care as a politicized issue, and (6) maintaining a feminist workplace.

Established soon after *Roe v. Wade*, in 1974 (FHC) and 1978 (WHC), I believe that both centers are women's health movement organizations that share in varying degrees Morgen's (2002) criteria. In terms of the first criterion, both centers are women-controlled where it is women who founded and mainly controlled the operation of the agency; WHC however, has a more medical and psychological model of organization (and care) that problematizes its degree of control by women.

FHC was founded by a group of women who, after years of discussion, realized the need for "a clinic run by and for women in a nurturing, respectful, and empowering manner, that encouraged taking charge of one's own body and life." And as mentioned by the staff at the time of the research, it was still owned and run by lay women (with no medical education). Doctors had no voting power in the running of the agency, even though the position of medical director gave some power in controlling medical protocols and the training of mid-level practitioners for abortion. Doctors and other medical personnel were also under the scrutiny of the lay workers.

WHC was founded by a woman who was the educational director of a Planned Parenthood in the area and the founder of the Abortion Rights Association and an information service for pregnant women in her county. From the beginning though, the medical and psychological model of the agency (the roles of counseling and medical staff in the agency) were

evident. In a newspaper article, the founding mother (who became the first executive director of WHC) states that:

the center will operate with a "hand picked staff" and provide birth control information and have a full nursing and counseling staff. The doctors will be board certified, the obstetricians and gynecologists "experienced in the procedure" [of abortion]

Local newspaper, September 8, 1978

At the time of the research, WHC was women-controlled in the sense that the center included a majority of female providers (in administrative, clerical, counseling, and nurse practitioner positions) and the critical positions such as the director and the medical services coordinator were filled with women without medical degrees. The head counselor, who was a woman as well, occupied an important position in the agency. Despite this dominance of female providers, WHC worked under a medical model. The physicians and nurse practitioners were contracted, however they did have a say in the running of the agency through serving in the "medical committee." The existence (and the composition) of the "medical committee" and the power of the "medical director", including the overseeing all staff physicians and nurse practitioners (thus making medical staff supervised by medical staff and not by lay women), show that WHC is a women-controlled center which works with a medical model (where physicians monopoly was challenged only so far). As hinted by its founding mother, WHC was also operating under a psychological model. In the definition of "women-controlled" centers, Morgen (2002) mentions fighting against medicalization. WHC's psychological model of care brings out a need to redefine "women-controlled" to include "non-professional" instead of nonmedical providers.

In terms of Morgen's criterion of self-help, only FHC had an explicit emphasis (and training) on self-help. In the quarterly publication of the center, FHC was depicted as "a licensed non-profit clinic offering: pregnancy testing, first trimester abortion, gynecology, counseling, and

self-help", a center "for women, by women." Self-help was realized by both the information provided in the journal on a multitude of women's health issues (e.g. how to prepare your own menstrual pad, do your own cervical examination, fertility awareness, etc.), as well as by the groups held by FHC on such topics as cervical exams, lesbian health, endometriosis, hysterectomy, PMS, women and alcohol, etc.). In the publication, it is mentioned that the center's self-help philosophy centers around: "gynecological self-help; cervical examinations, menstrual cycles, pregnancy testing, controlling conception, lesbian needs, nutrition, menopause, and other areas that contribute to the demystification of woman's health" (Fall 1978). Both the groups and the journal were discontinued over time:

At the time of the study, self-help was applied at both centers only at the level of information-providing. Staff at both centers provided women with information on birth control methods, gynecological exams, and abortion procedures; however, except for the breast self-exams, there existed no training in self-help *activities* such as learning cervical self-exams, taking one's blood pressure and pulse, or inserting a speculum, etc. This finding might be pointing to the legacy of the WHM for current providers in women's health, who either are aware of the original concept of self-help and are redefining it only at the informational level or who have never been aware of the original concept.

In terms of Morgen's (2002) third criterion for "women-controlled" settings, the value placed on egalitarian relationships, as discussed before, FHC had a more egalitarian (flat) structure than WHC, maintained through decreased specialization, increased job rotation, and use of lay workers. In terms of Morgen's fourth criterion, the value attached to low-cost care, the initial aim of both centers was to provide low-cost abortion alternatives to hospital-based abortions in their areas. FHC, though, had a larger mission of "empowering women to take charge of their body and health" whereas provision of abortion was the main mission of WHC. In line with the aim of providing low-cost care, both centers employed the strategies discussed in the

previous section, not to turn away any women for abortion. In gynecological care, even though the fees were lower than other centers, the centers did not employ any similar measures (e.g. sliding scale) to accommodate all gynecological clients.

Morgen's (2002) last two criteria for "women-controlled" settings are "feminist care as a politicized issue" and "maintaining a feminist work place." In terms of the first one, as discussed before, FHC employed "feminist care" derived from feminist principles, and WHC employed "patient-centered care". Both, though, employed political advocacy and community outreach efforts.

Regarding "feminist workplaces", Morgen writes that, in contrast to capitalist and impersonal bureaucratic organizations, feminist clinics were established as collectives, with an aim to empower staff, where the boundaries between public and private lives of staff were blurred, and working toward common values created solidarity among staff, for whom working in a feminist clinic was more than a job. This criterion is similar to two dimensions Thomas (1999) found to distinguish different types of feminist organizational structures. Thomas found that although established mainly as collectives with a decentralized, non-hierarchical structure, (where decisions were made by consensus, jobs were rotated, and salaries were equal), facing both internal and external pressures, most of the 14 feminist organizations she studied changed to include more specialization and hierarchy. She found that by 1990, three ideal types of feminist organizations emerged: collectivist democratic, participatory feminist bureaucratic, and feminist bureaucratic. What differentiated these three types were the decisions the organizations made on three ideological issues of: (1) the distribution of power in the agency, (2) organizational growth versus autonomy, and (3) feminism as an organizational outcome (services) or internal process (consensus, empowerment of staff). Thomas' first and third dimensions relate to Morgen's criterion of "feminist workplace" with equal distribution of power and a focus on process - empowerment of the staff.

As discussed before, FHC and WHC differ in the distribution of power in the agency. FHC is closer to Thomas' "collectivist democratic structure" where there is a low division of labor and critical decisions are made by the whole. At the time of the study, though, there were indications that FHC was moving to a more bureaucratic model, with increased specialization (where people stayed in their positions and teams, and more things lay workers did were delegated to the physician's assistant), decision-making was changed from a consensus to a 2/3 majority, and only full time staff had voting power and benefits. WHC, on the other hand, had a higher division of labor, where power resided in the Executive Director and the Board of Directors (which makes it similar to a "feminist bureaucracy"). However, there were various mechanisms (such as a management committee with a representative from each clinic department, staff meetings, sub committees, retreats) to guarantee staff input into the director's decisions. The director of WHC was seen as more successful than previous directors in opening up the communication between the administration and staff, and soliciting staff input, which then made WHC a "feminist bureaucracy" with participatory characteristics.

The current director of WHC was also very visible through the daily operation of the clinic, checking with staff, doing front office desk, checking with some patients, which also decreased social distance between administration and staff.

Both agencies acted as "incubators" or "launching pads" for workers, leading to professional and personal growth of staff members (including the doctors at both places). Janet, the Director of WHC, further discussed her efforts to "create niches for staff" by making opportunities for them to provide additional services they are interested in providing (such as massage and general counseling). However, "agency as an incubator" is more about personal/professional growth of the staff and does not directly relate to workers' empowerment in the agency. Empowerment of staff was listed as one of the goals of the FHC. Empowerment of

staff, especially through working as lay workers was also mentioned frequently in FHC staff interviews.

Transmitting the history of the organization to new members was another important strategy that contributed to the sense of empowerment through clarifying the relationship between the high division of labor (which created a sense of chaos and frustration) and empowerment.

In WHC, only Janet, the Executive Director mentioned staff empowerment, which she tried to accomplish through creating sub-committees, but had mixed results. It is clear that, in terms of the emphasis on process (empowerment of staff), FHC is more of a feminist workplace than WHC. Under "feminist workplace", Morgen (2002) further talks about blurring of the distinctions between the personal and public lives of the staff, increased feelings of solidarity, and seeing work as more than a job. All of these were present at both centers, where the relationships among staff were more personal and extended into friendships, a feeling of solidarity was created for working for a feminist (in FHC) or pro-choice (in WHC) cause, and work was seen as more meaningful than in other places.

Being defined by and defining the movement

Based on the preceding discussion I conclude that both WHC and FHC are movement organizations with varying degrees of women-controlled and feminist characteristics. With its high division of labor and medical (and psychological) model of care, and yet characteristics of feminist clinics, WHC is a hybrid between Ruzek's (1978) "traditional-egalitarian" type of organization and Thomas' (1999) "feminist bureaucracy." FHC, on the other hand is a hybrid between Thomas' "collectivist democracy" and "participatory democracy" that operated with a low division of labor, lay health workers, and a goal of empowering clients and staff but was moving towards increasing levels of specialization.

As movement organizations, as Ferree and Martin (1995) argue, WHC and FHC have a reciprocal relationship with the Women's Health Movement. The movement gave and keeps giving them their broad purpose and specific agenda (such as providing low cost abortion care in a respectful environment and working towards increasing women's control over their bodies and health). The centers were also affected by the internal and external pressures Morgen (2002), Thomas (1999), and Simonds, Kay, and Reagan (1984) found to affect other women-controlled clinics (movement organizations) between the 1970s and 1990s. While the movement and the pressures on the movement affected WHC and FHC, in line with the reciprocity Ferree and Martin (1995) mention, I argue that the centers also affected the movement, by redefining its goals and formulating new practices (new strategies to deal with medical, legal, and economic forces and the anti-abortion movement). In this section, I will discuss this reciprocal relationship between the centers and the movement, with an aim to situate the findings within the history of the WHM as discussed in chapter two.

When Morgen (2002) surveyed the staff of 50 women's health movement organizations about how their organizations and work have changed since their founding, she found that external pressures powerfully influenced the structure and work of these organizations between 1979 and 1989. These influences came from the anti-abortion movement, the state, and the health care establishment (including organized medicine and the capitalist medical care). Among these three, the respondents cited the anti-abortion movement as exerting the most negative influence.

The findings of this study show that WHC and FHC experienced all three of these external pressures. These pressures, however, had different effects on the centers. In FHC, the state scrutiny and change in reimbursement policies (both of which were also influenced by medicine) led to the abandonment of the use of lay workers for medical procedures, which in turn led to increased specialization and medicalization in the organizational structure. Internal pressures (e.g., frustrations with the consensus system) as aggravated by business pressures that

dictated efficiency ("time is money") also contributed to this structural change by further reinforcing specialization and medicalization, and bringing a change from consensus to two thirds majority vote. In WHC, the external pressures did not lead to such structural changes, perhaps because WHC already had a more medical and hierarchical structure than FHC. The state laws and scrutiny led to the reorganization of services, while state scrutiny combined with economic pressures (of the capitalist medical establishment) reinforced the existing medical model (e.g. hiring more nurses to address medical liability issues).

In terms of the specific external pressures experienced, both centers were affected by the antiabortion movement.

Pressures of and responses to the antiabortion movement

In her survey of movement organizations, Morgen (2002) found that 27 of the 50 organizations had direct contact with Operation Rescue, while others experienced considerable pressure from it. WHC and FHC also had direct contact with Operation Rescue in the forms of blocking of entry to the center (in FHC in late 1980s) and a blockade and occupation of the center (in WHC in 1991). FHC further experienced two arson attacks, a butyric acid attack ("stink bomb"), and the picketing of the house of the medical director, and WHC was subjected to antiabortion vigils, marches, pro-life newspaper ads, and the harassment of its doctors and their children.

The difference between the two centers' experiences with the antiabortion movement is that while antiabortion movement attacks on FHC seem to have increased in the 1980s, WHC has experienced antiabortion attacks directly and indirectly (in the form of state regulations) since its beginning. Shortly after WHC gained its zoning permit, 30 antiabortion supporters attended the township council meeting and pressured the council to revoke the permit. The council refused to revoke the permit. Months later, a more formal appeal to revoke the center's permit was filed by a

member of the township planning commission, the wife of a councilman, and the owner of the property adjacent to the center. WHC lost its permit based on "errors in its building permit" only to regain a new one two months later. WHC's experience fits in with the experiences of other women-controlled clinics that experienced the pressures of antiabortion movement acting in times with the state to exert their influence through zoning permits, regulations, and building codes.

In her survey Morgen (2002) found that antiabortion violence affected feminist centers more than other centers (including Planned Parenthoods and non-feminist abortion centers) because of fewer financial resources and fewer connections to the police forces and representatives of the local court systems in the community. The attacks put an additional financial burden on the centers by having to pay for damages and increased security measures. After the 2000 arson attack, FHC estimated its costs to exceed \$20,000 plus over \$2000 for 24-hour security service in the several days after the fire. However, both centers had good connections with the police forces in their community. FHC found law enforcement forces to be very helpful after the arson attack, and WHC had FBI officers who came in to investigate the Operation Rescue occupation. At the time of the study, I also observed Janet, the executive director of WHC, in contact with the police when the protesters trespassed to the center's parking lot.

The pressure of the antiabortion movement was seen not only through violent attacks, protests, and zoning permits, but also in the antiabortion climate of the communities where the two centers were located. As discussed in the findings, staff of both centers felt alienated by the lack of support from the medical community, friends, neighbors, and even the clients they served.

An unexpected effect of the antiabortion attacks was the newfound support for the centers that was quiet until that time. For this reason, the staff of both centers referred to their communities as "quietly pro-choice."

In the case of WHC, the newspaper clippings reveal that there has been pro-choice activists who supported the center against the antiabortion protesters in the past. I believe that, except for the escorts used, the current lack of visibility of active pro-choice support for both centers strengthens the antiabortion movement and contributes to the alienation of the staff, and feelings of vulnerability of the clients.

The cumulative effect of the antiabortion violence (in terms of protests) and the antiabortion climate on empowerment is evident in the emphasis of physical and emotional "safety" by the clients as an important indicator of empowerment. The security measures the centers adopted on one hand addressed these feelings of the clients while on the other hand became constant reminders of their unsafe and on-the-defensive status. I argue that such security measures, while necessary, sadly contribute to what I call 'recriminalization of abortion' and 'normalization of violence'. The more senior staff at both centers recalled the traumatic transition from providing abortions without safety concerns to providing them under high security and constant safety concerns.

For a generation of women who do not have the memory of the earlier times when security issues were not a concern at abortion clinics, the current high security gives the impression that something wrong, even criminal, was done there. Ironically, it is the women -and their providers- who are under lock and key to receive (and provide) a service that is protected by law. Moreover, the violence has become normalized.

These two trends (recriminalization of abortion and normalization of violence) are important developments that have implications for the Women's Health Movement. They reveal the politics of abortion and the success of the antiabortion movement in putting the WHM and its movement organizations on the defensive where violence against abortion is normalized. The organizations (centers) end up -by adopting the security measures- contributing to the criminalization of abortion and normalization of violence.

The main strategy FHC and WHC were using to combat the feelings of isolation and alienation and address the safety issue was the building of alliances within the community and at the national level. The staff of both centers emphasized the significance of feeling support from their clients (the clients' normalization of abortion by talking about it and by participating in pro-choice rallies).

Relationships with the state

Both centers felt the effect of the state directly through the policies around reproductive care and indirectly through the increased state scrutiny over their operation. In terms of the policies around reproduction, WHC experienced a strong pressure from the state, which instituted in 1994 a 24-hour waiting period for abortion after a required consultation with a physician (who gives the woman the state-mandated information on abortion, its complications, and alternatives). In response to these, WHC reorganized its services to include phone consultation with a physician from the center, and the provision of the state information through a video. Both of these adjustments were done to decrease women's visiting time (where "time" was an important part of feeling empowered), and to compete with other agencies in neighboring states without such laws. As discussed before in the findings, the group video decreased the time but increased women's sense of being herded, which was reflected in another dimension of empowerment, that of "individualized care." WHC also provided legal aid to the minors who wanted to by-pass parental consent, though I do not have any data on how frequently those services were utilized by the minors. State's pressure on WHC through restrictive policies reflects the political ascendance of the antiabortion movement (through legislative victories) after the 1980s, while WHC's responses reveal the WHM strategies to deal with such legislation and the conflicting effects of the strategies themselves.

FHC, on the other hand, was located in a state with more favorable reproductive laws. The state in which FHC was located did not have a "physician-only clause" in abortion services, which allowed the training of mid-level practitioners.

As mentioned by the FHC staff, the training of mid-level practitioners would increase the supply of abortion providers. An increase in the number of providers would in turn decrease physicians monopoly over services. As Ruzek argues, "altering the size of the profession relative to the clientele" was one of the five strategies used by the WHM activists to deinstitutionalize medical authority and restructure women's health. Ruzek (1978) stated that the size of the medical profession relative to its clientele was one of the factors that reinforced physicians' mandate and monopoly over goods and services. By having a restricted size, the medical profession kept professionals services in short supply, which in turn led to expensive and authoritative services. The relationship of the profession's size to physicians power was observed in FHC in Felicia's remark that the doctors' power in the agency was reinforced by the scarcity of abortion providers. Felicia stated that while in (feminist) theory the staff was supposed to challenge the doctors acts, they were not always able to do so for fear of losing them.

The Women's Health Movement activists attempted to alter the ratio of professionals to clients by increasing the number and visibility of women physicians and opening the practice to nurses and paraprofessionals. FHC was attempting to do this through increasing the use of nurse practitioners and physician's assistants in abortion services. In FHC, this attempt to increase the number of the abortion providers was blocked by the medical director.

Despite FHC's failure, their experience has implications for the current state of the WHM, showing that in states with less restrictive laws toward abortion, the Women's Health Movement organizations can navigate the legal system to their benefit and decrease medical authority.

Another state policy, which in this case FHC was able to benefit from, was the Contraceptive Equity Bill. Its success in providing equal access to women in contraceptive care was mediated through insurance policies and women's awareness of their insurance coverage and their willingness to use it. Both examples from FHC reveal the importance of a multilevel analysis of empowerment, looking at the intersections of state, medicine, economy (capitalist health care), and women's awareness of their rights to have a better understanding of empowerment processes.

In the literature review, I discussed the state's effect on feminist organizations through funding (and subsequent co-optation) or funding cuts. FHC seemed to be aware of the cooptive effect of state money. Iris stated that they did not apply for any federal or state funding because they did not want the "strings attached" that would affect their feminist work.

The laws on reproductive services (abortion and contraception) show the state's direct effect on FHC and WHC. There were also indirect state pressures on these agencies in the form of the increased state scrutiny over their operations. In WHC, increased state scrutiny was discussed within the context of liability. Liability concerns led to increased education and documentation, which increased time in services. In FHC, state scrutiny was related to medicine. It was the organized medicine acting through the state (in influencing the enforcement of medical licensure laws) that affected the use of lay workers.

Relationships with organized medicine

As discussed in the literature review, one of the major ways the WHM challenged medicine was through self-help, especially the use of non-professional (lay) workers in health care. To this, organized medicine responded by establishing and influencing the enforcement of medical licensure laws, and exerting pressure on the reimbursement policies and regulatory practices (Morgen, 2002). As stated by Morgen (2002), medical licensure laws were used to

regulate the practices of women-controlled clinics through criminalizing self-help gynecology (requiring physical licensure for gynecological and abortion services), and thereby maintaining physicians' monopoly over reproductive services. As Morgen (2002) said:

Despite their ideological commitment to overturning professional (and male) control of health care, feminist clinics had to work closely with doctors, often under the license of a physician -and the physician was typically a white male- if they sought to provide abortions, family planning, or many other gynecological services legally and in a way that could be reimbursed by private and third-party payers. (p. 127)

FHC staff also worked closely with Dr. Z (who was a white male), whose license covered them. Although a white male, Dr. Z was in line with the feminist ideology of the center and trained lay workers until the regulations became more strict. Morgen (2002) admitted that although physicians had power in feminist agencies (through their license), their relationships with the lay staff and power to dictate policies varied. It depended on their values and beliefs about the role of nonprofessionals in health care, about self-help, and the attitudes of the clinic staff about how they wanted the physician to function within the organization. On this point, it is interesting to compare Dr. Z and the current medical director Duncan in their beliefs on the use of lay workers (mid-level paraprofessionals in Duncan's case) in health care. Both are white male physicians, but they differ in their beliefs on self-help and consequent feminist consciousness in the context of women's health care. The current FHC lay staff also seemed to be less willing to perform medical tasks or even medical consultations over the phone relying increasingly on the physician's assistant for these tasks they used to perform on their own.

The reasons for increased reliance on practitioners seem to be economic pressures (efficiency) and the staff beliefs that women's needs changed. In terms of the women's needs, Iris and Hazel mentioned the decreased need for peer -lay- services, to which Hazel added women's changed (more positive) attitude toward doctors.

Both Iris and Hazel discussed the change in women's needs within the context of the changes in the Women's Health Movement, which shows the how staff's beliefs on the WHM's effectiveness might affect care. Iris believed that the Women's Health Movement increased the knowledge on women's bodies and health. FHC contributed to this through their quarterly publication. She links the stopping of their publication partly to this decreased need for information. When pushed further though, she does admit that even though there is more information on women's bodies, it is provided from a medical view, which shows the cooptation of the movement's aims as much as its accomplishments.

The intertwined effect of economy and medicine, thus, is another major force to coopt the WHM. Before discussing the economic issues, I would like to discuss two influences of organized medicine on FHC and WHC, specifically the reimbursement policies and marginalization of abortion.

Morgen (2002) states that it was not so much the licensing laws but the reimbursement policies of private and public health insurance plans that led to a decrease in the use of lay workers. Physicians had a tremendous effect on the development of the third-party payer policies according to which the insurance plans would only cover services that were provided by a physician. In FHC, while Iris stated the significance of medical licensure laws on the decreased use of lay workers in medical services, Felicia emphasized the role of reimbursement policies, which supports Morgen's (2002) argument. She stated that after the reorganization of health care around HMOs, the insurances no longer paid for lay workers to perform pelvic exams.

In addition to influencing licensing laws and reimbursement policies, organized medicine was also responsible for the marginalization and stigmatization of abortion through physicians' unwillingness to learn or perform the procedure and shunning of providers who provided them. The "doctors of conscience" Joffe (1991) studied testify that in spite of legalization, abortion has never been fully accepted by mainstream medicine, particularly by obstetrics and gynecology.

Abortion and abortion providers were also not accepted by the medical communities where FHC and WHC were located. This was seen in many physicians' unwillingness to provide abortion, in their attitude toward women, and, as Sam the medical director of WHC stated, in the lack of training for and residency in abortion.

As discussed before in the literature review, even though medicine as an organized force resisted and coopted the WHM, there have always been individual physicians who have worked within the movement or, like Joffe's (1991, 1995) "doctors of conscience", performed abortions before and after *Roe v. Wade*. The medical directors of both centers could be considered "doctors of conscience." Duncan performed abortions before *Roe v. Wade* and both Duncan and Sam witnessed the consequences of incompetent (botched) abortions. After *Roe vs. Wade*, both performed abortions for reasons of conscience, a deeply held belief that women should be able to end unwanted pregnancies, a belief formulated through observing women's determination to seek abortions, the humiliation of "therapeutic abortions", and the devastating consequences of incompetently performed abortions.

As Joffe's doctors, Sam and Duncan also belong to this dying breed of doctors who carry the "memory" of illegal times. Remembering the illegal times and increasing the supply of abortion providers through training gain special importance within the context of diminishing supply of abortion providers. Felicia claims that both the memory of the illegal times and the scarcity of abortion providers are lost to the current generation of women.

The relationship of the centers to organized medicine was a reciprocal one. FHC and WHC were not passive recipients of pressures. They were active participants on an ongoing challenge of medicine. Both centers provided women with alternative and more comprehensive information and a non-medical environment. FHC was also instrumental in the introduction of a non-hormonal method of contraception, the cervical cap. FHC further used lay workers towards the modeling of more egalitarian relationships between the women and providers (and between

medical and non-medical staff). Both centers also attempted to influence the medical community, specifically in recruiting doctors and educating them about abortion work through letters (FHC) and hospital ground rounds (WHC). In WHC, Mary also alluded to what I call a "spill-over effect." The doctors (and women) who interacted with the centers were introduced to a women-controlled health center where the doctors had limited power.

Economic pressures: The capitalist health care economy

FHC staff believed that there was a difference between the women's health information FHC used to provide through the newsletter and the (tons of) information that is now available in mainstream media. Iris states that this reflects cooptation of the WHM. The capitalist context of U.S. medicine is responsible for coopting the WHM's aim of empowering women through education, where providing women with information was expected to increase women's power against the doctor.

One way the cooptation was accomplished was through the formation of new "women's health centers." Morgen (2002) states that, with the reversal of federal spending on health care in 1980s that reinforced the competitive market model for the medical system, many hospitals and physician-owned groups developed women's health centers to provide primary care for women. These centers' rhetoric included empowerment, wellness, prevention, and education. Although the centers provided women with information, the information was from the mainstream medical model emphasizing, for example, the benefits of estrogen replacement therapy and other pharmaceuticals, mental health counseling, mammography and such costly and highly technological tests. Unlike feminist (or women-controlled) centers, these centers did not encourage political activism regarding women's reproductive rights, such as helping women understand the effects on women's health of cuts in social programs such as WIC, food stamps, or welfare or mobilizing them to fight against such cuts.

Within the competitive market economy of health care, feminist centers had to compete with these new women's health centers and with the Planned Parenthood Federation of America. Planned Parenthood organizations chose to open abortion clinics in communities served by small feminist clinics. Gail Sands of the Emma Goldman Clinic in Iowa states that, "instead of going into 'underserved areas', Planned Parenthood targets markets that have already been set up for them by the blood, sweat, and tears of feminist clinics" (Morgen, 2002, p. 150). This led to competition for clients and loss of services in some clinics due to diverting of federal funds to Planned Parenthoods. FHC's experience with the Planned Parenthood organizations in their region was typical of the experience of the other feminist clinics in losing clients and funds (donations). This competition with Planned Parenthoods also threatened the staff's retirement pensions. The strategy FHC was using to deal with this competition was to reach out to the community and acknowledge the business aspect of feminist care.

WHC's competition was with abortion providing centers in neighboring states without parental consent laws and waiting periods. WHC's director also discussed increased liability concerns and the need to "balance care with staff salaries", and "balancing care with liability." As with the FHC, WHC also had to recognize the business aspects of women-centered care.

The strategies WHC used to deal with these business pressures were to reorganize the services to accommodate client's time (by including phone consultation and group video) to deal with the competition with centers in neighboring states. To address liability issues, WHC maintained and hired more Registered Nurses for the recovery area and prohibited women's partners, friends, or family members from the procedure or recovery areas. Thus, liability issues also limited women's support during abortion and in aftercare to center counselors.

Accomplishments and challenges

As discussed in chapter two, the Women's Health Movement critique of modern medicine revolved around the medicalization of normal reproductive events, the male monopoly in medical education and practice (especially gynecology and obstetrics), a biomedical model of health, androcentric bias in medical education and research, and the growing relationship between capitalism, medicine, and patriarchy. Women's Health Movement activists fought for:

- Increased control for women in decision and actions affecting their bodies and health.
- The de-medicalization of women's life events and problems (defining health care issues so as to release women's experiences from needless medical ownership and excessive therapeutic control).
- An emphasis on information (around women's health issues), prevention and less invasive treatment.
- An atmosphere of interpersonal respect between physicians and patients, regardless of gender, class, and race.
- The centrality of a sociomedical as opposed to a biomedical model of health.
- Increased number of female providers (including physicians and paraprofessionals).
- Increased research on women's health research (including allocation of more funds to women's health research).
- A commitment to health care as a right, including legislative efforts to ensure women's reproductive right and guaranteeing access to physicians and hospitals regardless of financial or insurance status.

(Thomas, 2000; Zimmerman, 2000; Zimmerman and Hill, 2000, p. 773)

By the 1990s, the major accomplishments of the Women's Health Movement by 1990s were in the areas of raising women's and public consciousness about reproductive rights, scoring important gains in health policy and keeping abortion legal, leading to the attitudinal changes in some physicians, and contributing to the rise of information on women's health (Gordon, 1990; Morgen, 2002; Norsigian, 1996). In the issues of women and/in medicine, the WHM also succeeded in increasing the number of women (including women of color) in medical education

and practice, increasing federal money to women's health research, and helping to establish (by NIH) of the Office of Research on Women's Health and the NIH-mandated inclusion of women in all research grants (Morgen, 2002).

Despite these accomplishments, the WHM did not lead to a major change in the medical establishment (medical education, training, and practice). The movement did not fully succeed in de-medicalizing reproductive events, the provision of alternative services did not threaten or change established medical institutions (Norsigian, 1996; Gordon, 1990), and the "control of women's health care still remains in the province of physicians and other health professionals, who, although they manage patient care differently than before, still manage it nevertheless" (Morgen, 2002, p. 149). Although the movement led to an increase of women in medicine, as discussed in chapter two, women in medicine are concentrated in low-paying low status jobs and medical education and practice are still fraught with gender inequities (Zimmerman, 2000). Lastly, affordable, accessible respectful health care (especially for poor and uninsured women) remains an ongoing challenge.

In this last section, I will discuss the findings within the contexts of these aims, accomplishments, and continuing challenges of the WHM in order to address the underlying question of this research, namely what the findings reflect in terms of the legacy of the WHM.

Women's control over their body and health

In terms of the first aim of the WHM, that of increasing women's control in decisions and actions affecting their bodies and health, even though staff of both agencies discussed (and FHC's mission included) increasing women's control over their bodies and health, the findings of the present study reflect that women do not feel in control (or demand control) over their bodies. This is reflected in the main finding of the study, which is women's emphasis on safety and respect (over control). Women's made three references to control (i.e., receiving non-directive care, the

sense of empowerment derived from the abortion decision and going through with it in a safe, validating environment, and peer services), which again were discussed within the contexts of safety and respect.

While discussing safety, women made references to physical and emotional safety. They mentioned feeling vulnerable due to anti-abortion violence and uncomfortable or abusive interactions with providers. They felt being judged for receiving abortion and birth control services, and for asking questions of providers. Under humane care, women discussed the importance of time, information, and not being treated as a number in a mass-production setting. The centers stood out for the women from other providers for the ways they addressed these safety and dignity issues. While the centers addressed these issues, women's references to vulnerability and to judgmental, directive, inhumane care in most other providers means that after 30 years of struggle by the WHM's advocates, women still do not feel completely in control of their bodies and health in mainstream medicine. They instead feel vulnerable and judged, unsafe, and not respected by their providers, which shows the continuing authority of medicine and medical practitioners over women. The need for physical safety -from violence- and fear of being judged for having an abortion, on the other hand, shows the success of the anti-abortion movement in stigmatizing and criminalizing abortion.

Demedicalization

In order to increase women's control over their bodies and health, WHM activists worked to demedicalize women's reproductive life events. I will discuss FHC and WHC's accomplishments and challenges in demedicalization of women's reproductive lives within the context of strategies included in Ruzek's (1978) analysis of the WHM. When Ruzek (1978) wrote her analysis of the Women's Health Movement, she listed five main strategies women's health activists used to restructure health care and deinstitutionalize medical authority. These were: (1)

reducing the knowledge differential between patient and practitioner, (2) challenging the license and mandate of physicians to provide certain services, (3) reducing professionals' control and monopoly over related goods and services, (4) altering the size of the profession relative to clientele, and (5) transforming the clientele from an aggregate into a collectivity.

In order to reduce the power difference between professionals and women clients that is based on women's lack of knowledge about their bodies and the health care system, women's health activists employed strategies like educating patients, practitioners, and law-makers, selective utilization of practitioners, and self-help activities (Ruzek, 1978). As observed by the "being informed" dimension of the core category, both centers provided women with a multitude of information on women's health issues through staff interactions (interactions with lay workers, counselors, nurse practitioners and physician's assistants), pamphlets, and posters.

Ruzek (1978) stated that women's health activists also directed educational efforts towards medical personnel in both conventional and alternative settings, introducing them to atraumatic abortion techniques and raising questions involving psychological, legal, and social problems surrounding abortion. These were accomplished through conferences, workshops, physician-training programs (in early vacuum aspiration abortion in woman-controlled settings), demonstrations of self-examination in nursing and medical schools, and requiring medical schools to buy and distribute to medical students packets of materials including a copy of *Our Bodies, Ourselves*. Both centers "educated" their own medical personnel. In FHC, this was reflected in the physicians' (and physician's assistant's) introduction to an egalitarian workplace where the medical personnel's power over women and over non-medical staff was reduced.

In WHC, the physicians were also introduced to a workplace run by women, where they had less power than in a hospital or private practice setting, but also were exposed to a more supportive -less competitive- environment. However, as discussed more than once before, the

doctors in WHC did have power in the running of the agency through the medical committee and by holding key positions in the agency.

WHC also educated the doctors on less traumatic abortion techniques. Sam, was, however, resistant to the use of the manual aspirator, which Bridget (nurse practitioner) was trying to adopt in the reevacuation procedure in abortion complications for its less traumatic effect than a D & C. Both centers had outreach attempts to educate the physicians in the community on abortion (through letters in FHC, hospital ground rounds in WHC, and training of residents in both). They, however, had mixed success due to varying levels of acceptance from doctors and limited funds to continue such activities.

Ruzek (1978) includes selective utilization of providers and self-help activities as the other components of reducing the information gap between the women and the providers. Selective utilization refers to feminists' channeling of patients to approved physicians while cutting the supply to those offering inferior or overly expensive services through publishing health directories and guides that inform women about where abortions, contraceptives, maternity care, and health referral were available, what the fees were, whether the service provider accepted public or private insurance, and some evaluation of the services (Ruzek, 1978). Both centers did provide brochures of other abortion providers (including their fees); however there were no evaluation of their services and the providers were not compiled in a community guide. In terms of self-help activities, as mentioned in the previous section, self-help activities, which only existed in FHC, were discontinued, and self-help was practiced at both centers only at the informational (not the activity) level.

The second and third strategies Ruzek (1978) mentions are challenging the license and mandate of physicians to provide certain services and reducing the professionals' control and monopoly over related goods and services. Ruzek maintained that alternative (feminist) institutions that utilized paraprofessionals and lay women challenged professional mandate and

license of physicians. She distinguished between traditional-feminist and radical-feminist settings. Physicians' time with the women was minimized in both of these settings. In radical feminist settings, physicians were further relegated to a technician status (hired only to do the things restricted by law). Paraprofessionals and lay women provided most of the routine care in traditional and radical settings respectively. The relationship between the patient and provider in both was one of "mutual participation." The main differences between the settings were on the level of power doctors had, the use of lay women and assumptions on patients' responsibility over their own care. In radical settings, women were encouraged by lay staff to participate in their own care including performing exams and taking blood pressure.

As discussed in the first section of this chapter, in FHC and WHC physicians' time with the women was minimized and female professionals (nurse practitioners and counselors) in WHC, and female professionals (physician's assistant) and lay women in FHC provided most of the actual care. As mentioned before, the success of this in demedicalization of services is dependent upon the quality of the doctor-patient interaction. This in turn is determined by the doctors' fit with the empowerment ideology, her power (through division of labor) in the agency, and women's interpretation of time spent with lay workers and doctors (their awareness of the importance of lay women).

This finding of the study has important implications for the Women's Health Movement. The use of female professionals and lay women to minimize physician's power (through minimizing their time with patients) is not effective without challenging doctor's power through the division of labor and their ideology on sharing power with women. Simonds (1996) found in her study of a feminist clinic that, by providing feminist care that includes support, nurturance, and decreasing the distance between the provider and clients, health workers in effect were doing "emotional labor", which "shielded the physicians at the Center from involvement with clients." Simonds describes how the doctor enters the examining room after the client has undressed and

climbed into the table. The health worker introduces the doctor, tells what is happening step by step, and if there is any difficulty, helps the woman to relax. Simonds concludes that to accomplish feminist goals, health workers acted as mediators between the doctor and the client, which reinforced the typical doctor-lay staff (and I add typical doctor-patient) relations "in which doctors are excused from emotional involvement." I also observed that, in WHC and FHC, the all-female nonmedical and in WHC medical –nurses- did "prepare the clients for" and "made things flow" for the doctors, mediating the interaction between the doctor and patient during abortion. I need to qualify this by saying that this was the case only for the physicians. The nurse practitioners in WHC and the physician's assistant in FHC were emotionally involved and thus modeled a more egalitarian medical provider-client relationship. However, unless the lay workers also perform medical tasks and doctors share power with other staff and with women clients, then the WHM's strategy of using paraprofessionals or lay workers results in reinforcing doctors' power in doctor-patient relationships.

This raises a related larger issue WHM activists dealt with. As Ruzek (1978) states, feminists were divided on whether providing alternative institutions of health care for women challenged the existing medical system or helped "siphon off" discontent, allowing conventional institutions to ignore women's needs and/or dump "problem patients" to clinics. Thus, just as lay workers and paraprofessionals are doing the emotional work for doctors, so are the feminist or women-controlled agencies that provide abortion care in a nurturing way relieving mainstream medicine from performing abortions and providing alternative -more egalitarian and nurturing- care? Norsigian (1996) and Gordon (1990) state that the provision of alternative services did not threaten or change established medical institutions. And without such change in mainstream medicine (as influenced by influences of the centers and changes in medical education, training, and practice), women-controlled agencies (FHC and WHC) seem to be relieving mainstream

medicine from providing abortion care in specific and providing care in an egalitarian way in general.

The last two strategies Ruzek (1978) discusses are "altering the size of the profession relative to clientele" and "transforming the clientele from an aggregate into a collectivity". In terms of the first one, FHC was trying to increase abortion providers by training mid-level practitioners for abortion. Their attempts, though, were blocked by the medical director. Both centers were also sites for residency for medical students who wanted to work on abortion care. As quoted before though, Sam, the medical director of WHC, complained how few students in the community chose to do so. Regarding "transforming the clientele from an aggregate into a collectivity", as discussed under the category of "staff goals/motivations", one of the goals of the staff at both centers was to see the women talk about abortion and participate in pro-choice rallies. Even though some clients also mentioned the need to talk about abortion openly (and have famous people talk about their abortions), other findings such as women's judgments of self and others 'deserving an abortion', the overwhelming wish for anonymous *and* individual services (where collectivity was seen as 'herding') reflect that women did not think of themselves as a collective force in reproductive services. Even though the centers were involved in political advocacy and had posters and brochures about women's rights throughout the center, there were no efforts to "raise consciousness" in workshops or counseling.

Accomplishments and challenges in women and medicine

One of the aims of the WHM was to decrease the androcentric (male-centric) bias in medicine by increasing the number of female providers (physicians and paraprofessionals) in medicine. As noted before in chapter two, the WHM succeeded in increasing the number of women (including women of color) in medical education and practice (Morgen, 2002). Iris

recognized the WHM's success in increasing the number of paraprofessionals such as midwives and nurse-practitioners (who are predominantly women) in women's health care.

However, WHM activists soon realized that *adding more women* to medicine without changing the content and process of medical education and practice did not lead to major changes in the gendered structure of medicine (Zimmerman, 2000). As Zimmerman (2000) found, despite the increase in the number of women in medical education, not all of the female students moved on to residencies, and the women doing residencies were concentrated in the fields of family practice, internal medicine, obstetrics/gynecology, pediatrics and psychiatry⁴. As faculty in medical school, Zimmerman (2000) notes how women physicians experience a "glass ceiling" within medical schools, moving into positions of authority less often and more slowly than men. Zimmerman cites Bickel's (1995) suggestion that this is mainly a result of three processes of "cumulative disadvantage": sexist practices (e.g. collegial exclusion and harassment under the guise of joking); the inflexibility of the organizational structures to provide support to women in balancing work and family (through interpersonal sensitivity and adequate policies regarding insurance, maternity leave, child care, and flex-time arrangements); and the lack of mentoring. These factors, Zimmerman (2000) suggests, create barriers for women in professional advancement and might lead to self-selection into fields that are less populated by men (thus less hostile to women) and that have less demanding requirements (e.g. choosing internal medicine than general surgery). Sally's experience provides evidence for the self-selection of women into less demanding positions (physician's assistant instead of physician) due to the inflexibility of medical school and practice in supporting women (or men) in balancing family and work. Sally also knew about sexism in medical school through her friends and she experienced sexism in medical practice.

⁴ Citing Miller, Dunn, & Richter (1999), Zimmerman (2000) notes that in the 1998-1999 academic year, 37% of resident physicians were women, which was less than the proportion of women among undergraduate medical students.

Zimmerman (2000) found that sexism in medicine was also reinforced by deficiencies and male bias in the content and structure of medical curricula. Regarding medical curricula, she states that since most clinical teaching is done on an apprenticeship model, the changes in doctor-patient communication (in treating women with respect) that has been added to the curriculum should also be reflected in the faculty's behavior. Nel's (a medical intern in WHC) experience in medical school reflects the importance of learning through apprenticeship and the need to change practices along with the curriculum. In her education, she observed the gendered division of labor that exist between doctors and nurses/nurse practitioners where doctors performed the technical parts and left the nurturing (emotional care) to female nurses.

Women's Health Movement advocates have criticized this gendered division of labor in medicine in the forms of women's subjugation to systematic opposition in becoming physicians and their exploitation within medicine in low status and low paying positions, attributing it to the capitalistic and patriarchal nature of medicine.

These findings from FHC and WHC on women and medicine reveal that the WHM was not successful in abolishing sexism in current medical education and practice. Medical school still seems to be a hostile place for women where they have to 'prove themselves'. As Zimmerman suggests and Sally displays here, the inflexible structures of medical school and practice do seem to increase the concentration of women in the nurse practitioner and physician's assistant positions, where they are subject to further discrimination through the gendered division of labor that exists in medicine. The findings thus reveal that increasing the number of women in medicine is not effective in changing the male bias in medicine. It needs to be complemented by parallel efforts to change the sexist curriculum, practices, and the division of labor that privileges physicians.

Summary and implications for future research on empowerment

In this chapter I discussed the findings of the study in relation to the concept of empowerment and within the context of the Women's Health Movement (its history, aims, and legacy). In the context of the Women's Health Movement (WHM) I argued that both the Feminist Health Center (FHC) and the Women's Health Center (WHC) are movement organizations that are women-controlled -established and operated by women. I also argued, however, that WHC operated in a more hierarchical and medical model, whereas FHC had more of the typical characteristics of women-controlled settings, such as an egalitarian (collective) structure with the use of lay workers, job rotation, and (in the past) self-help to decrease medical authority and with the empowerment of staff accepted as an explicit goal of the center. I discussed how, as movement organizations, FHC and WHC both defined and were defined by the Women's Health Movement's; its aims and the external pressures on it from the state, economy, medicine, and the anti-abortion movement.

In terms of the concept of empowerment, women defined empowerment not as control but as safety and respect. I discussed possible reasons for this important finding: that, despite the Women's Health Movement's attempts, women still did not feel in control of their bodies and reproduction (in the context of services), or that safety and respect may also be denoting the *conditions* of empowerment, which is accomplished over time.

In relation to the empowerment models, I discussed the findings within the context of the three dimensions of empowerment: access, service delivery characteristics, and the ethics of care. In the access dimension, "time" was the main category that was meaningful for the women, followed by "distance." Findings of this study showed that, contrary to what the literature suggests, women interpreted time and distance as more than indicators of "access" to services. In this study, the concept of 'time' - time allowed for women to ask questions, to voice concerns, and to go through counseling, gynecological, and abortion procedures at a comfortable pace and time to accommodate women's scheduling needs - did not mean easy access but rather dignified

care. Women also interpreted the concept of distance as more than “access” - as access mediated by safety (anonymity) and good care. While some women chose the centers because of their proximity, others who lived far preferred them because they could remain anonymous or because of the high level of care they previously received from the centers.

In relation to “service delivery characteristics”, another dimension of empowerment models, all the components that were mentioned in the literature (e.g. providing correct and adequate information, choice of methods, etc.) also emerged in this study under the core category or under agency factors. In regards to the last dimension, “ethics of care”, in line with the literature, women in the present study did interpret certain aspects of “access” (i.e. time) and “service delivery characteristics” (i.e. being informed, being provided choices, individualized and egalitarian care) as ethical issues.

I believe that the most important implication of the findings for future research and theorizing on empowerment is in its support for feminist ethics and its concept of “relational autonomy.” Sherwin (1998) argues that within biomedical ethics, autonomy is conceptualized as an issue of control of medical decision-making at the moment of treatment between an individual doctor and a patient. This model of health care ethics neglects the fact that the range of options available to both parties at the time of treatment has been significantly reduced by prior decisions on research agendas, allocation and accessibility of health care resources, and by the power of the dominant medical tradition. Sherwin states that feminist ethics requires that these “prior layers of decision-making” be exposed and evaluated and “justice” and “autonomy” be redefined as socially situated terms. The findings of the present study do expose these prior layers of decision-making that affect women's feelings of autonomy or empowerment. The findings show how autonomy, which emerged here as feeling safe and respected, was affected by agency, community, and societal factors. The findings reveal the complexity of the interactions between these factors in enabling or limiting women’s empowerment. For example, in FHC, when a

woman wished to see her aborted fetus, the doctor refused it and the lay staff failed to confront him to advocate for the woman (as required by the feminist mission). The staff recounting this event attributed the lay staff's behavior partly to the fear of losing their doctors, a founded fear in the context of scarcity of abortion providers. This example shows how a woman's empowerment was curbed by medicalization (medical power) at the agency, as mediated by feminist consciousness and scarcity of abortion providers in the community. The scarcity itself was due to the success of the antiabortion movement in scaring the doctors and medicine's ongoing marginalization of abortion providers.

While exposing the prior levels of decision-making, the findings also showed that the effects of agency, community, and societal factors were mediated through women's awareness of them and their preferences regarding them. For example, even though the provision of insurance coverage for abortions has expanded over time, most women clients were not aware of it. And when they were aware of it, some were still unwilling to use abortion and at times birth control coverage for confidentiality purposes (for fear of judgments from family or providers). As another example, although women recognized and appreciated the peer-like approach, in neither clinic were they aware of the importance of having lay women in services as a strategy of empowerment. In terms of future research, these examples emphasize the need to take into consideration women's awareness and preferences while studying empowerment at multiple levels.

In addition to supporting Sherwin's thesis, the findings also bring out the unexpected aspects of empowerment. For example, while both agencies were subject to anti-abortion violence, the violence also brought out the silent pro-choice support in their respective communities. As Mary in WHC reported, there was also what I called a "spill-over" effect of demedicalization. The doctors and women who called the WHC were exposed to an agency run by women, where the doctors had less power than they did in private practice or hospital settings.

A negative unexpected aspect of empowerment, on the other hand, was seen in the category of “time.” When the state in which WHC was located adopted the laws on the 24-hour waiting period before an abortion, WHC adopted measures such as phone consultation and a group showing of the video on the state-mandated information to accommodate women’s time. While the decreasing of the waiting time is beneficial for empowerment, the group video increased the feelings of being herded, thus curbing women’s empowerment (in terms of their wish for individualized care). Taken together, these examples show the need to be aware of unintended aspects of empowerment in future research.

REFERENCES

Ainsworth-Vaughn, N. (1995). Claiming power in the medical encounter: The whirlpool discourse. *Qualitative Health Research*, 5(3), 270-291.

Behar, R. (1993). *Translated woman: Crossing the border with Esperanza's story*. Boston: Beacon Press.

Bickel, J. (1995). Scenarios for success-enhancing women physicians' professional advancement, *Western Journal of Medicine*, 162, 165-169.

Bleier, R. (1991). Sex differences research: Science or belief? In R. Bleier (Ed.), *Feminist approaches to science* (pp. 147-164). New York: Teachers College Press.

Bruce, J. (1990). Fundamental elements of the quality of care: A simple framework, *Studies in Family Planning*, 21(2), 61-91.

Cooksey, E. C., & Brown, P. (1998). Spinning on axes: DSM and the social construction of psychiatric diagnosis, *International Journal of Health Services*, 28(3), 525-554.

Cott, N. F. (1977). *The bonds of womanhood: Women's sphere in New England, 1780-1835*. New Haven, CT: Yale University Press.

Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.

Ehrenreich, B., & English, D. (1972). *Witches, midwives, and nurses: A history of women healers*. Glass Mountain Pamphlet, no. 2. Old Westbury, NY: The Feminist Press.

Fausto-Sterling, A. (1985). *Myths of gender*. New York: Basic Books.

Ferree, M. M., & Martin, P. Y. (1995). Doing the work of the movement: Feminist Organizations. In M. M. Ferree, & P. Y. Martin (Eds.), *Feminist organizations: Harvest of the Women's Movement* (pp. 1-23). Philadelphia: Temple University Press.

Foster, P. (1995). *Women and the health care industry: An unhealthy relationship?* Buckingham: Open University Press.

Frankfort, E. (1972). *Vaginal politics*. New York: Quadrangle Books.

- Freeman, J. (1972). The tyranny of structurelessness. In A. Koedt, E. Levine, & A. Lapone (Eds.), *Radical feminism*. New York: Quandrangle/New York Times Book Co.
- Freire, P. (1970). *Pedagogy of the oppressed*. New York: Continuum.
- Gibson, C. H. (1991). A concept of the analysis of empowerment. *Journal of Advanced Nursing*, 16, 354-361.
- Glazer, N. (1988). Overlooked, overworked: Women's unpaid and paid work in the health services "cost crisis", *International Journal of Health Services*, 18(1), 119-137.
- Gordon, L. (1990). *Woman's body, woman's right: (Revised and updated) Birth control in America*. New York, NY: Penguin Books.
- Griffith, P. J. (1997). Medical and social dynamics of college women's interactions with their gynecologists, *Sociological Inquiry*, 67(4), 397-408.
- Grosz, E. (1993). Bodies and knowledges: Feminism and the crisis of reason. In L. Alcoff, & E. Potter (Eds.), *Feminist epistemologies* (pp. 187-216). New York: Routledge.
- Harding, S. (1993). Rethinking standpoint epistemology: "What is strong objectivity?" In L. Alcoff, & E. Potter (Eds.), *Feminist epistemologies* (pp. 49-82). New York: Routledge.
- Illich, I. (1976). *Medical Nemesis: The expropriation of health*. New York: Pantheon Books.
- Joffe, C. (1991). Portraits of three "physicians of conscience": Abortion before legalization in the United States, *Journal of the History of Sexuality*, 2(1), 46-67.
- Joffe, C. (1995). *Doctors of conscience: The struggle to provide abortion before and after "Roe v. Wade"*. Boston: Beacon Press.
- Kols, A. J., Sherman, J. E., & Tilson Piotrow, P. (1999). Ethical foundations of client-centered care in family planning, *Journal of Women's Health*, 8(3), 303-312.
- LaCheen, C. (1986). Population control and the pharmaceutical industry. In K. McDonnell (Ed.), *Adverse effects* (pp. 89-136). Toronto: Women's Press.

- Lather, P. (2000). Drawing the line at angels: Working the ruins of feminist ethnography. In E. A. St. Pierre & W. S. Pillow (Eds.), *Working the ruins: Feminist poststructural theory and methods in education* (pp. 284-311). New York: Routledge.
- Lennon, K. & Whitford, M. (1994). Introduction. In K. Lennon, & M. Whitford (Eds.), *Knowing the difference: Feminist perspectives in epistemology* (pp. 1-14). London: Routledge.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage.
- Lorber, J. (1997). The doctor knows best: Gender and the medical encounter. In J. Lorber, *Gender and the social construction of illness* (pp. 35-54). Thousand Oaks, CA: Sage.
- Mansbridge, J. (1973). Time, emotion, and inequality: Three problems of participatory groups. *Journal of Applied Behavioral Science*, 9 (2/3), 351-368.
- Miles, A. (1991). *Women, health, and medicine*. London: Open University Press.
- Morantz-Sanchez, R. M. (1985). *Sympathy and Science: Women physicians in American medicine*. New York: Oxford University Press.
- Morgen, S. (2002). *Into our own hands. The women's health movement in the United States, 1969–1990*, Rutgers University Press, New Brunswick, NJ.
- Norsigian, J. (1996). The women's health movement in the United States. In K. L. Moss (Ed.), *Man-made medicine: Women's health, public policy, and reform* (pp. 79-97). Durham: Duke University Press.
- Oakley, A. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.), *Doing feminist research* (pp. 30-61). London: Routledge and Kegan Paul.
- Petchesky, R. P. (1990). *Abortion and woman's choice: The state, sexuality, and reproductive freedom (revised edition)*. Boston: Northeastern University Press.
- Pillow, W. S. (2000). Exposed methodology: The body as a deconstructive practice. In E. A. St. Pierre & W. S. Pillow (Eds.), *Working the ruins: Feminist poststructural theory and methods in education* (pp. 199-219). New York: Routledge.

- Pritchard Hughes, K. (1995). Feminist pedagogy and feminist epistemology: An overview, *International Journal of Lifelong Education*, 14(3), 214-230.
- Rappaport, J. (1981). In praise of paradox. *American Journal of Community Psychology*, 9(1), 1-25.
- Rappaport, J. (1985). The power of empowerment language. *Social Policy*, 16:15-21.
- Reinharz, S. (1992). *Feminist methods in social research*. New York: Oxford University Press.
- Richardson, L. (1994). Writing: A Method of Inquiry. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp 516-529). Thousand Oaks, CA: Sage.
- Richardson, L. (1997). *Fields of play: Constructing an academic life*. New Brunswick: Rutgers University Press.
- Riger, S. (1984). Vehicles for empowerment: The case of feminist movement organizations. *Prevention in Human Services*, 3(2/3), 99-117.
- Robertson, A., & Minkler, M. (1994). New health promotion movement: A critical examination. *Health Education Quarterly*, 2(3), 295-312.
- Rosser, S. V. (1994). Androcentric bias in clinical research. In S. V. Rosser, *Women's health missing from US Medicine* (pp. 3-15): IU Press.
- Ruzek, S. B. (1978). *The women's health movement: Feminist alternatives to medical control*. New York, NY: Praeger Publications.
- Sargent, C., & Brettell, C. (1996). Introduction: Gender, medicine, and health. In C. F. Sargent & C. B. Brettell (Eds.), *Gender and Health: An International Perspective* (pp. 1-28). New Jersey: Prentice Hall.
- Scheurich, J. J. (1997). A postmodern critique of research interviewing. In J. J. Scheurich, *Research in the postmodern* (pp. 61-77). London: The Falmer Press.
- Seaman, B. (1972). *Free and female*. New York: Fawcett.

Sheilds, L. E. (1995). Women's experiences of the meaning of empowerment. *Qualitative Health Research*, 5(1), 15-35.

Sherwin, S. (1998). A relational approach to autonomy. In S. Sherwin (Coordinator), *The Politics of Women's Health: Exploring agency and autonomy* (pp. 19-47). Philadelphia, PA: Temple University Press.

Sherwin, S. (1996). Cancer and women: Some feminist ethics concerns. In C. F. Sargent, & C. B. Brettell, *Gender and health: An international perspective* (pp. 187-204). New Jersey: Prentice Hall.

Simmons, R., Hall, P., Diaz, J., Diaz, M., Fajans, P., & Satia, J. (1997). The strategic approach to contraceptive introduction. *Studies in Family Planning*, 28(2), 79-94.

Simmons, R., Kay, B., & Regan, C. (1984). Women's health groups: Alternatives to the health care system. *International Journal of Health and Services*, 14 (4), 619-634.

Simonds, W. (1996). *Abortion at work: Ideology and practice in a feminist clinic*. New Brunswick: Rutgers University Press.

Spender, D. (1978). *Educational research and the feminist perspective*. Unpublished paper, British Educational Research Association Conference on "Women, Education, and Research", University of Leicester.

Stanley, L. & Wise, S. (1983). *Breaking out: Feminist consciousness and feminist research*. London: Routledge.

Strauss, A. L. (1995). *Qualitative analysis for social scientists*. Cambridge: Cambridge University Press

Szasz, T., & Hollander, M. H. (1956). A contribution of the philosophy of medicine: The basic models of the doctor-patient, *American Medical Association Archives of Internal Medicine*, 97 (May), 585-92.

Thomas, J. (1999). Everything about us is feminist: The significance of ideology in organizational change, *Gender and Society*, 13(1), 101-119.

Thomas, J. (2000). Incorporating empowerment into models of care: Strategies from feminist women's health centers, *Research in the Sociology of Health Care*, 17, 139-152.

Villenas, S. (2000). This ethnography called my back; Writings of the exotic gaze, "Othering" Latina, and recuperating Xicanisma. In E. A. St. Pierre & W. S. Pillow (Eds.), *Working the ruins: Feminist poststructural theory and methods in education* (pp. 74-95). New York: Routledge.

Weis, L., & Fine, M. (2000). *Speed bumps: A student-friendly guide to qualitative research*. New York: Teachers College Press.

Weisman, C. et al. (1995). The National Survey of Women's Health Centers: Current Models of women-centered care, *Women's Health Issues*, 5(3), 103-117.

Weisman, C. S., (1998). *Women's health care: Activist traditions and institutional change*. Baltimore: Johns Hopkins University Press.

Weltner, B. (1983). The cult of true womanhood: 1820-1860. In M. Gordon (Ed.), *The American family in social perspective*, Ed 3. New York: St. Martin's Press.

World Health Organization. (1986). *Ottawa Charter for Health Promotion*. Copenhagen.

Yanoshik, K., & Norsigian, J. (1989). Contraception, control, and choice: International perspectives. In R. Ratcliff (Ed.), *Healing technology: Feminist perspectives* (pp. 61-72). Ann Arbor: University of Michigan Press.

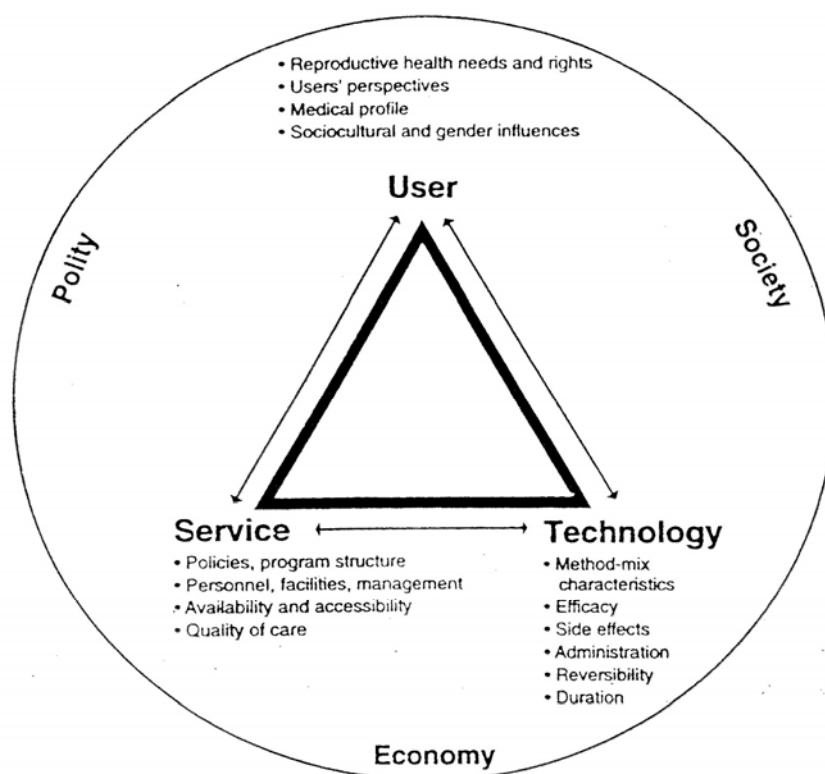
Zimmerman, M. K. (2000). Women's health and gender bias in medical education, *Research in the Sociology of Health Care*, 17, 121-138.

Zimmerman, M. K., & Hill, S. A. (2000). Reforming gendered health care: An assessment of change, *International Journal of Health Services*, 30(4), 771-795.

Zola, I. K. (1978). Medicine as an institution of social control. In J. Ehrenreich (Ed.), *The Cultural Crisis of Modern Medicine*. New York: Monthly Review Press.

APPENDIX A:

Strategic approach to contraceptive introduction (Simmons et al., 1997)



APPENDIX B:

Copies of the letter and consent form sent to agency directors

Date

Hazel Shimmer
Feminist Health Center
Address

Dear Hazel,

It was really good talking to you yesterday and I am sending this letter to explain in detail the research I would like to conduct at your agency. The research is partial fulfillment of the requirements for my doctoral degree in the department of Human Development and Family Studies at the Pennsylvania State University.

The purpose of the research is to study the empowerment of women clients in contraceptive services, which is women clients' participation in service provision. Reviewing the literature in reproductive services, I found out that, most research in this area is framed by the quality of care/customer satisfaction points of view, and concentrates on individual aspects of empowerment. Most studies also employ survey methods (with either providers or clients) or utilize results from national surveys on women and on providers (with the two not being matched). The present study, in contrast, will include an analysis of empowerment at multiple levels through qualitative methods such as interviews and observations. In contrast to the surveys that study women as abstracted from the service context, the study will also be one of the first case studies to investigate contraceptive services in their organizational setting and interview clients and providers of the same setting. Through the case study approach, the study will further contribute to research in women's settings (including organizations that are mainly run by and for women), which is lacking in sociology.

Enclosed here is a consent form for obtaining permission to review archival materials, such as agency policies, guidelines, educational pamphlets for clients, etc. The consent form details the procedures I would like to conduct in the agency. Through interviews with clients and staff involved in contraceptive service provision and observations, I would like to learn about the client and staff perceptions of service provision and the clients' participation in these services. I would like to interview all staff working in contraceptive services and 20 women clients between the ages of 20-40 receiving the services. If you agree to it, I propose to include 1-2 questions in staff and client interviews that your agency formulates on issues you would like to inquire from staff and clients. I would then analyze these separately and provide a report to your agency, which could be used in grant applications, etc.

I would like to discuss with you the best methods of recruiting staff and clients for interviews. What I had planned to do was to recruit women clients from the women waiting for services in the waiting room. Following this method, I will approach women clients, introduce myself as a graduate student at Penn State conducting research on empowerment of women in birth control services (participation of women in the services provided to them) and ask if they would agree to participate in an interview about the services they have received from this agency. I will tell the women that I am not affiliated with the agency, their participation is completely voluntary and that their refusal will not affect their service acquisition. (The staff who are approached for an interview will also be given the same information). If the women clients agree to participate in an interview, I will set up an appointment to meet with them either on the same day, or on another day that is convenient for them. If more women prefer to come on a separate day, a focus group might be set up. If your resources allow, I would appreciate the use of a room in the agency where I can conduct staff and client interviews in a confidential manner.

If you agree for your agency to participate research, I would need you to sign the informed consent form as well as write a letter of agreement from your agency, which is a letter with the agency letterhead that acknowledges my name, the project and your agreement to participate. This letter is required by Penn State research policies. The board that reviewed my research thought that approaching women 'cold' in the waiting room could be coercive, thus I might require a sentence from your in the letter of agreement that this procedure would be OK by the agency (in combination with for example the receptionist warning the incoming women to the presence of a Penn State researcher or the staff introducing me to the women clients, etc).

The research would take approximately two weeks: due to the in-depth nature of the interviews, I might be able to conduct only 3-4 client interviews a day and the availability of women clients for an interview would also determine the time frame. I am tentatively proposing the weeks of June 10th and June 24th to be there.

Please let me know what you think about all these. You can contact me from my home phone (814) 861 2146 or e-mail me at axd155@psu.edu.

Sincerely,

Ayse Dayi

**The empowerment of women clients in contraceptive services
Informed Consent Form: Agency Directors**

ABOUT THE RESEARCH:

The purpose of the research your agency is asked to participate in is to study the empowerment of women clients in contraceptive services, which is women clients' participation in service provision. The research is conducted by Ayse Dayi, a doctoral student at Penn State University in the department of Human Development and Family Studies, as part of her dissertation requirement.

WHAT WILL HAPPEN?:

If you agree for your agency to participate in this research:

- (1) All staff related to contraceptive service provision and a selected number of clients will be interviewed about their ideas and perceptions about the contraceptive services at your agency. The interview will take about an hour and will be audio taped and will include 1-2 questions you would like to staff and clients about your agency.
- (2) The investigator will also conduct unobtrusive observations of interactions between staff and clients and between the staff themselves and observations of a selected number of contraceptive counseling cases. The field notes from the observations will have no names of staff and clients, and only codes for staff. The observations of a selected number of contraceptive counseling sessions will be done only after getting signed consent from both the staff and client involved.
- (3) The investigator will review the agency policies and guidelines associated with contraceptive services, any forms or educational pamphlets provided to clients of contraceptive services, and any evaluations conducted by previous researchers. We need your signed consent to be able to review these materials.

The data from the interviews and observations will be used in writing a dissertation, articles and if negotiated, a general report to your agency about staff and client feedback of services. Your agency will not have any access to staff or client responses and any report provided to your agency will not have any identifying information on participating staff or clients.

WHO CAN I ASK IF I HAVE QUESTIONS ABOUT THE RESEARCH?

If you have any questions about this research, you can ask Ayse Dayi now or contact her at:

110 Henderson South
University Park, PA 16802
Phone: (814) 861 2146 (H)

WILL ANYONE KNOW MY AGENCY PARTICIPATED IN THIS RESEARCH?

No. All information will be kept strictly confidential. Any reporting of the data will have no names and no identifying information about the participants. Any reporting on the agency will not have the name of the agency but will refer to it as a women's health center in a mid-sized city in the east coast of the US. Only Ayse Dayi will have access to the identity of your agency. To assure confidentiality of staff and clients, a code number will be used on the tape transcripts and the list that matches names and identification codes as well as the actual tapes will be kept in a locked cabinet. The confidentiality of the clients will be assured by having no names on interview forms or transcripts. The list and the tapes will be destroyed two years after the completion of the study.

DOES MY AGENCY HAVE TO BE IN THIS RESEARCH?

No. Your participation in this research is voluntary. You may ask questions about the research, or withdraw entirely from the research without penalty.

ARE THERE ANY RISKS ASSOCIATED WITH PARTICIPATION?

The risks associated with staff participation are identification of agencies and individual staff in the resultant publications from the research. This risk will be minimized by (1) not including the names of the participating agencies in the published articles but referring to agencies as a feminist agency, or a health center run by department of public health all of which are located in a mid-size city in the east coast of the US, and (2) by not including the staff names on interview data or field notes.

The risks associated with client participation are breach of privacy of clients by asking questions about their contraceptive uses or by observing their session, and the possibility of information about forced sex coming through the course of the interview. Regarding the first, the participants will be told in the informed consent form that they might decline to answer specific questions during interview or withdraw from the study at any time. The participants will also read the Penn State's injury clause. Regarding the second risk, the investigator will ask the client if they received any help in dealing with the issue. In the case that they have not received any help, they will be given the referral sources listed on page 4.

IF YOU AGREE TO PARTICIPATE:

If you agree to have your agency participate in this research, please read and sign below and keep one copy for your records.

I am 18 years or older, have read and understand the information given to me, and I have received answers to any questions I may have had about the research procedure. .I understand and agree to the conditions of the research as described.

Participant's Signature

Date

I certify that the informed consent procedure has been followed, and that I have answered any questions from the participant as fully as possible.

Researcher's Signature

Date

APPENDIX C:
Recruitment flyer

Hello. Women's Health Center is currently supporting a research project being done by a graduate student from the Pennsylvania State University for her graduate dissertation. Her name is Ayse Dayi, and she is gathering information on women and reproductive services -how women perceive their contraceptive or abortion services and to what degree they participate in their own care. We would like to ask you to be a part of this research.

If you are between the ages of 18 and 45, and are willing to participate, Ayse (pronounced as Aisha) will call you in the week of March 11 to set up a confidential interview for the week of March 18. The interview could be done here at the center, or at another place of your choosing, such as your home, a restaurant or café, etc, and will last approximately 45 minutes. Ayse will audiotape the interview for her own convenience in retrieving accurate information for her research report, but your name will not be used and anything you say will be completely confidential.

Ayse would like to schedule the interviews in advance, as she will be travelling from State College, PA. If you are willing to be interviewed, please sign your name below and give us day or evening phone numbers and your preference as to where and what time of day you would prefer to be called.

We appreciate your cooperation. Thank you very much for your time and your commitment to women's health.

The Staff of Women's Health Center

Your Name: _____

Contact Information: _____

APPENDIX D:**Staff Interview Forms****Client Interview Form****Observation Protocol**

Staff Interview - Management

STAFF I.D.

<i>Pseudonym</i>	<i>Gender</i>	<i>Age</i>	<i>Position</i>	<i>Interview/Observation</i>
				S.I.

DEMOGRAPHICS

1. Gender
2. Age
3. Job Position in agency
4. Number of years with agency
5. Number of years in position
6. Previous experience in contraceptive services

AGENCY BACKGROUND

1. Can you tell me a little bit about the history of this agency?
 - How was it established? With what goals in mind?
 - What were the changes (in policy and services, personnel, etc) over the years?
 - The agency is defined as a progressive agency. How does that translate into everyday practice?
2. What were the models used in establishing and later running the agency?
3. What is the agency's position in the community? (How is it viewed by the community? Any collaborations with other agencies?)
4. What is the organizational structure like?
 - Who does what? (division of labor and ratio of professionals to volunteers and paraprofessionals?)
 - How are the decisions made?
5. Are there any staff meetings to talk about policies, policy changes, etc?

ACCESS TO SERVICES

- 1. What are the agency's funding sources? How do you think your (different sources of) funding affect services (especially GYN and abortion services)?**
- 2. What type of client insurances are accepted? How do these affect services?**
- 3. Are you contracted with an HMO and how does this affect your services? What was the change from before?**

PERSONAL BACKGROUND

- 1. How did you come to work in this agency?**
- 2. What are your goals in working here (in providing contraceptive or abortion care to the women)?**

SERVICE DELIVERY

- 1. What is the average time between scheduling a visit and the visit?**
- 2. What is the average waiting time of a client in the agency (for GYN? For abortion?)**
- 3. Do you provide any services on evenings or weekends for women (with irregular working hours, on special occasions like holidays, etc?)**
- 4. Does the staff receive any training for providing services? (initial and ongoing training, and what kind of training?)**

5. **How much support do you feel from the agency in doing your work in the agency?**
6. **What are the obstacles to providing services and what would make your life easier working here as a provider?**
7. **(IF UNANSWERED TILL NOW) What are your beliefs regarding women and reproductive services? (Are there any personal beliefs that guide your work?)**
8. **(a) What do you think about the documentation aspect of your job?**
(b) How would it be easier and better?

Staff Interview - Direct Service Providers

STAFF I.D.

<i>Pseudonym</i>	<i>Gender</i>	<i>Age</i>	<i>Position</i>	<i>Interview/Observation</i>
				S.I.

DEMOGRAPHICS

7. Gender
8. Age
9. Job Position in agency
10. Number of years with agency
11. Number of years in position
12. Previous experience in contraceptive or abortion services

PERSONAL BACKGROUND

3. How did you come to work in this agency?
4. What are your goals in working here (in providing contraceptive or abortion care to the women)?

SERVICE DELIVERY

9. Within the (GYN or abortion) services you provide, what are the routine services a woman receives at her initial visit? How about an annual visit or follow-up?
10. What kinds of follow-up mechanisms exist? (to follow up on individual clients and to guarantee continuity of care in general)
11. What are the contraceptive methods discussed with the women? (do these change according to different women -age, health profile, etc..?)
12. Which of these methods are available on site (for how much? Any free?)

- 13. Could you describe to me -from beginning to end- what happens in a typical birth control counseling session, exam (OR pre-abortion or post-abortion counseling)?**
- (a) How does the session start?**
 - (b) What do you discuss with the women?**
 - (c) Which methods do you talk about?**
 - (d) What if women want to switch methods or disagree with you on a method, etc?**
 - (e) Do the women generally ask questions, voice concerns?**
 - (f) How much time is spent on the issues brought up by the client? (on her specific needs, concerns?)**
 - (g) How much time -total- is spent with each client?**
- 14. From your experience as a professional, are there any methods you would advise for some clients more than others? What factors would use in deciding which methods to emphasize? (e.g. age, contraceptive intentions, health profile, cost of method, lactation status, after abortion, etc.)**
- 15. How much support do you feel from the agency in doing your work in the agency?**
- 16. What are the obstacles to providing services and what would make your life easier working here as a provider?**
- 17. (IF UNANSWERED TILL NOW) What are your beliefs regarding women and reproductive services? (Are there any personal beliefs that guide your work?)**
- 18. (a) What do you think about the documentation aspect of your job?**
(b) How would it be easier and better?

Client Interview

CLIENT I.D.

<i>Pseudonym</i>	<i>Age</i>	<i>Interview/Observation</i>
		C.I.

DEMOGRAPHICS

1. Age
2. Race
3. Have a partner at the present: (stable?)
4. (a) Marital status
(b) Do you have any children?
5. Income level:
 - (a) How many people earn money in your household?
 - (b) Which of the following is closer to your household income before tax? Your individual income?
 - (c) How many live in your household?

Household

Individual

Under \$5000
 \$5000 to \$7,499
 \$7,500 to \$9,999
 \$10,000 to \$12,499
 \$12,500 to \$14,999
 \$15,000 to \$17,499
 \$17,500 to \$19,999
 \$20,000 to \$24,999
 \$25,000 to \$29,999
 \$30,000 to \$34,999
 \$35,000 to \$39,999
 \$40,000 to \$44,999
 \$45,000 to \$49,999
 \$50,000 to \$54,999
 \$55,000 to \$59,999
 \$60,000 or above (how much?)

6. Time with the current agency and how many visits (years, months) with the agency?

7. How do you pay for your visits? (what type of insurance? Employer pays? What is the co-pay?)

QUESTIONS

1. How did you decide to come to the Women's Health Center?
 - What made you decide to come here over other places?
 - Did you call around to other places?
 - How did you learn about this center?
 - Did you confuse it with other places?

2. What are the different GYN or Abortion services you got from the center? (what kinds of things have you came here for?)

3. During your visits to the center, how did the staff treat you? (staff =health workers, receptionist, physicians, lab technicians)
 - was it comfortable talking to them, were they respectful, etc?

(a) What about for contraceptive care? How did the staff treat you then?

(b) How would you compare this experience to other places you have been to (for contraceptive care?)

4. What do you think of the general environment of the center?
 - waiting rooms, exam room, the procedure room, bathrooms, noticed the posters on the walls, read the pamphlets?

(a) how would you compare the environment to other places you have been to?

5. Now, I would like to ask a few questions about your most recent experience in getting contraceptive care (or abortion services) from the center?
- a) When was this visit? (how long ago?)
 - b) What was the reason for your visit?
 - c) Were you able to schedule a visit easily? (how long did you have to wait to schedule an appointment?)
 - d) What happened from the time you entered the agency that day?
 - How long did you wait?
 - What happened then?
 - Who did you see first?
 - What did you discuss with her/him?
 - Any mention of your method?
 - Any mention of other methods of birth control? (how? Enough info?)
 - Was the exam/session or procedure private?
 - Were there any instructions? (if there were, were they clear?)
 - Did you sign any informed consent forms? (if so, were they explained fully or in technical language?)
 - How did the discussion go?
 - Were you able to ask questions or talk about your concerns?
 - What was the decision reached?
 - Did you feel you had a say in the decision made?
 - Who did you see next?
 - Considering the whole visit, did everything go as you expected it or was there anything you were planning and did not happen?
 - e) Is it easy for you to get to the center?
 - f) Does it cost you a lot to get these services?

6. **When you need information on reproductive issues like contraceptives, childbirth, menstruation, menopause, etc, who or what do you turn to? (what do you do or who/where do you go to?)**

7. **In your visits to the Allentown Women's Health Center, did you feel that the staff respected you? (Examples of respect and/or disrespect)**

8. **Have going to the center and having contact with the staff there:**
 - (a) **Did you learn anything new on reproductive issues that you didn't know before?**

 - (b) **Do you think differently about your body or yourself?**

 - (c) **Did it change on how you make decisions on reproductive issues?**

 - (d) **Do you have any new decisions as a result of these visits?**

9. **If you were to design your own reproductive services (for GYN and abortion) what would it be like? What are the important things for you?**

10. **How much of that is realized here (at this center)?**

Observation of a Counseling Session

TYPE OF OBSERVATION (GYN OR ABORTION?):

WHICH STAFF MEMBER IS PRESENT?:

CLIENT DEMOGRAPHICS

1. Age
2. Race
3. Have a partner at the present: (stable?)
4. (a) Marital status
(b) Do you have any children?
5. Income level:
 - (d) How many people earn money in your household?
 - (e) Which of the following is closer to your household income before tax? Your individual income?
 - (f) How many live in your household?

Household

Individual

Under \$5000

\$5000 to \$7,499

\$7,500 to \$9,999

\$10,000 to \$12,499

\$12,500 to \$14,999

\$15,000 to \$17,499

\$17,500 to \$19,999

\$20,000 to \$24,999

\$25,000 to \$29,999

\$30,000 to \$34,999

\$35,000 to \$39,999

\$40,000 to \$44,999

\$45,000 to \$49,999

\$50,000 to \$54,999

\$55,000 to \$59,999

\$60,000 or above (PLEASE WRITE)

6. Time with agency: how many visits, years, months with the agency?

7. How do you pay for your visits? (what type of insurance? Employer pays? What is the co-pay?)

OBSERVATION PROTOCOL**(1) RECORD START-UP TIME****(2) Sketch of seating arrangement (include self) at the back of the sheet****(3) Interaction****(a) Who started the conversation? How?****(b) What is the reason of visit?****(c) What is discussed?**

- **List methods discussed**

- **Any method favored? For what reason?**

- **Advantages and disadvantages mentioned?**

- **Instructions clear or technical? (any materials given?)**

- **Did the client ask any questions, talk about concerns? (any disagreements and how were they solved?)**

(d) Overall climate of interaction (courteous, respectful, rushed)**(e) Reaction to me being there****(4) RECORD END TIME**

APPENDIX E:

**"Index trees" for FHC and WHC listing the categories that emerged
in the open coding phase**

INDEX TREE FOR THE FEMINIST HEALTH CENTER

PROJECT: Dissertation, User Ayse Dayi, 11:50 am, Feb 1, 2003.

(1) /FEMINIST HEALTH CENTER

*** No Definition

This node codes 0 documents.

(1 1) /FEMINIST HEALTH CENTER/Demographics

*** No Definition

This node codes 0 documents.

(1 1 1) /FEMINIST HEALTH CENTER/Demographics/Staff

*** No Definition

This node codes 0 documents.

(1 1 1 1) /FEMINIST HEALTH CENTER/Demographics/Staff/Gender

*** No Definition

This node codes 1 document.

(1 1 1 1 1) /FEMINIST HEALTH CENTER/Demographics/Staff/Gender/Female

*** No Definition

This node codes 8 documents.

(1 1 1 1 2) /FEMINIST HEALTH CENTER/Demographics/Staff/Gender/Male

*** No Definition

This node codes 1 document.

(1 1 1 2) /FEMINIST HEALTH CENTER/Demographics/Staff/Age

*** No Definition

This node codes 0 documents.

(1 1 1 2 1) /FEMINIST HEALTH CENTER/Demographics/Staff/Age/20-30

*** No Definition

This node codes 2 documents.

(1 1 1 2 2) /FEMINIST HEALTH CENTER/Demographics/Staff/Age/30-40

*** No Definition

This node codes 2 documents.

(1 1 1 2 3) /FEMINIST HEALTH CENTER/Demographics/Staff/Age/40-50

*** No Definition

This node codes 2 documents.

(1 1 1 2 4) /FEMINIST HEALTH CENTER/Demographics/Staff/Age/Over 50

*** No Definition

This node codes 2 documents.

(1 1 1 3) /FEMINIST HEALTH CENTER/Demographics/Staff/Job position

*** No Definition

This node codes 3 documents.

(1 1 1 3 1) /FEMINIST HEALTH CENTER/Demographics/Staff/Job position/rotation - juggling

*** No Definition

This node codes 7 documents.

(1 1 1 3 2) /FEMINIST HEALTH CENTER/Demographics/Staff/Job position/Specialization

*** No Definition

This node codes 8 documents.

(1 1 1 3 3) /FEMINIST HEALTH CENTER/Demographics/Staff/Job position/part-time

*** No Definition

This node codes 2 documents.

(1 1 1 3 4) /FEMINIST HEALTH CENTER/Demographics/Staff/Job position/Full-time

*** No Definition

This node codes 2 documents.

(1 1 1 4) /FEMINIST HEALTH CENTER/Demographics/Staff/Years in agency

*** Definition:

Numbers of years worked with the agency

This node codes 9 documents.

(1 1 1 5) /FEMINIST HEALTH CENTER/Demographics/Staff/Years in current position

*** Definition:

Numbers of years were in current position

This node codes 7 documents.

(1 1 1 6) /FEMINIST HEALTH CENTER/Demographics/Staff/Previous experience

*** Definition:

Previous experience in related fields

This node codes 6 documents.

(1 1 2) /FEMINIST HEALTH CENTER/Demographics/Clients

*** No Definition

This node codes 0 documents.

(1 1 2 1) /FEMINIST HEALTH CENTER/Demographics/Clients/Type of client

*** No Definition

This node codes 0 documents.

(1 1 2 1 1) /FEMINIST HEALTH CENTER/Demographics/Clients/Type of client/Gyn

*** No Definition

This node codes 4 documents.

(1 1 2 1 2) /FEMINIST HEALTH CENTER/Demographics/Clients/Type of client/AB

*** No Definition

This node codes 0 documents.

(1 1 2 1 2 1) /FEMINIST HEALTH CENTER/Demographics/Clients/Type of client/AB/Surgical AB

*** No Definition

This node codes 2 documents.

(1 1 2 1 2 2) /FEMINIST HEALTH CENTER/Demographics/Clients/Type of client/AB/Medical AB
 *** No Definition
 This node codes 3 documents.

(1 1 2 1 3) /FEMINIST HEALTH CENTER/Demographics/Clients/Type of client/AB + Gyn
 *** No Definition
 This node codes 3 documents.

(1 1 2 2) /FEMINIST HEALTH CENTER/Demographics/Clients/Age
 *** No Definition
 This node codes 0 documents.

(1 1 2 2 1) /FEMINIST HEALTH CENTER/Demographics/Clients/Age/18-30
 *** No Definition
 This node codes 7 documents.

(1 1 2 2 2) /FEMINIST HEALTH CENTER/Demographics/Clients/Age/31-40
 *** No Definition
 This node codes 5 documents.

(1 1 2 2 3) /FEMINIST HEALTH CENTER/Demographics/Clients/Age/41-50
 *** No Definition
 This node codes 0 documents.

(1 1 2 3) /FEMINIST HEALTH CENTER/Demographics/Clients/Partner
 *** No Definition
 This node codes 0 documents.

(1 1 2 3 1) /FEMINIST HEALTH CENTER/Demographics/Clients/Partner /Yes
 *** No Definition
 This node codes 10 documents.

(1 1 2 3 2) /FEMINIST HEALTH CENTER/Demographics/Clients/Partner /No
 *** No Definition
 This node codes 2 documents.

(1 1 2 3 3) /FEMINIST HEALTH CENTER/Demographics/Clients/Partner /Stable?
 *** No Definition
 This node codes 9 documents.

(1 1 2 4) /FEMINIST HEALTH CENTER/Demographics/Clients/Marital status
 *** No Definition
 This node codes 0 documents.

(1 1 2 4 1) /FEMINIST HEALTH CENTER/Demographics/Clients/Marital status/Single
 *** No Definition
 This node codes 5 documents.

(1 1 2 4 2) /FEMINIST HEALTH CENTER/Demographics/Clients/Marital status/Married
 *** No Definition
 This node codes 2 documents.

(1 1 2 4 3) /FEMINIST HEALTH CENTER/Demographics/Clients/Marital status/Divorced

*** No Definition

This node codes 3 documents.

(1 1 2 5) /FEMINIST HEALTH CENTER/Demographics/Clients/Income

*** No Definition

This node codes 0 documents.

(1 1 2 5 1) /FEMINIST HEALTH CENTER/Demographics/Clients/Income/# of people in house

*** No Definition

This node codes 2 documents.

(1 1 2 5 2) /FEMINIST HEALTH CENTER/Demographics/Clients/Income/# of earners

*** No Definition

This node codes 10 documents.

(1 1 2 5 3) /FEMINIST HEALTH CENTER/Demographics/Clients/Income/Amount earned

*** No Definition

This node codes 0 documents.

(1 1 2 5 3 1) /FEMINIST HEALTH CENTER/Demographics/Clients/Income/Amount earned/individual

*** No Definition

This node codes 4 documents.

(1 1 2 5 3 2) /FEMINIST HEALTH CENTER/Demographics/Clients/Income/Amount earned/total

*** No Definition

This node codes 3 documents.

(1 1 2 6) /FEMINIST HEALTH CENTER/Demographics/Clients/Time with agency

*** No Definition

This node codes 12 documents.

(1 1 2 7) /FEMINIST HEALTH CENTER/Demographics/Clients/Payment type

*** No Definition

This node codes 0 documents.

(1 1 2 7 1) /FEMINIST HEALTH CENTER/Demographics/Clients/Payment type/self-pay

*** No Definition

This node codes 6 documents.

(1 1 2 7 2) /FEMINIST HEALTH CENTER/Demographics/Clients/Payment type/Insurance

*** No Definition

This node codes 5 documents.

(1 1 2 8) /FEMINIST HEALTH CENTER/Demographics/Clients/Kids?

*** No Definition

This node codes 7 documents.

(1 1 2 9) /FEMINIST HEALTH CENTER/Demographics/Clients/Field notes

*** Definition:

Field notes written regarding the interviews, and on the interview transcript

This node codes 3 documents.

(1 1 2 10) /FEMINIST HEALTH CENTER/Demographics/Clients/ethnicity

*** No Definition

This node codes 1 document.

(1 2) /FEMINIST HEALTH CENTER/Agency history

*** No Definition

This node codes 0 documents.

(1 2 1) /FEMINIST HEALTH CENTER/Agency history/the founding

*** No Definition

This node codes 3 documents.

(1 2 2) /FEMINIST HEALTH CENTER/Agency history/Crises

*** No Definition

This node codes 6 documents.

(1 2 3) /FEMINIST HEALTH CENTER/Agency history/Violence

*** No Definition

This node codes 6 documents.

(1 2 4) /FEMINIST HEALTH CENTER/Agency history/Branching

*** Definition:

branching into other organizations or giving birth to other sister organizations

This node codes 4 documents.

(1 2 5) /FEMINIST HEALTH CENTER/Agency history/Research participation

*** Definition:

agency participating in research

This node codes 1 document.

(1 2 6) /FEMINIST HEALTH CENTER/Agency history/Feminism

*** Definition:

The feminist beliefs and practices of the agency across time

This node codes 4 documents.

(1 2 7) /FEMINIST HEALTH CENTER/Agency history/The zeitgeist

*** Definition:

the historical context through which the agency evolved.. times of illegal abortion, the women's health movement

This node codes 4 documents.

(1 3) /FEMINIST HEALTH CENTER/Agency structure

*** No Definition

This node codes 0 documents.

(1 3 1) /FEMINIST HEALTH CENTER/Agency structure/decision making

*** No Definition

This node codes 6 documents.

(1 3 2) /FEMINIST HEALTH CENTER/Agency structure/staff size

*** No Definition

This node codes 3 documents.

(1 3 3) /FEMINIST HEALTH CENTER/Agency structure/Being a collective-hierarchy

*** Definition:

how being a collective works or not.. hierarchy..

This node codes 8 documents.

(1 3 3 1) /FEMINIST HEALTH CENTER/Agency structure/Being a collective-hierarchy/Doctors

*** Definition:

how doctors fit in with the hierarchy or lack there os (fit in a feminist collective).. relates to "medicalization" code

This node codes 9 documents.

(1 3 3 1 1) /FEMINIST HEALTH CENTER/Agency structure/Being a collective-hierarchy/Doctors/Scarcity of ab providers

*** No Definition

This node codes 3 documents.

(1 3 3 1 2) /FEMINIST HEALTH CENTER/Agency structure/Being a collective-hierarchy/Doctors/Dedication

*** No Definition

This node codes 4 documents.

(1 3 3 1 3) /FEMINIST HEALTH CENTER/Agency structure/Being a collective-hierarchy/Doctors/Doctor as a technician

*** No Definition

This node codes 3 documents.

(1 3 3 2) /FEMINIST HEALTH CENTER/Agency structure/Being a collective-hierarchy/Chaos

*** Definition:

being a collective creates a chaotic, vague structure where accountability and leadership is not clear. but solidarity keeps them together

This node codes 2 documents.

(1 3 3 3) /FEMINIST HEALTH CENTER/Agency structure/Being a collective-hierarchy/Solidarity

*** Definition:

working under a common goal holding the staff together

This node codes 0 documents.

(1 3 3 4) /FEMINIST HEALTH CENTER/Agency structure/Being a collective-hierarchy/clients' choices

*** No Definition

This node codes 6 documents.

(1 3 3 5) /FEMINIST HEALTH CENTER/Agency structure/Being a collective-hierarchy/being a collective in 2000

*** Definition:

in being a collective now, need to balance "business" decisions (like competition, benefits) with sisterhood, feminism ideas like care, solidarity

This node codes 1 document.

(1 3 3 6) /FEMINIST HEALTH CENTER/Agency structure/Being a collective-hierarchy/Issue of privacy

*** Definition:

Issues about how to help women without invading their privacy.. Respect/Boundaries/rights. things i dealt with as an interviewer as well..

This node codes 5 documents.

(1 3 3 7) /FEMINIST HEALTH CENTER/Agency structure/Being a collective-hierarchy/recognizing different needs of different women

*** Definition:

recognizing and respecting the unique needs of women, instead of treating them as all the same (essentializing them and their repro needs)

This node codes 5 documents.

(1 3 3 7 1) /FEMINIST HEALTH CENTER/Agency structure/Being a collective-hierarchy/recognizing different needs of different women/some women want to SEE and KNOW during abortion

*** No Definition

This node codes 2 documents.

(1 3 4) /FEMINIST HEALTH CENTER/Agency structure/teams

*** No Definition

This node codes 4 documents.

(1 3 5) /FEMINIST HEALTH CENTER/Agency structure/Staff Communication

*** No Definition

This node codes 5 documents.

(1 3 5 1) /FEMINIST HEALTH CENTER/Agency structure/Staff Communication/emotions

*** No Definition

This node codes 2 documents.

(1 3 6) /FEMINIST HEALTH CENTER/Agency structure/Agency as evolving

*** Definition:

agency evolving (as an organism) towards a new structure..

This node codes 0 documents.

(1 3 6 1) /FEMINIST HEALTH CENTER/Agency structure/Agency as evolving/Evolution

*** No Definition

This node codes 0 documents.

(1 3 6 1 1) /FEMINIST HEALTH CENTER/Agency structure/Agency as evolving/Evolution/Agency evolving

*** No Definition

This node codes 6 documents.

(1 3 6 1 2) /FEMINIST HEALTH CENTER/Agency structure/Agency as evolving/Evolution/Individuals evolving

*** Definition:

individual staff evolving in beliefs and practices

This node codes 1 document.

(1 3 6 2) /FEMINIST HEALTH CENTER/Agency structure/Agency as evolving/Resistances

*** No Definition

This node codes 3 documents.

(1 3 7) /FEMINIST HEALTH CENTER/Agency structure/Medicalization

*** No Definition

This node codes 2 documents.

(1 3 7 1) /FEMINIST HEALTH CENTER/Agency structure/Medicalization/Prepare for the doctor - emotional work

*** Definition:

Relates to doctor's power..that they are not merely techs with little power. cause staff prepares the clients does all ground work for the doctors.

This node codes 4 documents.

(1 3 7 2) /FEMINIST HEALTH CENTER/Agency structure/Medicalization/Information Gap

*** Definition:

Monopoly over medical information held by doctors vs decreasing that by providing women with most info

This node codes 8 documents.

(1 3 7 2 1) /FEMINIST HEALTH CENTER/Agency structure/Medicalization/Information Gap/client has to be active as well

*** Definition:

active participation by the client in decreasing the information gap.. getting information to make informed decisions

This node codes 2 documents.

(1 3 7 3) /FEMINIST HEALTH CENTER/Agency structure/Medicalization/Use of lay women

*** Definition:

peer services, use of NONMEDICAL personnel helps DEMYSTIFY the services

This node codes 5 documents.

(1 3 7 4) /FEMINIST HEALTH CENTER/Agency structure/Medicalization/Humane treatment

*** Definition:

treating the women with respect and dignity, and as a whole person (holistic approach)

This node codes 8 documents.

(1 3 7 5) /FEMINIST HEALTH CENTER/Agency structure/Medicalization/Discourse strategies

*** Definition:

Discourses used by the medical personnel to justify medicalization (use of medical and technological things and by medical people only)

This node codes 6 documents.

(1 3 7 6) /FEMINIST HEALTH CENTER/Agency structure/Medicalization/Medical education

*** No Definition

This node codes 1 document.

(1 3 7 7) /FEMINIST HEALTH CENTER/Agency structure/Medicalization/women fearing provider's judgments

*** No Definition

This node codes 1 document.

(1 3 8) /FEMINIST HEALTH CENTER/Agency structure/Services

*** No Definition

This node codes 0 documents.

(1 3 8 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services

*** No Definition

This node codes 0 documents.

(1 3 8 1 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/gender of physician

*** No Definition

This node codes 8 documents.

(1 3 8 1 1 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/gender of physician/why men go into OB-GYN

*** No Definition

This node codes 3 documents.

(1 3 8 1 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/compared to other agencies, providers

*** Definition:

how the services of the center compares to other places..

This node codes 3 documents.

(1 3 8 1 2 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/compared to other agencies, providers/Specialized

*** Definition:

more specialized for women's reproductive health than other places..

This node codes 0 documents.

(1 3 8 1 2 1 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/compared to other agencies, providers/Specialized/specialized in repro health

*** No Definition

This node codes 0 documents.

(1 3 8 1 2 1 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/compared to other agencies, providers/Specialized/specialized within repro health

*** Definition:

towards younger women and for PREVENTING pregnancy (via contraceptives or abortion) within repro health

This node codes 2 documents.

(1 3 8 1 2 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/compared to other agencies, providers/other providers observed

*** Definition:

other providers that the woman know of but did not go for gyn or abortion

This node codes 1 document.

(1 3 8 1 2 7) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/compared to other agencies, providers/previous or current provider

*** Definition:

who women used or still use for gyn or abortion care.. according to whom are they comparing the center's services

This node codes 10 documents.

(1 3 8 1 3) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/Filtering mechanisms

*** Definition:

counseling women and rejecting those that look ambivalent

This node codes 2 documents.

(1 3 8 1 4) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A typical visit

*** No Definition

This node codes 0 documents.

(1 3 8 1 4 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A typical visit/Phone

*** No Definition

This node codes 4 documents.

(1 3 8 1 4 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A typical visit/Visit

*** No Definition

This node codes 0 documents.

(1 3 8 1 4 2 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A typical visit/Visit/birth control options

*** No Definition

This node codes 9 documents.

(1 3 8 1 4 2 1 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A typical visit/Visit/birth control options/side effects of methods

*** No Definition

This node codes 7 documents.

(1 3 8 1 4 2 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A typical visit/Visit/preferred methods

*** Definition:

whether the staff favors and recommends some methods over others

This node codes 8 documents.

(1 3 8 1 4 2 3) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A typical visit/Visit/Cost part of Access

*** No Definition

This node codes 2 documents.

(1 3 8 1 4 2 3 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A typical visit/Visit/Cost part of Access/Free methods?

*** No Definition

This node codes 2 documents.

(1 3 8 1 4 2 3 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A typical visit/Visit/Cost part of Access/payment

*** No Definition

This node codes 1 document.

(1 3 8 1 4 2 4) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A typical visit/Visit/Visit and its stages

*** No Definition

This node codes 3 documents.

(1 3 8 1 5) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/clientele

*** Definition:

Who is using the services??

This node codes 0 documents.

(1 3 8 1 5 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/clientele/Class

*** No Definition

This node codes 1 document.

(1 3 8 1 5 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/clientele/Age

*** No Definition

This node codes 8 documents.

(1 3 8 1 5 3) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/clientele/Diversity

*** Definition:

Women from different cultures, ethnic groups and with learning disabilities.. creates communication problems

This node codes 3 documents.

(1 3 8 1 5 4) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/clientele/not passive

*** Definition:

clients are not passive recipients of services but do maneuver the system to their advantage

This node codes 2 documents.

(1 3 8 1 5 5) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/clientele/Ab vs Gyn

*** No Definition

This node codes 1 document.

(1 3 8 1 5 6) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/clientele/Coercion

*** Definition:

screening for whether the decision to abort belongs to the woman or she is coerced by a partner or family

This node codes 4 documents.

(1 3 8 1 5 7) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/clientele/gestation period

*** No Definition

This node codes 2 documents.

(1 3 8 1 6) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/Safety

*** No Definition

This node codes 4 documents.

(1 3 8 1 7) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/Confidentiality

*** No Definition

This node codes 1 document.

(1 3 8 1 8) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A real visit

*** No Definition

This node codes 0 documents.

(1 3 8 1 8 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A real visit/I called in

*** Definition:

how the women called for an appointment

This node codes 7 documents.

(1 3 8 1 8 1 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A real visit/I called in/TIME - time to schedule

*** No Definition

This node codes 11 documents.

(1 3 8 1 8 1 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A real visit/I called in/how I knew them

*** Definition:

how the women came to the center.. referral, self experience, etc..

This node codes 0 documents.

(1 3 8 1 8 1 2 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A real visit/I called in/how I knew them/referral

*** No Definition

This node codes 2 documents.

(1 3 8 1 8 1 2 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A real visit/I called in/how I knew them/yellow pages

*** No Definition

This node codes 1 document.

(1 3 8 1 8 1 2 3) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A real visit/I called in/how I knew them/friends

*** No Definition

This node codes 2 documents.

(1 3 8 1 8 1 2 4) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A real visit/I called in/how I knew them/been here before

*** No Definition

This node codes 0 documents.

(1 3 8 1 8 1 2 5) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A real visit/I called in/how I knew them/job connection

*** No Definition

This node codes 1 document.

(1 3 8 1 8 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/I waited..

*** Definition:

waiting period to see the first person

This node codes 10 documents.

(1 3 8 1 8 3) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/saw counselor or PA

*** No Definition

This node codes 3 documents.

(1 3 8 1 8 3 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/saw counselor or PA/topics discussed

*** No Definition

This node codes 8 documents.

(1 3 8 1 8 3 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/saw counselor or PA/any questions, concerns?

*** Definition:

whether the women asked the counselor or PA any questions..

This node codes 5 documents.

(1 3 8 1 8 3 2 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/saw counselor or PA/any questions, concerns?/contraceptive related

*** No Definition

This node codes 7 documents.

(1 3 8 1 8 3 2 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/saw counselor or PA/any questions, concerns?/complications, infertility

*** No Definition

This node codes 0 documents.

(1 3 8 1 8 3 3) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/saw counselor or PA/feelings about abortion

*** Definition:

intense

This node codes 1 document.

(1 3 8 1 8 3 4) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/saw counselor or PA/had the gyn exam

*** No Definition

This node codes 4 documents.

(1 3 8 1 8 3 5) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/saw counselor or PA/just had the birth control check or renewal

*** No Definition

This node codes 2 documents.

(1 3 8 1 8 3 6) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/saw counselor or PA/had the gyn plus the method

*** No Definition

This node codes 1 document.

(1 3 8 1 8 3 7) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/saw counselor or PA/watched the video before ab

*** No Definition

This node codes 1 document.

(1 3 8 1 8 4) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/abortion

*** No Definition

This node codes 0 documents.

(1 3 8 1 8 4 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/abortion/I had the procedure

*** Definition:

I call it "procedure" on purpose.. using women's own terms

This node codes 3 documents.

(1 3 8 1 8 4 1 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/abortion/I had the procedure/PAIN

*** No Definition

This node codes 4 documents.

(1 3 8 1 8 4 1 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/abortion/I had the procedure/felt herded

*** Definition:

relates to personal is political.. abortion is seen as personal, a private matter

This node codes 1 document.

(1 3 8 1 8 4 1 3) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/abortion/I had the procedure/support person helped

*** No Definition

This node codes 3 documents.

(1 3 8 1 8 4 1 4) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/abortion/I had the procedure/family or friend supporting

*** No Definition

This node codes 1 document.

(1 3 8 1 8 4 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/abortion/I had the pill

*** Definition:

medical abortion

This node codes 2 documents.

(1 3 8 1 8 4 3) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/abortion/asked questions

*** No Definition

This node codes 2 documents.

(1 3 8 1 8 5) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/I came for the follow-up

*** No Definition

This node codes 3 documents.

(1 3 8 1 8 6) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/anything unexpected?

*** No Definition

This node codes 12 documents.

(1 3 8 1 8 7) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/all clearly explained?

*** Definition:

whether there was any technical language or not

This node codes 6 documents.

(1 3 8 1 8 8) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/protesters

*** No Definition

This node codes 1 document.

(1 3 8 1 8 9) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/lead to any self-efficacy

*** No Definition

This node codes 0 documents.

(1 3 8 1 8 9 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/lead to any self-efficacy/new knowledge?

*** No Definition

This node codes 10 documents.

(1 3 8 1 8 9 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/lead to any self-efficacy/body and self

*** No Definition

This node codes 11 documents.

(1 3 8 1 8 9 3) /FEMINIST HEALTH CENTER/Agency structure/Services/Existing services/A
real visit/lead to any self-efficacy/new decisions?

*** No Definition

This node codes 11 documents.

(1 3 8 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Changes

*** Definition:

expansion of services or change in services

This node codes 1 document.

(1 3 8 2 1) /FEMINIST HEALTH CENTER/Agency structure/Services/Changes/Expansion
of services

*** No Definition

This node codes 2 documents.

(1 3 8 2 2) /FEMINIST HEALTH CENTER/Agency structure/Services/Changes/Revision

*** No Definition

This node codes 2 documents.

(1 3 8 2 3) /FEMINIST HEALTH CENTER/Agency structure/Services/Changes/Holistic health

*** No Definition

This node codes 2 documents.

(1 3 8 3) /FEMINIST HEALTH CENTER/Agency structure/Services/technology and touch

*** No Definition

This node codes 4 documents.

(1 3 8 4) /FEMINIST HEALTH CENTER/Agency structure/Services/Time

*** Definition:

how much time services take, waiting time, time to get in the agency etc..

This node codes 8 documents.

(1 3 8 5) /FEMINIST HEALTH CENTER/Agency structure/Services/(homy) environment

*** Definition:

Atmosphere at the center.. with the space use, being a house, magazines etc..

This node codes 4 documents.

(1 3 9) /FEMINIST HEALTH CENTER/Agency structure/Agency in community:

Alliances and alienation

*** Definition:

Colloboration with other agencies, physicians in the community vs. alienation

This node codes 5 documents.

(1 3 9 1) /FEMINIST HEALTH CENTER/Agency structure/Agency in community:

Alliances and alienation/Competition

*** No Definition

This node codes 2 documents.

(1 3 9 2) /FEMINIST HEALTH CENTER/Agency structure/Agency in community:

Alliances and alienation/Abortion mill

*** No Definition

This node codes 1 document.

(1 3 9 3) /FEMINIST HEALTH CENTER/Agency structure/Agency in community:

Alliances and alienation/Identity as an abortion provider

*** No Definition

This node codes 2 documents.

(1 3 9 4) /FEMINIST HEALTH CENTER/Agency structure/Agency in community:

Alliances and alienation/support from clients

*** Definition:

support or silence. relates to category "personal is political" through how women do not realize that and/or are shamed into silence even if they do

This node codes 4 documents.

(1 3 10) /FEMINIST HEALTH CENTER/Agency structure/staff support

*** Definition:

how much support the staff feel in doing their work. Put this question in based on some literature suggesting to empower you need to be empowered

This node codes 0 documents.

(1 3 10 1) /FEMINIST HEALTH CENTER/Agency structure/staff support/general

*** No Definition

This node codes 7 documents.

(1 3 10 2) /FEMINIST HEALTH CENTER/Agency structure/staff support/financial

*** No Definition

This node codes 6 documents.

(1 3 10 3) /FEMINIST HEALTH CENTER/Agency structure/staff support/Emotional

*** No Definition

This node codes 4 documents.

(1 3 10 4) /FEMINIST HEALTH CENTER/Agency structure/staff support/Changes

*** Definition:

what would make the staff's lives easier.. changes in the agency structure that would ease the lives of the staff

This node codes 0 documents.

(1 3 10 4 1) /FEMINIST HEALTH CENTER/Agency structure/staff support/Changes/More accountability

*** Definition:

everybody pulling their own weight in the agency

This node codes 5 documents.

(1 3 10 4 2) /FEMINIST HEALTH CENTER/Agency structure/staff support/Changes/More initiative

*** No Definition

This node codes 3 documents.

(1 3 10 4 3) /FEMINIST HEALTH CENTER/Agency structure/staff support/Changes/Expansion of services

*** No Definition

This node codes 3 documents.

(1 3 10 4 4) /FEMINIST HEALTH CENTER/Agency structure/staff support/Changes/Safety

*** Definition:

wish to have less violence.. not to have to worry about safety (of staff and clients)..

This node codes 2 documents.

(1 3 10 4 5) /FEMINIST HEALTH CENTER/Agency structure/staff support/Changes/clarity in agency structure

*** No Definition

This node codes 1 document.

(1 3 10 4 6) /FEMINIST HEALTH CENTER/Agency structure/staff support/Changes/day to day running

*** No Definition

This node codes 0 documents.

(1 3 10 4 6 1) /FEMINIST HEALTH CENTER/Agency structure/staff support/Changes/day to day running/scheduling

*** No Definition

This node codes 3 documents.

(1 3 10 5) /FEMINIST HEALTH CENTER/Agency structure/staff support/I am a part of this agency

*** No Definition

This node codes 1 document.

(1 3 10 6) /FEMINIST HEALTH CENTER/Agency structure/staff support/from community

*** Definition:

level of understanding and support staff receives from the communities they are in

This node codes 1 document.

(1 3 10 7) /FEMINIST HEALTH CENTER/Agency structure/staff support/from friends and family

*** No Definition

This node codes 0 documents.

(1 3 11) /FEMINIST HEALTH CENTER/Agency structure/Staff Training

*** No Definition

This node codes 3 documents.

(1 3 12) /FEMINIST HEALTH CENTER/Agency structure/Running

*** Definition:

Day to day running of the agency vs administrative work.. have to recode here visions vs daily runnings envisioned by staff

This node codes 1 document.

(1 3 13) /FEMINIST HEALTH CENTER/Agency structure/importance of feminist history

*** Definition:

the ways the feminist history of the agency affects its running and how much people are aware of it..

This node codes 2 documents.

(1 3 14) /FEMINIST HEALTH CENTER/Agency structure/Spatial arrangements

*** Definition:

the ways the space is arranged like front office, back office (staff) points to power relations as well. relates to code "being a collective"

This node codes 2 documents.

(1 4) /FEMINIST HEALTH CENTER/Motivation to work

*** Definition:

How the staff came to work in the agency and what their current goals for themselves and the clients are

This node codes 0 documents.

(1 4 1) /FEMINIST HEALTH CENTER/Motivation to work/Initial

*** Definition:

How they came to work in the agency.. whether for (feminist) ideology or else..

This node codes 1 document.

(1 4 1 1) /FEMINIST HEALTH CENTER/Motivation to work/Initial/family related

*** No Definition

This node codes 4 documents.

(1 4 1 2) /FEMINIST HEALTH CENTER/Motivation to work/Initial/work is meaningful

*** No Definition

This node codes 3 documents.

(1 4 1 3) /FEMINIST HEALTH CENTER/Motivation to work/Initial/feminist beliefs

*** No Definition

This node codes 4 documents.

(1 4 1 4) /FEMINIST HEALTH CENTER/Motivation to work/Initial/Abortion experience

*** No Definition

This node codes 0 documents.

(1 4 1 4 1) /FEMINIST HEALTH CENTER/Motivation to work/Initial/Abortion experience/illegal

*** No Definition

This node codes 1 document.

(1 4 1 4 2) /FEMINIST HEALTH CENTER/Motivation to work/Initial/Abortion experience/Positive

*** No Definition

This node codes 1 document.

(1 4 1 5) /FEMINIST HEALTH CENTER/Motivation to work/Initial/networking

*** No Definition

This node codes 1 document.

(1 4 2) /FEMINIST HEALTH CENTER/Motivation to work/Current (motivation and goals)

*** No Definition

This node codes 2 documents.

(1 4 2 1) /FEMINIST HEALTH CENTER/Motivation to work/Current (motivation and goals)/as savior

*** Definition:

motivated by thoughts of "saving women:... acting as a priest, a minister to "soul sick" women

This node codes 2 documents.

(1 4 2 2) /FEMINIST HEALTH CENTER/Motivation to work/Current (motivation and goals)/work is meaningful

*** No Definition

This node codes 1 document.

(1 4 2 2 1) /FEMINIST HEALTH CENTER/Motivation to work/Current (motivation and goals)/work is meaningful/Pure, cleansing vs dirty

*** Definition:

the work at the center is seen as purifying as opposed to what the anti-abortionists' claim.: dirty work, abortion mill.. "getting your hands dirty"

This node codes 3 documents.

(1 4 2 3) /FEMINIST HEALTH CENTER/Motivation to work/Current (motivation and goals)/Increased outreach

*** No Definition

This node codes 4 documents.

(1 4 2 4) /FEMINIST HEALTH CENTER/Motivation to work/Current (motivation and goals)/empowerment

*** No Definition

This node codes 2 documents.

(1 4 2 5) /FEMINIST HEALTH CENTER/Motivation to work/Current (motivation and goals)/personal agendas

*** Definition:

the little agendas each staff has for the clients

This node codes 0 documents.

(1 4 2 5 1) /FEMINIST HEALTH CENTER/Motivation to work/Current (motivation and goals)/personal agendas/Body image

*** No Definition

This node codes 5 documents.

(1 4 2 5 2) /FEMINIST HEALTH CENTER/Motivation to work/Current (motivation and goals)/personal agendas/Including men

*** No Definition

This node codes 1 document.

(1 4 2 5 3) /FEMINIST HEALTH CENTER/Motivation to work/Current (motivation and goals)/personal agendas/Decrease pregnancy

*** Definition:

Decrease pregnancy and repeated pregnancies through birth control

This node codes 1 document.

(1 4 2 5 4) /FEMINIST HEALTH CENTER/Motivation to work/Current (motivation and goals)/personal agendas/preventive health

*** No Definition

This node codes 2 documents.

(1 4 2 5 5) /FEMINIST HEALTH CENTER/Motivation to work/Current (motivation and goals)/personal agendas/increase cultural competency

*** No Definition

This node codes 1 document.

(1 4 2 6) /FEMINIST HEALTH CENTER/Motivation to work/Current (motivation and goals)/increased client support

*** No Definition

This node codes 1 document.

(1 5) /FEMINIST HEALTH CENTER/Feminisms

*** Definition:

Definition of feminism, how it applies to work..

This node codes 0 documents.

(1 5 1) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?

*** No Definition

This node codes 3 documents.

(1 5 1 1) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?/Choice

*** No Definition

This node codes 4 documents.

(1 5 1 1 1) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?/Choice/makes choices without apology

*** No Definition

This node codes 2 documents.

(1 5 1 2) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?/Judgement

*** Definition:

being non-judgemental, accepting of differences in staff or clients..

This node codes 1 document.

(1 5 1 3) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?/In relationship to men

*** Definition:

feminism as it relates to men.. equality with men, hating men.. power over men..

This node codes 4 documents.

(1 5 1 4) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?/what is a woman

*** Definition:

feminism, being feminine.. whatever feminine is.. nurturing, caring.. could be instinctual

This node codes 3 documents.

(1 5 1 5) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?/Control

*** No Definition

This node codes 1 document.

(1 5 1 6) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?/not abstract

*** No Definition

This node codes 1 document.

(1 5 1 7) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?/Culture

*** Definition:

how do you respect cultural differences and maintain a feminist service?

This node codes 3 documents.

(1 5 1 8) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?/white middle class feminism

*** No Definition

This node codes 1 document.

(1 5 1 9) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?/Self-reliance, independence

*** No Definition

This node codes 2 documents.

(1 5 1 10) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?/Activism - bucking the system

*** No Definition

This node codes 4 documents.

(1 5 1 11) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?/what a feminist looks like

*** No Definition

This node codes 1 document.

(1 5 1 12) /FEMINIST HEALTH CENTER/Feminisms/what is feminism?/Class and gender

*** No Definition

This node codes 1 document.

(1 5 2) /FEMINIST HEALTH CENTER/Feminisms/feminism at work

*** Definition:

how feminist ideas translate into the workings of the agency, in staff-staff and staff-client interactions. Includes challenging doctors

This node codes 7 documents.

(1 5 3) /FEMINIST HEALTH CENTER/Feminisms/personal is political

*** No Definition

This node codes 4 documents.

(1 5 4) /FEMINIST HEALTH CENTER/Feminisms/staff's beliefs

*** Definition:

staff's beliefs on feminism, and identification as a feminist or not

This node codes 3 documents.

(1 5 4 1) /FEMINIST HEALTH CENTER/Feminisms/staff's beliefs/trust in women

*** No Definition

This node codes 5 documents.

(1 5 4 2) /FEMINIST HEALTH CENTER/Feminisms/staff's beliefs/I am not just an abortionist

*** No Definition

This node codes 1 document.

(1 5 5) /FEMINIST HEALTH CENTER/Feminisms/Connotations of the word "feminist"

*** Definition:

what the connotations are for the word "feminist" and whether women identify themselves as feminists or not..

This node codes 2 documents.

(1 5 6) /FEMINIST HEALTH CENTER/Feminisms/Strong female role models

*** No Definition

This node codes 1 document.

(1 6) /FEMINIST HEALTH CENTER/Nurturing agency

*** No Definition

This node codes 0 documents.

(1 6 1) /FEMINIST HEALTH CENTER/Nurturing agency/As an incubator

*** Definition:

agency as an incubator for the staff.. as a launching pad for staff..

This node codes 5 documents.

(1 6 2) /FEMINIST HEALTH CENTER/Nurturing agency/As a resource for the community

*** No Definition

This node codes 4 documents.

(1 6 3) /FEMINIST HEALTH CENTER/Nurturing agency/Nurturing for the clients

*** Definition:

center creates a nurturing environment for the clients, and staff genuinely care for the clients
This node codes 3 documents.

(1 7) /FEMINIST HEALTH CENTER/Structural factors

*** No Definition

This node codes 0 documents.

(1 7 1) /FEMINIST HEALTH CENTER/Structural factors/Recent history

*** Definition:

Current historical context that affects the running of the agency and the empowerment process
This node codes 2 documents.

(1 7 1 1) /FEMINIST HEALTH CENTER/Structural factors/Recent history/politics of abortion

*** Definition:

shame, stigma over abortion

This node codes 6 documents.

(1 7 1 1 1) /FEMINIST HEALTH CENTER/Structural factors/Recent history/politics of abortion/clientele is not a collective

*** Definition:

clientele is silenced & divided. does not see that personal is political.. but keep abortion as a private secret matter EVEN AT THE CENTER with oth

This node codes 7 documents.

(1 7 2) /FEMINIST HEALTH CENTER/Structural factors/Legalities

*** Definition:

Laws, policies, that enable or restrict empowering services

This node codes 6 documents.

(1 7 3) /FEMINIST HEALTH CENTER/Structural factors/Economy

*** Definition:

Economical forces such as HMOs, funding sources, that affect empowerment

This node codes 8 documents.

(1 7 4) /FEMINIST HEALTH CENTER/Structural factors/Research agendas

*** Definition:

pharmaceuticals paying for research thus determining research agendas

This node codes 1 document.

(1 7 5) /FEMINIST HEALTH CENTER/Structural factors/Women's awareness

*** Definition:

awareness about insurance coverage of abortion and birth contro, and of medicalization of women's health, bodies

This node codes 4 documents.

(1 7 5 1) /FEMINIST HEALTH CENTER/Structural factors/Women's awareness /of rights

*** No Definition

This node codes 4 documents.

(1 7 5 2) /FEMINIST HEALTH CENTER/Structural factors/Women's awareness /of medicalization

*** No Definition

This node codes 1 document.

(1 8) /FEMINIST HEALTH CENTER/Abortion

*** No Definition

This node codes 0 documents.

(1 8 1) /FEMINIST HEALTH CENTER/Abortion/Feelings of violation

*** No Definition

This node codes 3 documents.

(1 8 1 1) /FEMINIST HEALTH CENTER/Abortion/Feelings of violation/medical ab less invasive

*** No Definition

This node codes 1 document.

(1 8 2) /FEMINIST HEALTH CENTER/Abortion/Pain

*** No Definition

This node codes 3 documents.

(1 8 3) /FEMINIST HEALTH CENTER/Abortion/Normalization and criminalization

*** No Definition

This node codes 9 documents.

(1 8 4) /FEMINIST HEALTH CENTER/Abortion/I will never have sex again

*** No Definition

This node codes 1 document.

(1 8 5) /FEMINIST HEALTH CENTER/Abortion/scared of complications

*** Definition:

women fearing possible complication related to abortion, such as infertility, infection, death..

This node codes 1 document.

(1 8 6) /FEMINIST HEALTH CENTER/Abortion/empowering

*** Definition:

the process of going through such a thing and being able to handle it makes you stronger

This node codes 3 documents.

(1 8 7) /FEMINIST HEALTH CENTER/Abortion/reasons for decision

*** Definition:

why abortion was the right choice for them

This node codes 4 documents.

(1 8 8) /FEMINIST HEALTH CENTER/Abortion/mixed feelings & views on abortion

*** Definition:

women thinking it would not happen to them, but it did... and mixed feelings at times complicated by opposing held beliefs on it

This node codes 5 documents.

(1 8 9) /FEMINIST HEALTH CENTER/Abortion/family control over women's body?

*** Definition:

women keeping silent about abortion because their parents would want more grandkids

This node codes 2 documents.

(1 8 10) /FEMINIST HEALTH CENTER/Abortion/I do not wanna know

*** Definition:

heard lot of women, mostly younger, saying they chose to sleep cause they did not wanna know what would happen.out of fear, maybe conflicting emoti

This node codes 1 document.

(1 8 11) /FEMINIST HEALTH CENTER/Abortion/it was a mistake

*** No Definition

This node codes 1 document.

(1 8 11 1) /FEMINIST HEALTH CENTER/Abortion/it was a mistake/a punishment

*** No Definition

This node codes 1 document.

(1 8 11 2) /FEMINIST HEALTH CENTER/Abortion/it was a mistake/can serve as a lesson for self & others

*** No Definition

This node codes 1 document.

(1 8 12) /FEMINIST HEALTH CENTER/Abortion/thinking back on it...

*** No Definition

This node codes 1 document.

(1 8 13) /FEMINIST HEALTH CENTER/Abortion/got exposed to an alternative care due to abortion

*** No Definition

This node codes 1 document.

(1 9) /FEMINIST HEALTH CENTER/motivation to choose FHC

*** No Definition

This node codes 0 documents.

(1 9 1) /FEMINIST HEALTH CENTER/motivation to choose FHC/Access

*** Definition:

easy access in terms of distance, cost

This node codes 6 documents.

(1 9 2) /FEMINIST HEALTH CENTER/motivation to choose FHC/abortion provider

*** No Definition

This node codes 5 documents.

(1 9 2 1) /FEMINIST HEALTH CENTER/motivation to choose FHC/abortion provider/provides medical abortion

*** No Definition

This node codes 1 document.

(1 9 3) /FEMINIST HEALTH CENTER/motivation to choose FHC/specialized in women's health

*** No Definition

This node codes 3 documents.

(1 9 4) /FEMINIST HEALTH CENTER/motivation to choose FHC/been here before

*** No Definition

This node codes 1 document.

(1 9 5) /FEMINIST HEALTH CENTER/motivation to choose FHC/safe place

*** Definition:

less violence than other places

This node codes 3 documents.

(1 9 6) /FEMINIST HEALTH CENTER/motivation to choose FHC/they take care of you here

*** No Definition

This node codes 1 document.

(1 9 7) /FEMINIST HEALTH CENTER/motivation to choose FHC/nice environment

*** No Definition

This node codes 1 document.

(1 9 8) /FEMINIST HEALTH CENTER/motivation to choose FHC/pro-choice or feminist place

*** No Definition

This node codes 3 documents.

(1 9 9) /FEMINIST HEALTH CENTER/motivation to choose FHC/female gynecologist

*** No Definition

This node codes 2 documents.

(1 9 10) /FEMINIST HEALTH CENTER/motivation to choose FHC/looked like a nice place

*** No Definition

This node codes 1 document.

(1 9 11) /FEMINIST HEALTH CENTER/motivation to choose FHC/replicate a previous good experience

*** No Definition

This node codes 3 documents.

(1 9 12) /FEMINIST HEALTH CENTER/motivation to choose FHC/clinic vs a doctor's office

*** Definition:

could relate to serving younger women vs older women with various other repro issues

This node codes 1 document.

(1 9 13) /FEMINIST HEALTH CENTER/motivation to choose FHC/avoiding a bad experience

*** No Definition

This node codes 2 documents.

(1 9 14) /FEMINIST HEALTH CENTER/motivation to choose FHC/anonymity

*** Definition:

wanting anonymity in abortion as well as birth control services.. both are stigmatic.. means you are having sex (as a young, unmarried? woman)

This node codes 2 documents.

(1 9 15) /FEMINIST HEALTH CENTER/motivation to choose FHC/continuity in care

*** No Definition

This node codes 1 document.

(1 9 16) /FEMINIST HEALTH CENTER/motivation to choose FHC/Age and life stages of women served

*** No Definition

This node codes 0 documents.

(1 9 16 10) /FEMINIST HEALTH CENTER/motivation to choose FHC/Age and life stages of women served/specialized for needs of younger women

*** No Definition

This node codes 1 document.

(1 9 16 15) /FEMINIST HEALTH CENTER/motivation to choose FHC/Age and life stages of women served/for women older than teenagers

*** No Definition

This node codes 2 documents.

(1 10) /FEMINIST HEALTH CENTER/Staff treatment of clients

*** No Definition

This node codes 0 documents.

(1 10 1) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC

*** No Definition

This node codes 0 documents.

(1 10 1 1) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/nice, wonderful, comforting

*** No Definition

This node codes 11 documents.

(1 10 1 2) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/it's all women here

*** Definition:

gender of staff is important in ths type of setting

This node codes 1 document.

(1 10 1 3) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/patient-oriented

*** No Definition

This node codes 3 documents.

(1 10 1 4) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/TIME - not rushed

*** No Definition

This node codes 5 documents.

(1 10 1 5) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/non-judgmental, non-directive

*** No Definition

This node codes 5 documents.

(1 10 1 6) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/made it feel ok

*** Definition:

confirmed women's feelings

This node codes 2 documents.

(1 10 1 6 1) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/made it feel ok /I KNEW what I had to do

*** Definition:

I knew what I had to do, just needed a confirmation

This node codes 1 document.

(1 10 1 7) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/scary

*** No Definition

This node codes 1 document.

(1 10 1 8) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/professional

*** No Definition

This node codes 1 document.

(1 10 1 9) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/they know how to handle situations

*** No Definition

This node codes 1 document.

(1 10 1 10) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/accomodating

*** No Definition

This node codes 1 document.

(1 10 1 11) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/informing

*** Definition:

staff providing a lot of information to the clients

This node codes 2 documents.

(1 10 1 12) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/abrasive

*** No Definition

This node codes 2 documents.

(1 10 1 13) /FEMINIST HEALTH CENTER/Staff treatment of clients/in FHC/peer approach

*** No Definition

This node codes 1 document.

(1 10 2) /FEMINIST HEALTH CENTER/Staff treatment of clients/in comparison to other places

*** No Definition

This node codes 10 documents.

(1 11) /FEMINIST HEALTH CENTER/Environment

*** No Definition

This node codes 0 documents.

(1 11 1) /FEMINIST HEALTH CENTER/Environment/the center

*** No Definition

This node codes 0 documents.

(1 11 1 1) /FEMINIST HEALTH CENTER/Environment/the center/relaxing & supporting

*** No Definition

This node codes 3 documents.

(1 11 1 2) /FEMINIST HEALTH CENTER/Environment/the center/clean

*** No Definition

This node codes 1 document.

(1 11 1 3) /FEMINIST HEALTH CENTER/Environment/the center/pleasant

*** No Definition

This node codes 1 document.

(1 11 1 4) /FEMINIST HEALTH CENTER/Environment/the center/small spaces

*** No Definition

This node codes 1 document.

(1 11 2) /FEMINIST HEALTH CENTER/Environment/in comparison

*** No Definition

This node codes 0 documents.

(1 11 2 1) /FEMINIST HEALTH CENTER/Environment/in comparison/relaxing, caring

*** No Definition

This node codes 1 document.

(1 11 2 2) /FEMINIST HEALTH CENTER/Environment/in comparison/homy not medical

*** No Definition

This node codes 10 documents.

(1 11 2 3) /FEMINIST HEALTH CENTER/Environment/in comparison/TIME- they take
their time

*** No Definition

This node codes 3 documents.

(1 11 2 4) /FEMINIST HEALTH CENTER/Environment/in comparison/accommodating

*** Definition:

accommodating to the needs of the patients

This node codes 1 document.

(1 11 2 5) /FEMINIST HEALTH CENTER/Environment/in comparison/information
provided

*** No Definition

This node codes 2 documents.

(1 11 2 6) /FEMINIST HEALTH CENTER/Environment/in comparison/staff training

*** No Definition

This node codes 1 document.

(1 11 2 7) /FEMINIST HEALTH CENTER/Environment/in comparison/humane treatment -
not a number

*** No Definition

This node codes 2 documents.

(1 11 2 7 1) /FEMINIST HEALTH CENTER/Environment/in comparison/humane treatment
- not a number/nice gowns

*** No Definition

This node codes 1 document.

(1 11 2 8) /FEMINIST HEALTH CENTER/Environment/in comparison/Security

*** No Definition

This node codes 1 document.

(1 11 2 9) /FEMINIST HEALTH CENTER/Environment/in comparison/less hectic.
crowded?

*** Definition:

other places the women went to (like Planned Parenthoods or Health Dept Clinics) had large
volumes of patients..

This node codes 1 document.

(1 11 2 10) /FEMINIST HEALTH CENTER/Environment/in comparison/relevant and new
magazines

*** No Definition

This node codes 1 document.

(1 11 3) /FEMINIST HEALTH CENTER/Environment/educational materials

*** Definition:

whether the client noticed them and/or took them

This node codes 9 documents.

(1 12) /FEMINIST HEALTH CENTER/Women's knowledge - ways of knowing

*** Definition:

where women get their knowledge for reproductive issues. WAYS OF KNOWING

This node codes 0 documents.

(1 12 1) /FEMINIST HEALTH CENTER/Women's knowledge - ways of
knowing/experiential knowledge

*** No Definition

This node codes 5 documents.

(1 12 2) /FEMINIST HEALTH CENTER/Women's knowledge - ways of knowing/I call my
doctor or clinic

*** No Definition

This node codes 4 documents.

(1 12 3) /FEMINIST HEALTH CENTER/Women's knowledge - ways of knowing/I'd call
here or come here

*** No Definition

This node codes 9 documents.

(1 12 4) /FEMINIST HEALTH CENTER/Women's knowledge - ways of knowing/Internet

*** No Definition

This node codes 7 documents.

(1 12 5) /FEMINIST HEALTH CENTER/Women's knowledge - ways of knowing/I do not
have any or lot of questions

*** No Definition

This node codes 3 documents.

(1 12 6) /FEMINIST HEALTH CENTER/Women's knowledge - ways of knowing/family & friends

*** No Definition

This node codes 3 documents.

(1 12 7) /FEMINIST HEALTH CENTER/Women's knowledge - ways of knowing/phone book

*** No Definition

This node codes 1 document.

(1 12 8) /FEMINIST HEALTH CENTER/Women's knowledge - ways of knowing/Planned Parenthood

*** No Definition

This node codes 1 document.

(1 12 9) /FEMINIST HEALTH CENTER/Women's knowledge - ways of knowing/knowledge from job

*** No Definition

This node codes 2 documents.

(1 13) /FEMINIST HEALTH CENTER/Access to services

*** No Definition

This node codes 0 documents.

(1 13 1) /FEMINIST HEALTH CENTER/Access to services/Distance

*** No Definition

This node codes 11 documents.

(1 13 2) /FEMINIST HEALTH CENTER/Access to services/Cost

*** No Definition

This node codes 11 documents.

(1 13 3) /FEMINIST HEALTH CENTER/Access to services/should not be too convenient

*** No Definition

This node codes 1 document.

(1 13 4) /FEMINIST HEALTH CENTER/Access to services/evening hours

*** No Definition

This node codes 1 document.

(1 14) /FEMINIST HEALTH CENTER/Respect

*** No Definition

This node codes 9 documents.

(1 15) /FEMINIST HEALTH CENTER/women's visions

*** Definition:

women's expectations, visions of an ideal service

This node codes 1 document.

(1 15 1) /FEMINIST HEALTH CENTER/women's visions/type of services provided

*** No Definition

This node codes 1 document.

(1 15 1 1) /FEMINIST HEALTH CENTER/women's visions/type of services provided/focus on preventing pregnancy

*** No Definition

This node codes 1 document.

(1 15 2) /FEMINIST HEALTH CENTER/women's visions/staff

*** No Definition

This node codes 0 documents.

(1 15 2 1) /FEMINIST HEALTH CENTER/women's visions/staff/medical or not?

*** No Definition

This node codes 4 documents.

(1 15 2 1 1) /FEMINIST HEALTH CENTER/women's visions/staff/medical or not?/knowledge is more important

*** Definition:

staff's knowledge and skills? are more important than their title, or certification..

This node codes 1 document.

(1 15 2 2) /FEMINIST HEALTH CENTER/women's visions/staff/gender

*** No Definition

This node codes 4 documents.

(1 15 2 3) /FEMINIST HEALTH CENTER/women's visions/staff/informative

*** No Definition

This node codes 1 document.

(1 15 2 4) /FEMINIST HEALTH CENTER/women's visions/staff/non-judgemental

*** No Definition

This node codes 3 documents.

(1 15 2 5) /FEMINIST HEALTH CENTER/women's visions/staff/making it safe & comfortable

*** No Definition

This node codes 1 document.

(1 15 2 6) /FEMINIST HEALTH CENTER/women's visions/staff/caring

*** Definition:

women expect the professionals in such services to be caring, maybe even more so than other health areas

This node codes 1 document.

(1 15 2 7) /FEMINIST HEALTH CENTER/women's visions/staff/respecting where the women are at

*** Definition:

respecting the specific needs, knowledge, and emotional state of different women. and listening to them before offering advice

This node codes 1 document.

(1 15 3) /FEMINIST HEALTH CENTER/women's visions/Environment

*** No Definition

This node codes 1 document.

(1 15 3 1) /FEMINIST HEALTH CENTER/women's visions/Environment/non-medical

*** No Definition

This node codes 5 documents.

(1 15 3 2) /FEMINIST HEALTH CENTER/women's visions/Environment/security

*** No Definition

This node codes 1 document.

(1 15 3 3) /FEMINIST HEALTH CENTER/women's visions/Environment/details for comfort

*** No Definition

This node codes 1 document.

(1 15 4) /FEMINIST HEALTH CENTER/women's visions/continuity

*** No Definition

This node codes 2 documents.

(1 15 5) /FEMINIST HEALTH CENTER/women's visions/do not have one till you see a good one

*** Definition:

women not having high expectations or any visions of a repro care, before we see one which is empowering

This node codes 2 documents.

(F) //Free Nodes

*** No Definition

This node codes 0 documents.

(F 1) //Free Nodes/My resistances

*** Definition:

My resistances in the interviews to medicalization

This node codes 3 documents.

(F 2) //Free Nodes/My submissions

*** Definition:

agreeing with what is said

This node codes 3 documents.

(F 3) //Free Nodes/My feminist assertions

*** Definition:

Assertions I made based mainly on readings.. that sometimes directly resist interviewee's arguments but also impositions on their thoughts/beliefs

This node codes 15 documents.

(F 4) //Free Nodes/protective of the group

*** Definition:

the interviewee does not speak freely as to protect others..

This node codes 1 document.

(F 5) //Free Nodes/My self-disclosures

*** No Definition

This node codes 10 documents.

(F 6) //Free Nodes/My inappropriate declarations - interruptions

*** No Definition

This node codes 3 documents.

(F 7) //Free Nodes/ayse as the educator

*** No Definition

This node codes 1 document.

(F 7 1) //Free Nodes/ayse as the educator/advocacy for the center

*** No Definition

This node codes 2 documents.

(F 7 2) //Free Nodes/ayse as the educator/"educating" the interviewee

*** No Definition

This node codes 7 documents.

(F 8) //Free Nodes/communication problems

*** Definition:

problems i had in communicating with women who are in lower socioeconomic status etc..

This node codes 4 documents.

(F 9) //Free Nodes/interpreting questions

*** Definition:

sometimes the interviewers interpreted the questions differently than i did, which alerted me to things I forgot about as well

This node codes 5 documents.

(F 10) //Free Nodes/ayse educated

*** Definition:

what i learned from the interviewees.. in terms of repro health or women's health movement etc..

This node codes 3 documents.

(F 11) //Free Nodes/Participants' reasons for interviewing

*** No Definition

This node codes 0 documents.

(F 11 1) //Free Nodes/Participants' reasons for interviewing/maybe it helps other women

*** No Definition

This node codes 1 document.

(F 12) //Free Nodes/Capturing the process of revising the interview

*** Definition:

I revised some questions and added others after the first couple of interviews.added questions about kids after Frances' interview..Add field note

This node codes 3 documents.

INDEX TREE FOR WHC (7:14 pm, Mar 20, 2003).

(2) /WOMEN'S HEALTH CENTER

- (2 1) /WOMEN'S HEALTH CENTER/Demographics
- (2 1 1) /WOMEN'S HEALTH CENTER/Demographics/Staff
- (2 1 1 1) /WOMEN'S HEALTH CENTER/Demographics/Staff/Gender
- (2 1 1 1 1) /WOMEN'S HEALTH CENTER/Demographics/Staff/Gender/Female
- (2 1 1 1 2) /WOMEN'S HEALTH CENTER/Demographics/Staff/Gender/Male
- (2 1 1 2) /WOMEN'S HEALTH CENTER/Demographics/Staff/Age
- (2 1 1 2 1) /WOMEN'S HEALTH CENTER/Demographics/Staff/Age/20-30
- (2 1 1 2 2) /WOMEN'S HEALTH CENTER/Demographics/Staff/Age/31-40
- (2 1 1 2 3) /WOMEN'S HEALTH CENTER/Demographics/Staff/Age/41-50
- (2 1 1 2 4) /WOMEN'S HEALTH CENTER/Demographics/Staff/Age/over 51
- (2 1 1 3) /WOMEN'S HEALTH CENTER/Demographics/Staff/Job position
- (2 1 1 3 1) /WOMEN'S HEALTH CENTER/Demographics/Staff/Job position/Rotation
- (2 1 1 3 2) /WOMEN'S HEALTH CENTER/Demographics/Staff/Job position/Specialization
- (2 1 1 3 3) /WOMEN'S HEALTH CENTER/Demographics/Staff/Job position/part-time
- (2 1 1 3 4) /WOMEN'S HEALTH CENTER/Demographics/Staff/Job position/Full-time
- (2 1 1 4) /WOMEN'S HEALTH CENTER/Demographics/Staff/Years in agency
- (2 1 1 5) /WOMEN'S HEALTH CENTER/Demographics/Staff/Years in current position
- (2 1 1 6) /WOMEN'S HEALTH CENTER/Demographics/Staff/Previous experience
- (2 1 1 6 1) /WOMEN'S HEALTH CENTER/Demographics/Staff/Previous experience/counseling experience
- (2 1 1 6 2) /WOMEN'S HEALTH CENTER/Demographics/Staff/Previous experience/women's health related
- (2 1 1 6 2 1) /WOMEN'S HEALTH CENTER/Demographics/Staff/Previous experience/women's health related/educational
- (2 1 1 6 2 2) /WOMEN'S HEALTH CENTER/Demographics/Staff/Previous experience/women's health related/Medical
- (2 1 1 6 3) /WOMEN'S HEALTH CENTER/Demographics/Staff/Previous experience/administrative -clerical experience
- (2 1 1 6 4) /WOMEN'S HEALTH CENTER/Demographics/Staff/Previous experience/medical (general)
- (2 1 1 6 5) /WOMEN'S HEALTH CENTER/Demographics/Staff/Previous experience/no previous experience

(2 1 1 7) /WOMEN'S HEALTH CENTER/Demographics/Staff/Race,
 ethnicity
 (2 1 2) /WOMEN'S HEALTH CENTER/Demographics/Clients
 (2 1 2 1) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Type of client
 (2 1 2 1 1) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Type of client/Gyn only
 (2 1 2 1 2) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Type of client/Ab only
 (2 1 2 1 2 1) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Type of client/Ab only/Awake
 (2 1 2 1 2 2) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Type of client/Ab only/Asleep
 (2 1 2 1 3) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Type of client/Ab + Gyn or Gyn + Ab
 (2 1 2 2) /WOMEN'S HEALTH CENTER/Demographics/Clients/Age
 (2 1 2 2 1) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Age/18-24
 (2 1 2 2 2) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Age/25-30
 (2 1 2 2 3) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Age/31-40
 (2 1 2 3) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Partner
 (2 1 2 3 1) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Partner/Yes
 (2 1 2 3 2) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Partner/No
 (2 1 2 3 3) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Partner/Stable?
 (2 1 2 4) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Marital status
 (2 1 2 4 1) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Marital status/Single
 (2 1 2 4 2) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Marital status/Married
 (2 1 2 4 3) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Marital status/Divorced
 (2 1 2 5) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Income
 (2 1 2 5 1) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Income/# of people
 (2 1 2 5 2) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Income/# of earners
 (2 1 2 6) /WOMEN'S HEALTH
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 (2 1 2 7) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Payment type
 (2 1 2 7 1) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Payment type/Self-pay
 (2 1 2 7 2) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Payment type/Insurance
 (2 1 2 7 3) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Payment type/Insurance but self-pay

(2 1 2 8) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Kids?
 (2 1 2 9) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Field Notes
 (2 1 2 10) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Ethnicity
 (2 1 2 10 1) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Ethnicity/white
 (2 1 2 10 2) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/Ethnicity/non-white
 (2 1 2 11) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/county they are from
 (2 1 2 12) /WOMEN'S HEALTH
 CENTER/Demographics/Clients/gestation

 (2 2) /WOMEN'S HEALTH CENTER/Agency history
 (2 2 1) /WOMEN'S HEALTH CENTER/Agency history/the
 founding
 (2 2 2) /WOMEN'S HEALTH CENTER/Agency history/Crises
 (2 2 2 1) /WOMEN'S HEALTH CENTER/Agency
 history/Crises/management changes
 (2 2 2 2) /WOMEN'S HEALTH CENTER/Agency
 history/Crises/violence
 (2 2 3) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of staff
 (2 2 3 1) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of staff/in prochoice beliefs
 (2 2 3 2) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of staff/ professional development
 (2 2 8) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of agency
 (2 2 8 1) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of agency/more insurance contracts
 (2 2 8 2) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of agency/more input from staff into management
 (2 2 8 3) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of agency/decrease in abortions
 (2 2 8 4) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of agency/changes in technology
 (2 2 8 5) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of agency/expansion of services
 (2 2 8 6) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of agency/decrease in protesters but increase in security
 (2 2 8 7) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of agency/patient care the same
 (2 2 8 7 1) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of agency/patient care the same/yet balanced with liability issues
 (2 2 8 8) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of agency/more communication between gyn and ab sides
 (2 2 8 9) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of agency/more alliances with doctors and hospitals
 (2 2 8 10) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of agency/no mid wife any more
 (2 2 8 11) /WOMEN'S HEALTH CENTER/Agency history/evolution
 of agency/group care (video)

(2 3) /WOMEN'S HEALTH CENTER/Agency structure
 (2 3 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Organizational structure
 (2 3 1 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Organizational structure/board of directors
 (2 3 1 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Organizational structure/executive director
 (2 3 1 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Organizational structure/medical director
 (2 3 1 4) /WOMEN'S HEALTH CENTER/Agency
 structure/Organizational structure/medical services coordinator
 (2 3 1 5) /WOMEN'S HEALTH CENTER/Agency
 structure/Organizational structure/clinic supervisor
 (2 3 1 6) /WOMEN'S HEALTH CENTER/Agency
 structure/Organizational structure/head counselor
 (2 3 1 7) /WOMEN'S HEALTH CENTER/Agency
 structure/Organizational structure/accounts receivable coordinator
 (2 3 1 8) /WOMEN'S HEALTH CENTER/Agency
 structure/Organizational structure/lab ancillary
 (2 3 1 9) /WOMEN'S HEALTH CENTER/Agency
 structure/Organizational structure/head nurse
 (2 3 1 10) /WOMEN'S HEALTH CENTER/Agency
 structure/Organizational structure/sub committees
 (2 3 1 11) /WOMEN'S HEALTH CENTER/Agency
 structure/Organizational structure/training of staff

 (2 3 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Medicalization
 (2 3 2 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Medicalization/Use of lay women
 (2 3 2 1 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Medicalization/Use of lay women/worked my way up
 (2 3 2 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Medicalization/Doctors
 (2 3 2 2 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Medicalization/Doctors/scarcity of ab providers
 (2 3 2 2 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Medicalization/Doctors/working with doctors
 (2 3 2 2 2 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Medicalization/Doctors/working with doctors/make everything
 flow quickly for doctors
 (2 3 2 2 2 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Medicalization/Doctors/working with doctors/I am sort of a
 technician
 (2 3 2 2 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Medicalization/Doctors/dedication
 (2 3 2 2 4) /WOMEN'S HEALTH CENTER/Agency
 structure/Medicalization/Doctors/doctors' power
 (2 3 2 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Medicalization/use of alternative methods
 (2 3 2 4) /WOMEN'S HEALTH CENTER/Agency
 structure/Medicalization/respecting women's knowledge
 (2 3 2 5) /WOMEN'S HEALTH CENTER/Agency
 structure/Medicalization/medical knowledge

(2 3 2 6) /WOMEN'S HEALTH CENTER/Agency
structure/Medicalization/division of medical labor

(2 3 2 7) /WOMEN'S HEALTH CENTER/Agency
structure/Medicalization/art of pelvic exam (touch)

(2 3 3) /WOMEN'S HEALTH CENTER/Agency structure/Agency
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(2 3 3 1) /WOMEN'S HEALTH CENTER/Agency structure/Agency
in community/identity as an abortion provider

(2 3 3 2) /WOMEN'S HEALTH CENTER/Agency structure/Agency
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(2 3 3 3) /WOMEN'S HEALTH CENTER/Agency structure/Agency
in community/lack of understanding or support

(2 3 3 4) /WOMEN'S HEALTH CENTER/Agency structure/Agency
in community/resource for the community

(2 3 3 6) /WOMEN'S HEALTH CENTER/Agency structure/Agency
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(2 3 3 7) /WOMEN'S HEALTH CENTER/Agency structure/Agency
in community/alliances with other AB clinics and prochoice
organizations

(2 3 3 8) /WOMEN'S HEALTH CENTER/Agency structure/Agency
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(2 3 3 9) /WOMEN'S HEALTH CENTER/Agency structure/Agency
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(2 3 3 10) /WOMEN'S HEALTH CENTER/Agency structure/Agency
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(2 3 3 11) /WOMEN'S HEALTH CENTER/Agency structure/Agency
in community/anti-choice doctors

(2 3 3 12) /WOMEN'S HEALTH CENTER/Agency structure/Agency
in community/changing community through alternative care

(2 3 3 12 1) /WOMEN'S HEALTH CENTER/Agency structure/Agency
in community/changing community through alternative care/spill over (or
not) to family friends

(2 3 3 12 2) /WOMEN'S HEALTH CENTER/Agency structure/Agency
in community/changing community through alternative care/spill over to
medical community

(2 3 3 12 3) /WOMEN'S HEALTH CENTER/Agency structure/Agency
in community/changing community through alternative care/spill over to
women clients

(2 3 4) /WOMEN'S HEALTH CENTER/Agency
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(2 3 4 1) /WOMEN'S HEALTH CENTER/Agency
structure/Services/questions women ask

(2 3 4 1 1) /WOMEN'S HEALTH CENTER/Agency
structure/Services/questions women ask/about the procedure

(2 3 4 1 1 1) /WOMEN'S HEALTH CENTER/Agency
structure/Services/questions women ask/about the
procedure/confidentiality

(2 3 4 1 1 2) /WOMEN'S HEALTH CENTER/Agency
structure/Services/questions women ask/about the procedure/protesters

(2 3 4 1 1 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about the procedure/infertility concerns

(2 3 4 1 1 4) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about the procedure/spiritual moral beliefs

(2 3 4 1 1 5) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about the procedure/relationship issues

(2 3 4 1 1 6) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about the procedure/how to decide

(2 3 4 1 1 7) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about the procedure/pain

(2 3 4 1 1 8) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about the procedure/laminaria

(2 3 4 1 1 9) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about the procedure/sleep time under IV

(2 3 4 1 1 10) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about the procedure/negative type blood

(2 3 4 1 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/birth control related

(2 3 4 1 2 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/birth control related/weight gain - body image

(2 3 4 1 2 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/birth control related/bleeding

(2 3 4 1 2 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/birth control related/side effects

(2 3 4 1 2 4) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/birth control related/getting pregnant after the pill

(2 3 4 1 2 5) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/birth control related/how soon to start

(2 3 4 1 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about the doctors

(2 3 4 1 4) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about after-care

(2 3 4 1 5) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/info needs time to sink in

(2 3 4 1 6) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about menopause

(2 3 4 1 7) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about lab tests

(2 3 4 1 8) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/direct vs indirect questions

(2 3 4 1 9) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about consents

(2 3 4 1 10) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about mental health

(2 3 4 1 11) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about the fetus
 (2 3 4 1 12) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/questions women ask/about STDs

 (2 3 4 2) /WOMEN'S HEALTH CENTER/Agency
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 (2 3 4 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options

 (2 3 4 3 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/birth control options
 (2 3 4 3 1 1) /WOMEN'S HEALTH CENTER/Agency
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 (2 3 4 3 1 1 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/birth control options/preferred
 methods/medical reasons
 (2 3 4 3 1 1 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/birth control options/preferred
 methods/depending on women
 (2 3 4 3 1 1 2 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/birth control options/preferred
 methods/depending on women/body image issues -weight gain
 (2 3 4 3 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/counseling
 (2 3 4 3 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/consultation visit as a counseling
 (2 3 4 3 4) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/post ab counseling
 (2 3 4 3 5) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/support provided to women's support persons
 (2 3 4 3 6) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/general counseling services
 (2 3 4 3 7) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/medical abortion as an option
 (2 3 4 3 8) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/emergency contraception
 (2 3 4 3 9) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/required lab tests
 (2 3 4 3 10) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/crisis options
 (2 3 4 3 11) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/support during abortion and in aftercare
 (2 3 4 3 12) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/awake or asleep abortion
 (2 3 4 3 12 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/awake or asleep abortion/depends on the cost
 (2 3 4 3 12 7) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/awake or asleep abortion/extra medication
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 (2 3 4 3 13) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/can stop at any time
 (2 3 4 3 14) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/referring to other places

(2 3 4 3 15) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/options/pregnancy test before BC shots
 (2 3 4 3 16) /WOMEN'S HEALTH CENTER/Agency
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 (2 3 4 3 17) /WOMEN'S HEALTH CENTER/Agency
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(2 3 4 4) /WOMEN'S HEALTH CENTER/Agency
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 (2 3 4 4 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/how prepared and
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 (2 3 4 4 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/Experiential
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 (2 3 4 4 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/based on age
 (2 3 4 4 4) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/based on ethnicity
 (2 3 4 4 5) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/based on child
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 (2 3 4 4 6) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/health status
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 (2 3 4 4 7) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/how much they wanna
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 (2 3 4 4 8) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/based on readiness
 for parenthood
 (2 3 4 4 9) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/different
 experiences of medical abortion
 (2 3 4 4 10) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/decided on BC
 (2 3 4 4 11) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/women from all walks
 of life
 (2 3 4 4 12) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/in physical recovery
 after abortion
 (2 3 4 4 13) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/woman's repro
 history
 (2 3 4 4 14) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/had CV or not
 (2 3 4 4 15) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/individual differences of women/had abortion before

(2 3 4 5) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/an empowered client
 (2 3 4 6) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/ask them their abortion decision twice

(2 3 4 7) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/characteristics of providers -coworkers
 (2 3 4 7 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/characteristics of providers -coworkers/Gender
 (2 3 4 7 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/characteristics of providers -coworkers/Age
 (2 3 4 7 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/characteristics of providers -coworkers/chidbearing
 (2 3 4 8) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/clinic days and patient volume
 (2 3 4 9) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/how women know about WHC
 (2 3 4 9 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/how women know about WHC/referral
 (2 3 4 9 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/how women know about WHC/friends
 (2 3 4 9 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/how women know about WHC/been here
 (2 3 4 9 4) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/how women know about WHC/phone book
 (2 3 4 9 5) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/how women know about WHC/grew up here
 (2 3 4 9 6) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/how women know about WHC/political commitment
 (2 3 4 9 7) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/how women know about WHC/confusion with the other
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 (2 3 4 10) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/comfort level of clients with staff
 (2 3 4 12) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/follow up mechanisms
 (2 3 4 13) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A real visit
 (2 3 4 13 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A real visit/I called
 (2 3 4 13 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A real visit/stages of visit
 (2 3 4 13 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A real visit/Counseling
 (2 3 4 13 4) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A real visit/Birth Control discussions
 (2 3 4 13 5) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A real visit/Abortion
 (2 3 4 13 6) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A real visit/Aftercare
 (2 3 4 13 7) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A real visit/Follow-up
 (2 3 4 13 8) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A real visit/anything unexpected?
 (2 3 4 13 9) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A real visit/gyn visit
 (2 3 4 13 9 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A real visit/gyn visit/discomfort of the exam
 (2 3 4 14) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/Time

(2 3 4 14 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/Time/number of visits
 (2 3 4 14 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/Time/time to schedule
 (2 3 4 14 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/Time/waiting time
 (2 3 4 14 4) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/Time/time in sessions, lab, abortion etc
 (2 3 4 15) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A typical visit
 (2 3 4 15 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A typical visit/lab work
 (2 3 4 15 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A typical visit/Counseling
 (2 3 4 15 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A typical visit/Abortion and follow up
 (2 3 4 15 4) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A typical visit/gyn -initial- visit
 (2 3 4 15 5) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A typical visit/video
 (2 3 4 15 6) /WOMEN'S HEALTH CENTER/Agency
 structure/Services/A typical visit/first phone

 (2 3 5) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 communication

 (2 3 5 1) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 communication/constructive, quick feedback
 (2 3 5 2) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 communication/staff meetings
 (2 3 5 3) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 communication/through memos
 (2 3 5 4) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 communication/between staff and administration
 (2 3 5 5) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 communication/between medical and counseling part
 (2 3 5 6) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 communication/conflict resolution
 (2 3 5 7) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 communication/between front and back staff
 (2 3 5 8) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 communication/need time to exchange ideas
 (2 3 5 9) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 communication/need to feel safe - not gossiping
 (2 3 5 10) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 communication/disrupted due to part time work

 (2 3 6) /WOMEN'S HEALTH CENTER/Agency
 structure/Documentation

 (2 3 6 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Documentation/tedious -time consuming
 (2 3 6 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Documentation/back up person

(2 3 6 3) /WOMEN'S HEALTH CENTER/Agency
 structure/Documentation/improvements suggested?
 (2 3 6 3 1) /WOMEN'S HEALTH CENTER/Agency
 structure/Documentation/improvements suggested?/visual cues are helpful
 (2 3 6 3 2) /WOMEN'S HEALTH CENTER/Agency
 structure/Documentation/improvements suggested?/keeping and checking
 computer and paper files
 (2 3 6 4) /WOMEN'S HEALTH CENTER/Agency
 structure/Documentation/staff input into it
 (2 3 6 5) /WOMEN'S HEALTH CENTER/Agency
 structure/Documentation/important
 (2 3 6 6) /WOMEN'S HEALTH CENTER/Agency
 structure/Documentation/keep updating
 (2 3 6 7) /WOMEN'S HEALTH CENTER/Agency
 structure/Documentation/important to communicate about documentation
 (2 3 6 8) /WOMEN'S HEALTH CENTER/Agency
 structure/Documentation/confidentiality in documentation

(2 3 7) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support

(2 3 7 1) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/care for each other and self
 (2 3 7 2) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/solidarity
 (2 3 7 3) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/can vent to each other
 (2 3 7 4) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/Financial
 (2 3 7 5) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/short-staffed
 (2 3 7 6) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/have time for you - resourceful
 (2 3 7 7) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/improvements?
 (2 3 7 7 1) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/improvements?/Technical improvements
 (2 3 7 7 2) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/improvements?/Trained staff
 (2 3 7 7 3) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/improvements?/improve transportation
 (2 3 7 7 4) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/improvements?/need more initiative - ownership of duties
 (2 3 7 7 5) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/improvements?/better conflict resolution
 (2 3 7 7 6) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/improvements?/positive environment
 (2 3 7 7 7) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/improvements?/less mistakes
 (2 3 7 7 8) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/improvements?/spacial improvements
 (2 3 7 7 9) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/improvements?/increased pay
 (2 3 7 7 10) /WOMEN'S HEALTH CENTER/Agency structure/Staff
 support/improvements?/protesters -safety

(2 3 7 8) /WOMEN'S HEALTH CENTER/Agency structure/Staff support/comfort and trust
 (2 3 7 9) /WOMEN'S HEALTH CENTER/Agency structure/Staff support/I am part of this place
 (2 3 7 10) /WOMEN'S HEALTH CENTER/Agency structure/Staff support/flexibility for raising a family
 (2 3 7 11) /WOMEN'S HEALTH CENTER/Agency structure/Staff support/support from the Board or sister clinics
 (2 3 7 12) /WOMEN'S HEALTH CENTER/Agency structure/Staff support/financial benefits
 (2 3 7 13) /WOMEN'S HEALTH CENTER/Agency structure/Staff support/emotionally charged environment -work
 (2 3 7 13 10) /WOMEN'S HEALTH CENTER/Agency structure/Staff support/emotionally charged environment -work/humor as a coping strategy
 (2 3 7 14) /WOMEN'S HEALTH CENTER/Agency structure/Staff support/agency as an incubator for staff

(2 3 8) /WOMEN'S HEALTH CENTER/Agency structure/Staff size

(2 3 9) /WOMEN'S HEALTH CENTER/Agency structure/Decision making

(2 3 9 1) /WOMEN'S HEALTH CENTER/Agency structure/Decision making/Directors' meeting
 (2 3 9 2) /WOMEN'S HEALTH CENTER/Agency structure/Decision making/Full-staff meeting
 (2 3 9 3) /WOMEN'S HEALTH CENTER/Agency structure/Decision making/management committee
 (2 3 9 4) /WOMEN'S HEALTH CENTER/Agency structure/Decision making/medical committee meetings
 (2 3 9 5) /WOMEN'S HEALTH CENTER/Agency structure/Decision making/medical director's decisions
 (2 3 9 6) /WOMEN'S HEALTH CENTER/Agency structure/Decision making/board of directors

(2 3 10) /WOMEN'S HEALTH CENTER/Agency structure/Compared to other agencies -providers

(2 3 10 1) /WOMEN'S HEALTH CENTER/Agency structure/Compared to other agencies -providers/more TIME per patient

(2 3 10 2) /WOMEN'S HEALTH CENTER/Agency structure/Compared to other agencies -providers/same concerns over abortion

(2 3 10 3) /WOMEN'S HEALTH CENTER/Agency structure/Compared to other agencies -providers/safer abortion with less side effects

(2 3 10 4) /WOMEN'S HEALTH CENTER/Agency structure/Compared to other agencies -providers/better documentation here

(2 3 10 5) /WOMEN'S HEALTH CENTER/Agency structure/Compared to other agencies -providers/less power plays and more support than a hospital setting

(2 3 10 6) /WOMEN'S HEALTH CENTER/Agency
 structure/Compared to other agencies -providers/more responsive
 (2 3 10 7) /WOMEN'S HEALTH CENTER/Agency
 structure/Compared to other agencies -providers/lower fees for gyn
 (2 3 10 8) /WOMEN'S HEALTH CENTER/Agency
 structure/Compared to other agencies -providers/Abortion counseling
 which is non existent in private practice
 (2 3 10 9) /WOMEN'S HEALTH CENTER/Agency
 structure/Compared to other agencies -providers/less hierarchical due
 to rotation
 (2 3 10 10) /WOMEN'S HEALTH CENTER/Agency
 structure/Compared to other agencies -providers/specialized in women's
 health

 (2 3 11) /WOMEN'S HEALTH CENTER/Agency structure/Funding
 sources
 (2 3 11 1) /WOMEN'S HEALTH CENTER/Agency structure/Funding
 sources/Fees
 (2 3 11 2) /WOMEN'S HEALTH CENTER/Agency structure/Funding
 sources/drug companies

 (2 4) /WOMEN'S HEALTH CENTER/Structural factors

 (2 4 1) /WOMEN'S HEALTH CENTER/Structural
 factors/Recent history
 (2 4 1 1) /WOMEN'S HEALTH CENTER/Structural
 factors/Recent history/Politics of abortion
 (2 4 2) /WOMEN'S HEALTH CENTER/Structural factors/legal
 factors
 (2 4 2 1) /WOMEN'S HEALTH CENTER/Structural factors/legal
 factors/PA Abortion Control Act
 (2 4 2 2) /WOMEN'S HEALTH CENTER/Structural factors/legal
 factors/Parental Consent Law
 (2 4 2 3) /WOMEN'S HEALTH CENTER/Structural factors/legal
 factors/reflecting the mistrust in women
 (2 4 3) /WOMEN'S HEALTH CENTER/Structural
 factors/Economic factors
 (2 4 3 1) /WOMEN'S HEALTH CENTER/Structural
 factors/Economic factors/balancing care for staff and clients and
 business - efficiency
 (2 4 3 2) /WOMEN'S HEALTH CENTER/Structural
 factors/Economic factors/liability issues
 (2 4 4) /WOMEN'S HEALTH CENTER/Structural
 factors/Medical system
 (2 4 4 1) /WOMEN'S HEALTH CENTER/Structural
 factors/Medical system/training of AB providers
 (2 4 4 2) /WOMEN'S HEALTH CENTER/Structural
 factors/Medical system/research on male BC methods
 (2 4 5) /WOMEN'S HEALTH CENTER/Structural
 factors/Women's awareness of rights and insurance

 (2 5) /WOMEN'S HEALTH CENTER/Motivation to work

 (2 5 1) /WOMEN'S HEALTH CENTER/Motivation to
 work/Initial

(2 5 1 1) /WOMEN'S HEALTH CENTER/Motivation to
 work/Initial/networking
 (2 5 1 2) /WOMEN'S HEALTH CENTER/Motivation to
 work/Initial/feminist beliefs
 (2 5 1 3) /WOMEN'S HEALTH CENTER/Motivation to
 work/Initial/pro-choice beliefs
 (2 5 1 4) /WOMEN'S HEALTH CENTER/Motivation to
 work/Initial/interested in this age group
 (2 5 1 5) /WOMEN'S HEALTH CENTER/Motivation to
 work/Initial/better work environment
 (2 5 1 6) /WOMEN'S HEALTH CENTER/Motivation to
 work/Initial/had an abortion experience myself
 (2 5 1 7) /WOMEN'S HEALTH CENTER/Motivation to
 work/Initial/flexibility - family related reasons
 (2 5 1 8) /WOMEN'S HEALTH CENTER/Motivation to
 work/Initial/for internship
 (2 5 1 9) /WOMEN'S HEALTH CENTER/Motivation to
 work/Initial/interest in reproductive health
 (2 5 2) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)
 (2 5 2 1) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/take care of my staff
 (2 5 2 2) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/safe, comfortable, affordable care
 (2 5 2 3) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/personal agendas
 (2 5 2 3 1) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/personal agendas/promote safe sex -
 BC
 (2 5 2 3 2) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/personal agendas/increase outreach
 (2 5 2 3 3) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/personal agendas/expansion of
 services
 (2 5 2 3 4) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/personal agendas/keep a stable
 staff
 (2 5 2 3 4 1) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/personal agendas/keep a stable
 staff/hard due to funding
 (2 5 2 3 4 2) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/personal agendas/keep a stable
 staff/by providing a safe place for staff
 (2 5 2 3 4 3) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/personal agendas/keep a stable
 staff/by creating niches for staff
 (2 5 2 4) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/increase my skills
 (2 5 2 5) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/help women participate in services
 (2 5 2 6) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/give women choice
 (2 5 2 7) /WOMEN'S HEALTH CENTER/Motivation to
 work/current (motivation and goals)/give normalcy to abortion

(2 5 2 7 1) /WOMEN'S HEALTH CENTER/Motivation to
work/current (motivation and goals)/give normalcy to abortion/through
public talk

(2 5 2 7 8) /WOMEN'S HEALTH CENTER/Motivation to
work/current (motivation and goals)/give normalcy to abortion/have
clients talk about abortion with others

(2 5 2 8) /WOMEN'S HEALTH CENTER/Motivation to
work/current (motivation and goals)/be the best I can, accepting the
limits

(2 5 2 9) /WOMEN'S HEALTH CENTER/Motivation to
work/current (motivation and goals)/support women's support persons too

(2 5 2 10) /WOMEN'S HEALTH CENTER/Motivation to
work/current (motivation and goals)/nature of job

(2 5 2 10 1) /WOMEN'S HEALTH CENTER/Motivation to
work/current (motivation and goals)/nature of job/job is meaningful

(2 5 2 10 7) /WOMEN'S HEALTH CENTER/Motivation to
work/current (motivation and goals)/nature of job/job with a human
connection

(2 6) /WOMEN'S HEALTH CENTER/Access

(2 6 1) /WOMEN'S HEALTH CENTER/Access/Cost

(2 6 1 1) /WOMEN'S HEALTH CENTER/Access/Cost/free samples

(2 6 1 2) /WOMEN'S HEALTH CENTER/Access/Cost/free post ab
counseling

(2 6 1 3) /WOMEN'S HEALTH CENTER/Access/Cost/helping with
fees

(2 6 1 4) /WOMEN'S HEALTH CENTER/Access/Cost/insurance
coverage

(2 6 1 4 1) /WOMEN'S HEALTH CENTER/Access/Cost/insurance
coverage/insurance agreements

(2 6 1 4 2) /WOMEN'S HEALTH CENTER/Access/Cost/insurance
coverage/women's willingness to use insurance

(2 6 1 4 3) /WOMEN'S HEALTH CENTER/Access/Cost/insurance
coverage/serving underinsured or uninsured through low fees

(2 6 1 4 4) /WOMEN'S HEALTH CENTER/Access/Cost/insurance
coverage/medical assistance

(2 6 1 5) /WOMEN'S HEALTH CENTER/Access/Cost/services at
lower fee

(2 6 1 6) /WOMEN'S HEALTH CENTER/Access/Cost/costly but
worth it

(2 6 1 7) /WOMEN'S HEALTH CENTER/Access/Cost/cost of late
ab

(2 6 2) /WOMEN'S HEALTH CENTER/Access/hours

(2 6 3) /WOMEN'S HEALTH CENTER/Access/Phone CV

(2 6 4) /WOMEN'S HEALTH CENTER/Access/outpatient
facility

(2 6 5) /WOMEN'S HEALTH CENTER/Access/info on the web

(2 6 6) /WOMEN'S HEALTH CENTER/Access/till which
gestation period

(2 6 7) /WOMEN'S HEALTH CENTER/Access/spanish phone
counselor

(2 6 8) /WOMEN'S HEALTH CENTER/Access/distance

(2 7) /WOMEN'S HEALTH CENTER/feminisms

(2 7 1) /WOMEN'S HEALTH CENTER/feminisms/definitions
 (2 7 1 1) /WOMEN'S HEALTH
 CENTER/feminisms/definitions/feminist vs. activist
 (2 7 1 2) /WOMEN'S HEALTH
 CENTER/feminisms/definitions/equality with anyone
 (2 7 1 3) /WOMEN'S HEALTH
 CENTER/feminisms/definitions/make own decisions
 (2 7 2) /WOMEN'S HEALTH CENTER/feminisms/self-
 identification
 (2 7 2 1) /WOMEN'S HEALTH CENTER/feminisms/self-
 identification/prochoice
 (2 7 2 2) /WOMEN'S HEALTH CENTER/feminisms/self-
 identification/feminist
 (2 7 3) /WOMEN'S HEALTH CENTER/feminisms/strong role
 models
 (2 7 4) /WOMEN'S HEALTH CENTER/feminisms/spill over to
 family friends
 (2 7 5) /WOMEN'S HEALTH CENTER/feminisms/feminist
 beliefs

 (2 8) /WOMEN'S HEALTH CENTER/violence -protesters

 (2 8 1) /WOMEN'S HEALTH CENTER/violence -
 protesters/normalized
 (2 8 2) /WOMEN'S HEALTH CENTER/violence -
 protesters/limits of protesting

 (2 9) /WOMEN'S HEALTH CENTER/Abortion

 (2 9 1) /WOMEN'S HEALTH CENTER/Abortion/range of
 responses to abortion
 (2 9 2) /WOMEN'S HEALTH CENTER/Abortion/feeling
 irresponsible as a general reaction
 (2 9 3) /WOMEN'S HEALTH CENTER/Abortion/Illegal
 abortion times
 (2 9 4) /WOMEN'S HEALTH CENTER/Abortion/normalization
 of abortion
 (2 9 4 1) /WOMEN'S HEALTH CENTER/Abortion/normalization
 of abortion/abortion as a psychological event
 (2 9 4 2) /WOMEN'S HEALTH CENTER/Abortion/normalization
 of abortion/abortion as a medical "procedure"
 (2 9 4 2 1) /WOMEN'S HEALTH CENTER/Abortion/normalization
 of abortion/abortion as a medical "procedure"/"terminating pregnancy"
 (2 9 4 3) /WOMEN'S HEALTH CENTER/Abortion/normalization
 of abortion/through validating their feelings are normal
 (2 9 4 4) /WOMEN'S HEALTH CENTER/Abortion/normalization
 of abortion/through knowing others who go through it
 (2 9 5) /WOMEN'S HEALTH CENTER/Abortion/abortion as a
 transformative event
 (2 9 6) /WOMEN'S HEALTH CENTER/Abortion/decided yet
 scared
 (2 9 7) /WOMEN'S HEALTH CENTER/Abortion/regulation by
 family & friends

(2 9 7 1) /WOMEN'S HEALTH CENTER/Abortion/regulation by family & friends/providing kids for the family

(2 9 8) /WOMEN'S HEALTH CENTER/Abortion/support by family

(2 9 9) /WOMEN'S HEALTH CENTER/Abortion/men and abortion

(2 9 10) /WOMEN'S HEALTH CENTER/Abortion/conflicting & challenging views and self

(2 9 11) /WOMEN'S HEALTH CENTER/Abortion/I am not having sex any more!

(2 9 12) /WOMEN'S HEALTH CENTER/Abortion/women with multiple abortions

(2 9 13) /WOMEN'S HEALTH CENTER/Abortion/reasons for abortion

(2 9 13 1) /WOMEN'S HEALTH CENTER/Abortion/reasons for abortion/women's limits

(2 9 14) /WOMEN'S HEALTH CENTER/Abortion/women need validation

(2 9 15) /WOMEN'S HEALTH CENTER/Abortion/felt disappointed

(2 9 16) /WOMEN'S HEALTH CENTER/Abortion/women who are in the same boat

(2 9 17) /WOMEN'S HEALTH CENTER/Abortion/pain!!

(2 9 18) /WOMEN'S HEALTH CENTER/Abortion/have to be in the situation -even for teh coounselors

(2 9 19) /WOMEN'S HEALTH CENTER/Abortion/women judging self and other women in abortion

(2 9 19 1) /WOMEN'S HEALTH CENTER/Abortion/women judging self and other women in abortion/abortion ok for extereme cases (rape, incest)

(2 9 20) /WOMEN'S HEALTH CENTER/Abortion/decision is a process

(2 9 21) /WOMEN'S HEALTH CENTER/Abortion/women think hard on it - not as convenient as prochoice claims it is

(2 9 22) /WOMEN'S HEALTH CENTER/Abortion/abortion within the larger context of female sexualization

(2 9 23) /WOMEN'S HEALTH CENTER/Abortion/I did not think it would happen to me

(2 9 24) /WOMEN'S HEALTH CENTER/Abortion/after the abortion

(2 9 24 1) /WOMEN'S HEALTH CENTER/Abortion/after the abortion/other pregnancies reminding of mine

(2 9 24 2) /WOMEN'S HEALTH CENTER/Abortion/after the abortion/support from family & friends

(2 9 24 3) /WOMEN'S HEALTH CENTER/Abortion/after the abortion/still thinking about the baby

(2 9 24 4) /WOMEN'S HEALTH CENTER/Abortion/after the abortion/complications xperienced

(2 9 25) /WOMEN'S HEALTH CENTER/Abortion/silence or talking about it to family, friends

(2 9 26) /WOMEN'S HEALTH CENTER/Abortion/it's draining

(2 9 27) /WOMEN'S HEALTH CENTER/Abortion/compared to other pelvic surgeries

(2 10) /WOMEN'S HEALTH CENTER/Women's visions of care

(2 10 1) /WOMEN'S HEALTH CENTER/Women's visions of
 care/type of services
 (2 10 1 1) /WOMEN'S HEALTH CENTER/Women's visions of
 care/type of services/abortion integrated or separate
 (2 10 1 2) /WOMEN'S HEALTH CENTER/Women's visions of
 care/type of services/abortion counseling
 (2 10 1 3) /WOMEN'S HEALTH CENTER/Women's visions of
 care/type of services/pro-choice, for all women
 (2 10 1 4) /WOMEN'S HEALTH CENTER/Women's visions of
 care/type of services/general counseling included
 (2 10 1 5) /WOMEN'S HEALTH CENTER/Women's visions of
 care/type of services/affordable
 (2 10 1 6) /WOMEN'S HEALTH CENTER/Women's visions of
 care/type of services/more info on pregnancy
 (2 10 2) /WOMEN'S HEALTH CENTER/Women's visions of
 care/environment
 (2 10 2 1) /WOMEN'S HEALTH CENTER/Women's visions of
 care/environment/comfortable, soothing
 (2 10 2 2) /WOMEN'S HEALTH CENTER/Women's visions of
 care/environment/bigger rooms
 (2 10 2 3) /WOMEN'S HEALTH CENTER/Women's visions of
 care/environment/empowering messages on walls
 (2 10 2 4) /WOMEN'S HEALTH CENTER/Women's visions of
 care/environment/homy
 (2 10 2 5) /WOMEN'S HEALTH CENTER/Women's visions of
 care/environment/welcoming, inviting
 (2 10 2 6) /WOMEN'S HEALTH CENTER/Women's visions of
 care/environment/health information
 (2 10 2 7) /WOMEN'S HEALTH CENTER/Women's visions of
 care/environment/oasis
 (2 10 2 8) /WOMEN'S HEALTH CENTER/Women's visions of
 care/environment/heated rooms
 (2 10 2 9) /WOMEN'S HEALTH CENTER/Women's visions of
 care/environment/clean
 (2 10 3) /WOMEN'S HEALTH CENTER/Women's visions of
 care/Staff
 (2 10 3 1) /WOMEN'S HEALTH CENTER/Women's visions of
 care/Staff/gender
 (2 10 3 2) /WOMEN'S HEALTH CENTER/Women's visions of
 care/Staff/friendly, welcoming
 (2 10 3 3) /WOMEN'S HEALTH CENTER/Women's visions of
 care/Staff/medical or not
 (2 10 3 4) /WOMEN'S HEALTH CENTER/Women's visions of
 care/Staff/informing but non-directive
 (2 10 3 5) /WOMEN'S HEALTH CENTER/Women's visions of
 care/Staff/energetic staff
 (2 10 3 6) /WOMEN'S HEALTH CENTER/Women's visions of
 care/Staff/respectful treatment
 (2 10 4) /WOMEN'S HEALTH CENTER/Women's visions of
 care/as affected by the media
 (2 10 5) /WOMEN'S HEALTH CENTER/Women's visions of
 care/clinic vs private practice or hospital
 (2 10 6) /WOMEN'S HEALTH CENTER/Women's visions of
 care/ideal vs the WHC

(2 10 7) /WOMEN'S HEALTH CENTER/Women's visions of
 care/accessible hours
 (2 10 8) /WOMEN'S HEALTH CENTER/Women's visions of
 care/efficient, timely services
 (2 10 9) /WOMEN'S HEALTH CENTER/Women's visions of
 care/no weighing
 (2 10 10) /WOMEN'S HEALTH CENTER/Women's visions of
 care/more autonomy, flexibility, self-help gyn
 (2 10 11) /WOMEN'S HEALTH CENTER/Women's visions of
 care/outreach to normalize abortion

 (2 11) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients

 (2 11 1) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC
 (2 11 1 1) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/comforting
 (2 11 1 2) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/they take care of you
 (2 11 1 3) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/not judgemental
 (2 11 1 4) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/they take their time with each patient
 (2 11 1 5) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/Respectful?
 (2 11 1 6) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/attitude problem
 (2 11 1 7) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/professionalism
 (2 11 1 8) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/personal relationship to provider
 (2 11 1 9) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/knowledgeable
 (2 11 1 10) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/honestly informing
 (2 11 1 11) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/non-directive
 (2 11 1 12) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/chit chat
 (2 11 1 13) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/confidentiality
 (2 11 1 14) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/dedicated to and satisfied in their work
 (2 11 1 15) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/good with needles
 (2 11 1 16) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/patient-centered
 (2 11 1 17) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/you're not a number -humane treatment
 (2 11 1 17 1) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/you're not a number -humane treatment/herding
 (2 11 1 17 2) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/you're not a number -humane treatment/pamphleting vs
 human contact

(2 11 1 18) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/peer services
 (2 11 1 19) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/accomodating (within limits?)
 (2 11 1 20) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/concerned about holistic health
 (2 11 1 21) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/in WHC/building trust in counseling
 (2 11 2) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/Compared to others
 (2 11 2 1) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/Compared to others/friendly, welcoming
 (2 11 2 2) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/Compared to others/more informing
 (2 11 2 3) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/Compared to others/similar
 (2 11 2 4) /WOMEN'S HEALTH CENTER/Staff Treatment of
 clients/Compared to others/waiting time

 (2 12) /WOMEN'S HEALTH CENTER/Women's way of knowing

 (2 12 1) /WOMEN'S HEALTH CENTER/Women's way of
 knowing/experiential
 (2 12 2) /WOMEN'S HEALTH CENTER/Women's way of
 knowing/internet
 (2 12 3) /WOMEN'S HEALTH CENTER/Women's way of
 knowing/own gynecologist or doctor
 (2 12 4) /WOMEN'S HEALTH CENTER/Women's way of
 knowing/call here
 (2 12 5) /WOMEN'S HEALTH CENTER/Women's way of
 knowing/family or friends
 (2 12 6) /WOMEN'S HEALTH CENTER/Women's way of
 knowing/sex ed classes
 (2 12 7) /WOMEN'S HEALTH CENTER/Women's way of
 knowing/medical books

 (2 13) /WOMEN'S HEALTH CENTER/Motivation to choose WHC

 (2 13 1) /WOMEN'S HEALTH CENTER/Motivation to choose
 WHC/abortion provider
 (2 13 2) /WOMEN'S HEALTH CENTER/Motivation to choose
 WHC/access (distance or cost)
 (2 13 3) /WOMEN'S HEALTH CENTER/Motivation to choose
 WHC/level of care
 (2 13 4) /WOMEN'S HEALTH CENTER/Motivation to choose
 WHC/anonymity
 (2 13 5) /WOMEN'S HEALTH CENTER/Motivation to choose
 WHC/specialized in women's care

 (2 14) /WOMEN'S HEALTH CENTER/Previous or current
 providers

 (2 14 1) /WOMEN'S HEALTH CENTER/Previous or current
 providers/gynecologist (private practice)

(2 14 2) /WOMEN'S HEALTH CENTER/Previous or current providers/planned parenthood
 (2 14 3) /WOMEN'S HEALTH CENTER/Previous or current providers/bad experiences with previous providers
 (2 14 4) /WOMEN'S HEALTH CENTER/Previous or current providers/general practitioner

(2 15) /WOMEN'S HEALTH CENTER/Environment

(2 15 1) /WOMEN'S HEALTH CENTER/Environment/in WHC
 (2 15 1 1) /WOMEN'S HEALTH CENTER/Environment/in WHC/homy not medical
 (2 15 1 1 1) /WOMEN'S HEALTH CENTER/Environment/in WHC/homy not medical/mellow mood
 (2 15 1 2) /WOMEN'S HEALTH CENTER/Environment/in WHC/clean
 (2 15 1 3) /WOMEN'S HEALTH CENTER/Environment/in WHC/educational materials
 (2 15 1 3 1) /WOMEN'S HEALTH CENTER/Environment/in WHC/educational materials/too much use of it
 (2 15 1 4) /WOMEN'S HEALTH CENTER/Environment/in WHC/need bigger rooms
 (2 15 1 4 1) /WOMEN'S HEALTH CENTER/Environment/in WHC/need bigger rooms/Crowded
 (2 15 1 4 2) /WOMEN'S HEALTH CENTER/Environment/in WHC/need bigger rooms/for gyn or ab procedures
 (2 15 1 5) /WOMEN'S HEALTH CENTER/Environment/in WHC/comfortable, soothing, distracting
 (2 15 1 6) /WOMEN'S HEALTH CENTER/Environment/in WHC/security
 (2 15 1 7) /WOMEN'S HEALTH CENTER/Environment/in WHC/change sitting to make interaction possible
 (2 15 2) /WOMEN'S HEALTH CENTER/Environment/in comparison

(2 16) /WOMEN'S HEALTH CENTER/Self-efficacy

(2 16 1) /WOMEN'S HEALTH CENTER/Self-efficacy/New knowledge?
 (2 16 1 1) /WOMEN'S HEALTH CENTER/Self-efficacy/New knowledge?/already knew things before
 (2 16 1 2) /WOMEN'S HEALTH CENTER/Self-efficacy/New knowledge?/new BC methods
 (2 16 1 3) /WOMEN'S HEALTH CENTER/Self-efficacy/New knowledge?/learned about the medical abortion
 (2 16 1 4) /WOMEN'S HEALTH CENTER/Self-efficacy/New knowledge?/about shortage of b providers
 (2 16 1 5) /WOMEN'S HEALTH CENTER/Self-efficacy/New knowledge?/learned about emergency contraception
 (2 16 1 6) /WOMEN'S HEALTH CENTER/Self-efficacy/New knowledge?/learned anatomy
 (2 16 1 7) /WOMEN'S HEALTH CENTER/Self-efficacy/New knowledge?/effectiveness of methods
 (2 16 2) /WOMEN'S HEALTH CENTER/Self-efficacy/view of self and body

(2 16 2 1) /WOMEN'S HEALTH CENTER/Self-efficacy/view of
 self and body/more responsibility
 (2 16 2 2) /WOMEN'S HEALTH CENTER/Self-efficacy/view of
 self and body/have the experience to help other women
 (2 16 2 3) /WOMEN'S HEALTH CENTER/Self-efficacy/view of
 self and body/confirmed belief in safe abortion
 (2 16 2 4) /WOMEN'S HEALTH CENTER/Self-efficacy/view of
 self and body/a reality check on readiness to parent
 (2 16 2 5) /WOMEN'S HEALTH CENTER/Self-efficacy/view of
 self and body/confirmed i am not infertile
 (2 16 2 6) /WOMEN'S HEALTH CENTER/Self-efficacy/view of
 self and body/abortion should be legal but not multiple
 (2 16 2 7) /WOMEN'S HEALTH CENTER/Self-efficacy/view of
 self and body/effect on relationships
 (2 16 2 8) /WOMEN'S HEALTH CENTER/Self-efficacy/view of
 self and body/respect for the body
 (2 16 3) /WOMEN'S HEALTH CENTER/Self-efficacy/change in
 decisions?
 (2 16 3 1) /WOMEN'S HEALTH CENTER/Self-efficacy/change in
 decisions?/be more cautious
 (2 16 3 2) /WOMEN'S HEALTH CENTER/Self-efficacy/change in
 decisions?/taking time for decisions
 (2 16 3 3) /WOMEN'S HEALTH CENTER/Self-efficacy/change in
 decisions?/never have an abortion again
 (2 16 3 4) /WOMEN'S HEALTH CENTER/Self-efficacy/change in
 decisions?/having a tubal

 (2 17) /WOMEN'S HEALTH CENTER/empowerment
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V I T A

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EDUCATION

2005	<i>Ph.D./ Human Development and Family Studies (Minor: Women Studies)</i> The Pennsylvania State University	State College, PA USA
1997	<i>M.S./Human Development and Family Studies</i> The Pennsylvania State University	State College, PA USA
1994	<i>B.S./ Psychology (Valedictorian)</i> <i>B.S./Political Science and International Relations</i> Bogazici University	Istanbul, TURKEY
1989	<i>Middle School-High School (High Honors)</i> Uskudar American Academy for Girls	Istanbul, TURKEY

AWARDS RECEIVED

1997-1998	<i>Center for Prevention Fellowship</i> Department of Human Development and Family Studies
1994	<i>Distinction Award for finishing with the highest GPA in Psychology</i> Bogazici University, Department of Psychology
1992	<i>North Atlantic Treaty Organization (NATO) Scholarship</i> Bogazici University, Department of Political Science and International Relations

TEACHING INTERESTS

- Women's health
- Feminist Theory and Research Methods
- Adolescent, adult, and family development
- Qualitative Methods

PROFESSIONAL AFFILIATIONS

- Member of ASA (The American Sociological Association)
- Sections: Sex & Gender, Medical Sociology, and Sociology of Reproduction