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## MAKING REPRODUCTIVE HEALTH MEANINGFUL: AN ANTHROPOLOGICAL STUDY OF PLANNED PARENTHOOD PERSONNEL IN LEXINGTON, KY

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MAKING REPRODUCTIVE HEALTH MEANINGFUL: AN ANTHROPOLOGICAL  
STUDY OF PLANNED PARENTHOOD PERSONNEL IN LEXINGTON, KY

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THESIS

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A thesis submitted in partial fulfillment of the  
requirements for the degree of Master of Arts in the  
College of Arts and Sciences  
at the University of Kentucky

By

Hannah M. Wohltjen

Lexington, KY

Director: Dr. Erin Koch Professor of Anthropology

Lexington, KY

2011

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## ABSTRACT OF THESIS

### MAKING REPRODUCTIVE HEALTH MEANINGFUL: AN ANTHROPOLOGICAL STUDY OF PLANNED PARENTHOOD PERSONNEL IN LEXINGTON, KY

This thesis focuses on how reproductive health is made meaningful in the context of a Planned Parenthood clinic in Kentucky. Using ethnographic field methods, including participant observation and semi-structured interviews, the paper explores how staff members negotiate definitions of reproductive health as employees of Planned Parenthood health center. The analysis addresses reproductive health discourse among the clinic staff and how reproductive health is used as a site of intervention. It also explores the sociocultural processes and interactions the staff members engage in at the national and local levels and the role these play in shaping the conceptualization of reproductive health and how it is deployed at the clinic level. This analysis illuminates the fluid nature of reproductive health meanings and the ways in which health care delivery is contextually and socially mediated.

**KEYWORDS:** reproductive health, health care provision, meaning-making, ethnography, Planned Parenthood

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Hannah M. Wohltjen

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December, 13 2011

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## **Chapter 1**

### **Introduction**

On February 18<sup>th</sup>, 2011 members of the United States Republican Party voted to support a House budget bill that would cut federal spending on family planning by eliminating Title X funds and discontinuing all federal support to Planned Parenthood clinics. In a speech to the House, Republican Mike Pence, a major proponent of the bill, asserted, “Nobody is saying Planned Parenthood cannot continue to be the largest abortion provider in America, but why do millions of pro-life taxpayers have to pay for it?” (Samuels 2011). Planned Parenthood relies heavily on federal funds to provide affordable reproductive health services for men and women, and supporters of Planned Parenthood were outraged that, once again, reproductive health had been reduced to providing abortions and targeted by politicians catering to pro-life constituencies (Foley 2011).

As these recent events show, reproduction and reproductive health are intensely political in the contemporary United States. However, perhaps less obvious are the ways these debates and policy proposals surrounding reproductive health at the national level affect individual family planning clinics on the ground. How do discussions and debates at the national level shape understandings of reproductive health at the clinic level? How do they structure a clinic’s ability to provide certain types of reproductive health services in conjunction with structural and social forces at the state and local levels? How do Planned Parenthood clinic providers themselves negotiate these multi-leveled networks and in doing so reveal the fluid nature of constructions of reproductive health? Using research conducted at the Planned Parenthood clinic in Lexington, KY, this thesis



attempts to explore how understandings of reproductive health are negotiated within the clinic site through its relationships and interactions with actors at multiple levels and how these understandings shape reproductive health care delivery.

*Reproductive Health: The International and National Contexts*

Reproductive health and reproductive rights have had a prominent presence on the international stage, though it has a checkered history. While today birth control stands as one of the primary symbols of reproductive rights, reproductive health, and specifically women's control over their bodies, birth control played a large role in reproductive eugenics efforts in the mid 20<sup>th</sup> century. This was particularly true for minority women who were often the guinea pigs for testing new forms of birth control (Roberts 1997; Chavez 2004). These women were often forced or coerced into using birth control or were unwittingly sterilized in an effort to stem what was perceived to be a dangerous overabundance of nonwhite reproduction. In more recent decades, the international discourse surrounding reproductive health and reproductive rights has shifted toward a more holistic and positive direction. This transition was highlighted and framed more explicitly at the International Conference of Population and Development (ICPD) in Cairo, Egypt in 1994. At this conference, which brought together policy makers, development thinkers, and world leaders, reproductive rights were conceptualized in terms of total reproductive health (DeJong 2000). Conference attendees strove to take the reproductive rights discourse back from abortion, eugenics, and the external control of reproductive bodies in order to transform it into one that encompassed reproductive health - and an individual's ability to access health services and make decisions about their reproductive health - as a basic human right.

At the national level within the United States, reproductive health and reproductive rights are highly enmeshed and have had a long and embattled history. The Comstock Laws, enacted in 1873, effectively banned the dissemination of information about birth control, abortion, sexually transmitted infections (STIs), and other reproductive health topics deemed “obscene” or “immoral” (Solinger 2005). Early reproductive rights and reproductive health advocates in the United States, particularly Margaret Sanger, fought bitterly for its repeal, a goal that was finally achieved in 1938. Throughout the mid-20<sup>th</sup> century organizations such as the Birth Control Federation, which eventually became the precursor to the Planned Parenthood Federation of America, continued to lobby for the development of and access to various forms of birth control. While this movement played a shadowy role in reproductive eugenics, particularly among Latino(a) and African American populations at home and abroad, it also influenced the women’s rights and women’s health movements (Chavez 2004). During the 1960’s and 1970’s the conceptualization of reproductive health, reproductive rights, and the female body was radically transformed. Women in the United States demanded access to reproductive health services and claimed their bodies and the decisions made about them as spaces of reproductive freedom in fervent and sometimes violent rallies and protests (Morgen 2002). One of the most important events of this time was the Supreme Court decision made in *Roe vs. Wade*, which made abortion legal and, more significantly, acknowledged a woman’s right to make individual choices about her body. Though this ruling has become a symbol of a major victory for the reproductive rights movement and women’s rights more generally, it has been a trenchant source of debate, protest, and violence throughout the late 20<sup>th</sup> and early 21<sup>st</sup> centuries. *Roe vs. Wade* and the

individuals and organizations that support it have come under fire, both figuratively and literally, many times. In 1992 the Roe vs. Wade ruling was challenged and almost overturned in *Planned Parenthood of Southeastern Pennsylvania vs. Casey* (Solinger 2005). While abortion ultimately remained legal after the Supreme Court case was closed, the bitter debates that took place stood as a reminder that the provision of reproductive rights and access to reproductive health services was still a major challenge and had to be fought for continually. Many reproductive health service providers, particularly those who perform abortions, and reproductive rights advocates have suffered violence and have even died in this fight. Abortion clinics, including Planned Parenthood clinics, have been vandalized and bombed, and personnel from abortion clinics across the country have been kidnapped and even murdered (Morgen 2002; Solinger 2005; Ginsburg 1989). As recently as 2009, Dr. George Tiller, an abortion provider in Wichita, KS was shot and killed by an anti-abortion protester (Abcarian and Riccardi 2009). The pressure against reproductive rights and reproductive health services also manifests in the contemporary moment through annual anti-abortion and anti-reproductive rights demonstrations, educational policies that only allow abstinence education in schools, the notable dearth of medical students being trained to perform abortion, and the attempted budget cuts to reproductive health service providers (Solinger 2005; Lane 2008).

#### *Planned Parenthood: A Brief Background*

Planned Parenthood is a reproductive health care provider and reproductive rights advocate. The organization was originally founded in 1916 by Margaret Sanger, who opened the first birth control clinic in Brooklyn, New York (Solinger 2005). The Planned

Parenthood Federation of America still has its headquarters in New York today. Throughout its history, Planned Parenthood has been a major contributor to the reproductive health and reproductive rights movement, initially providing financial backing for the researchers who developed the birth control pill and lobbying to remove legislative barriers to family planning in several states. This past has also been a checkered one. Planned Parenthood advocates and administrators played a large role in defining reproduction as a “class privilege” in the 1940’s and worked to restrict the reproduction of minorities and poor individuals through the use of birth control (Solinger 2005). Today, Planned Parenthood offers reproductive health services and education, funds birth control research, and promotes access to family planning. There are currently 88 Planned Parenthood affiliates in the United States, including Lexington, KY’s Planned Parenthood of Kentucky Bluegrass Health Center.

Planned Parenthood’s presence in Kentucky, and the in city of Lexington in particular, is not a new phenomenon, and facilities with similar missions have operated in the area since the 1930’s. The Kentucky Birth Control League, founded in Louisville in 1933, was one of the first facilities in the state that offered reproductive health care services, particularly birth control, that women had limited access to elsewhere and advocated the importance of family planning. Soon the Louisville branch of the Kentucky Birth Control League expanded to other parts of the state and opened a clinic in Lexington KY in 1936 ([www.plannedparenthood.org](http://www.plannedparenthood.org)). While there was certainly a level of opposition to the League’s mission at this time, it was able to garner enough support to hold public conferences in an effort to make family planning a basic health care service.

The current branch of Planned Parenthood that exists in Lexington today grew out of the Kentucky Birth Control League clinic located there. Though the Louisville branch became a member of the Planned Parenthood Federation in 1942, it was not until 1966 that the Lexington branch of the Kentucky Birth Control League adopted the Planned Parenthood name and became a non-profit organization ([www.plannedparenthood.org](http://www.plannedparenthood.org)). For a number of years the Lexington Planned Parenthood facility continued to operate more as an extension of the Louisville clinic. However, in 2010, the clinic passed its official Planned Parenthood Federation accreditation and is now an independent facility. Like all three Planned Parenthood clinics in Kentucky, it is a member of the Planned Parenthood of Kentucky affiliate, founded in 2008, which works to connect statewide Planned Parenthood operations. Within the Lexington community, the clinic provides primary clinical and educational services to women and men of all ages<sup>1</sup>. Specifically, the staff members work to offer services to individuals who do not have access to medical insurance, and it is estimated that nearly 60% of the clinic's clientele make use of the clinic's sliding scale payment policy. While other clinics within the Lexington area offer the same types of clinical services, the Lexington Planned Parenthood clinic is one of the only ones that caters to an uninsured demographic and complements their clinical services with additional educational opportunities for patients.

#### *The Relationship between the Federation and the Lexington Clinic*

The Planned Parenthood federation of America is a large organization that currently consists of a network of 87 affiliates and 825 health centers nationwide. Essentially, the federation administration, with national offices located in New York City

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<sup>1</sup> I was unable to obtain data on the exact racial and age breakdown of the clinic patients.

and Washington D.C., develops standards and guidelines for what constitutes a Planned Parenthood clinic, lobbies at the capitol for reproductive rights, and collects its own statistics and data on the reproductive health status of the nation. According to the staff at the Lexington Planned Parenthood, the federation office does not often get involved directly with each and every individual health center under its banner. More often it is the affiliate administrations to which health centers belong that interact directly with the federation officials, passing along reproductive health information, policy changes, and bureaucratic guidance from above. However, federation emails and newsletters are regularly forwarded to individual health centers keeping them “in the know electronically” as Jane, one of the staff members, explained one day while she was trying to sort through the week’s electronic correspondence on her computer. Federation officials, compared to affiliate administrators, are also more directly involved in the accreditation process of individual health centers. They conduct the examinations of each clinic or center to insure that it meets policy standards. The Lexington Planned Parenthood clinic had actually just renewed its full accreditation in the spring of 2010. The clinic did not meet all of the federation requirements in a previous accreditation and were put under probation as an extension of the Louisville Planned Parenthood clinic rather than an independent Planned Parenthood clinic. Many of the staff had worked very hard to bring the clinic back up to Planned Parenthood standards by improving clinic management and operating procedures, and they were proud to have received full accreditation as an official Planned Parenthood clinic. Without Planned Parenthood accreditation, the clinic could still have been in operation, but it would not have been able to claim the Planned Parenthood name. As Brittany put it the clinic would “just be the

Bluegrass Health Center rather than the Planned Parenthood of Kentucky Bluegrass Health Center.” Brittany had been working with clients in the clinic for almost two years and had participated in bringing the clinic up to federation standards. Most of the staff agreed that the federation standards were good and they strongly believed that these standards gave their clinic more credibility.

Within this national federation sphere the Lexington Planned Parenthood clinic is also controlled by the administration of Planned Parenthood’s Kentucky affiliate. Though the state of Kentucky has one affiliate it is rather on the low side with regard to Planned Parenthood health center representation. Some states have multiple affiliates that oversee several health centers. For example, seventeen states in the U.S. have 2 or more affiliates that administer to at least five health centers; the state of New York alone has twelve affiliates that manage sixty-eight health centers. The Kentucky affiliate only oversees two independent clinics in the entire state (one in Louisville, KY and one in Lexington, KY) and a Planned Parenthood representative nurse working within the student clinic at Eastern Kentucky University in Richmond, KY. While most of the Lexington Planned Parenthood clinic’s general policies and guidelines come from the national federation, more specific guidelines within respect to Kentucky state law and the demographics of the state come from the affiliate administrators.

The Lexington clinic staff has a much more direct relationship with the Louisville affiliate administration than with the federation administration. Since there is a Planned Parenthood clinic in Louisville, many of the administrators actually work from that clinic and seem to be both the administrators of the Louisville clinic as well as administrators of the affiliate. The Lexington and Louisville staff members have bimonthly meetings in

which federation news is shared and staff can discuss how things are going at their respective locations and share ideas. Every staff member, from the clinic manager to the desk attendant is required to attend these meetings and most of the Lexington staff communicate on a weekly basis with their counterparts at the Louisville clinic. There is also quite a bit of traveling between clinics and what the staff like to call “sharing” of staff members between the Kentucky Planned Parenthood clinics. For instance, one of the Planned Parenthood nurses at EKU works summers and holidays at the Lexington clinic while EKU is not in session. Planned Parenthood “experts” or individuals with special skills or training, such as the ability to insert IUD’s, were also shared monthly between clinics to expand the services individual clinics could offer. Over the course of the summer, the Lexington Planned Parenthood was experiencing staffing shortages because several staff members left to continue their education. Staff from Louisville came regularly to work at the Lexington clinic on the days when there simply were not enough people around to maintain clinic operations. In this way, the Lexington clinic maintained a close relationship with its affiliate administration and all of the staff knew and were known by the affiliate administration on a first name basis.

Being part of a larger federation body definitely has its benefits. In fact, without the support of the federation, many of the staff noted that they probably would not even have a clinic. One of the most important of these benefits as stressed by the staff is the ability to network with other Planned Parenthood facilities across the country. Alex, one of the staff members who had been working at the clinic for several years was particularly interested in this network to gather educational resources for patients and community members.



As she, put it,

“If I have a question, you know if somebody asks me something that just absolutely stumps me at an education event, I can type an email and be connected to every single educator who’s affiliated with Planned Parenthood. And really, some of them are the foremost experts in sexual health in the country, and having access to them at your fingertips is a phenomenal resource.”

This network allows all Planned Parenthood branches to not only deal with questions from the community, but also to mediate potential safety crises and to stay up to date on federation guidelines. Many of these guidelines deal with pregnancy or abortion counseling, reproductive health screening, contraception and to whom or how it should be delivered, STI treatment and prevention, and clinic safety. Several staff members noted that they regularly communicate with the Louisville clinic, and sometimes clinics in other states to confer about new federation policy changes.

Many staff members also explained that being a Planned Parenthood clinic gives them access to other resources provided by the federation such as liability insurance. According to Sarah, a relatively new member of the Planned Parenthood staff who conducted many of the patient financial assessments:

“Without the resources we get from the Planned Parenthood Federation of America I don’t know if this clinic would be possible. If for no other reason than for malpractice insurance, which is insanely expensive. So things like that by being connected to that larger affinity, you know, it makes us more able to spend what money we have on doing the work instead of covering some of those expenses.”

The Planned Parenthood federation does not pay for this insurance, but all of its clinics are united under the same provider and may have access to discounts. Liability insurance is a massive expense, particularly for small non-profit clinics. In addition, reproductive clinics’ somewhat controversial status may put them at risk for more legal entanglements.

### *Anthropological Background and Theoretical Perspective*

Anthropologists, and medical anthropologists in particular, have been interested in issues surrounding reproduction, women's health, and the medical service encounter for several decades. Some of the themes that have characterized this research include the manipulation of reproduction and reproductive bodies, the medicalization of reproductive processes, and the cultural shaping of reproductive health issues and experiences of them. These themes contribute to this project by exploring the processes of politicization and medicalization that can influence how health, and reproductive health specifically, is understood in varying contexts and, by extension, the underlying social and structural forces that have physical bearing on individual bodies in the ways these forces shape health care delivery at clinics such as Planned Parenthood.

First, there is a rich body of anthropological literature on the manipulation and control of reproductive bodies (Roberts 1997b; Reed and Saukko 2010; Root and Browner; Ginsburg and Rapp 1995; Martin 1987). Many anthropologists have explored how women continue to be subjugated through a societal emphasis on their reproductive capacities and institutional control over when and how they reproduce. These concepts have also been used to explore how reproduction and reproductive bodies are used more broadly to shape populations, determining who qualifies as a member of a community or nation-state (Chavez 2004; Lane 2008; Roberts 1997a). Women's access to reproductive, prenatal, and abortion services can all shape the demographics of a population and the health outcomes of sub-populations within them. Reproductive bodies also become politicized, or subject to larger social and structural debates, through these measures as several researchers have demonstrated. For instance, in his anthropological studies on the

politics of immigration in the United States, Chavez shows how the focus on Chicana and Mexican immigrant women's reproduction in U.S. anti-immigration discourse has served to make the bodies of these women the site of contestations about race, American economics, and citizenship (Chavez 2004).

Several anthropologists have also documented the increasing medicalization of women's bodies through the use of increasing technological and medical interventions in "natural" processes like conceiving children, giving birth, and managing menopause (Inhorn 2008; Rapp 1993a; Rapp 1993b; Davis-Floyd 1992; Lock 1993; Becker 2000; Thompson 2005). For instance, in her anthropological examination of assisted reproductive and genetic technologies, Thompson presents the assisted reproductive technology (ART) clinic as a site where the meaning of reproduction and parenthood is contested and negotiated. She argues that the use of medical technology like ART's is reflective of the shift in the United States toward making physical conditions that carry social weight or meaning, such as infertility, into biomedical questions. (Thompson 2005). Researchers have also explored instances where women are challenged on their decisions to use or not use such procedures through a rhetoric of "proper" womanhood or "good" mothering (Craven 2005). Craven examined the implementation of such rhetoric in relation to women's decision to give birth at home with the assistance of a midwife rather than in a medical facility, and argues that this rhetoric functions to disempower women in favor of government and medical institutions (Craven 2005). Feminist and medical anthropological researchers have also specifically examined amniocentesis, Caesarean sections, and invitro fertilization as vehicles through which women's reproductive capacities are manipulated and concepts of gender are shaped.

Reproductive health and reproductive health related issues are both biologically and socially shaped. While the types of diseases individual bodies can contract are conditioned by biology, the perception of those diseases and what they imply for individual and community health is influenced by culture (Castro and Farmer 2007; Singer and Baer 1995). For the purposes of this project, “culture” refers to the beliefs, ideas, and understandings within a specific community and the subsequent actions exhibited in that community based on these phenomena. This definition of culture is indicative of the discipline of anthropology’s goal to understand the relationship between specific behaviors or events and the lived experiences, cultural knowledge, and social relationships or dynamics that make up the contexts in which they take place. In this way, understanding how or why individuals or communities make decisions about and manage reproductive health in the way that they do requires an examination of the contexts in which those decisions or management practices occur and the models or understandings of reproductive health that people bring to the table. These understandings and contexts that shape action and decision-making around reproductive health are not static, but are continually negotiated over time, across geographical space, and through social relationships and dynamics. This holistic framework utilized in anthropological research makes examining reproductive health solely in terms of human anatomy and disease biology too simplistic. In her comparative work on the experience, diagnosis, and treatment of menopause in the United States and Japan, Lock uses the concept of “local biologies” to describe a confluence of biology and culture in the awareness and incidence of disease (Lock 1993; Lock and Kaufert 2001). Other anthropological researchers have conducted similar studies, in both the U.S. and countries across the globe, focusing on

how reproductive health may be conceptualized culturally and socially on the basis of specific political systems (Rivkin-Fish 2005), religions (Popenoe 2004) class statuses (Lazarus 1994), and genders (Browner and Sargent 2007). All of these factors are culturally based and shape the ways in which individuals or communities perceive health. These perceptions and definitions, in turn, contribute to specific bodies of reproductive health knowledge.

Since the processes of meaning making surrounding health in general, and reproductive health in particular, are in part culturally constructed, understandings of health and health related issues may vary according to context in which they are found. Many researchers have examined the connections and relationships between an individual's health decision-making and these contexts or social locations. For example, in her exploration of the ways the "conjugal dynamic," or the amount of power men wield in relationships with women, shapes women's decisions about their reproductive health in three Latin American contexts Browner reveals how reproductive health choices are shaped by both the structural and cultural processes present in specific physical and social contexts (Browner 2000). This research complicates our understanding about access to care and what it means to be "healthy" by putting health and health-related issues into the context of the individual to include their lived experiences (Browner 2000; Lazarus 1994; Lock and Kaufert 1998; Root and Browner 2001), recognizing that socially constructed racial, economic, gendered, and political strata crosscut and shape health behavior. In addition, anthropological scholars have also examined the provider-patient relationship within medical institutional settings (Craven 2005; Jordan 1997; Abel and Browner 1998). These relationships may often reveal power dynamics that are not

always present overtly, but do play a role in shaping health outcomes. For example, in her work on childbirth and obstetric care, Jordan found the delivery room to be a site where “authoritative knowledge” is reinforced and constructed. This concept of “authoritative knowledge,” or the knowledge systems that “come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority),” reveals some of the structural and cultural processes that continually shape and reshape the provider/patient relationship and can influence who has a voice in medical or health related interactions (Jordan 1997:56). Such interactions also play a role in shaping the dissemination of health information and the construction of health and effective health care.

While this body of research is broad in its scope, there are some different directions that have not been as readily addressed. For instance, much of the medical anthropological literature on reproduction uses individual patients, often women, and their experiences as the point of departure for examining the ways social constructions of reproduction and the issues that surround them are embodied and negotiated. While these analyses sometimes incorporate the perspectives of reproductive health service providers and policy makers, few focus their attention solely on the providers themselves. This method of “studying up,” or analyzing institutions and organizations rather than just their effects on individuals, has been used in anthropological studies, particularly development studies, where specific social and power dynamics are at work (Nader 1972). Providers’ perspectives and analyses of the economic, political, and social structures of the organizations through which they deliver health services can add to our understanding of

the multiple levels at which reproduction is given meaning, constructed in connection with other social issues, and negotiated or manipulated through interactions with patients. Health outcomes and individual health experiences are influenced by the health care methods and systems in place, which shape what types of health care services are available to different groups of people and how they function in a variety of contexts. In examining not only recipients of those services but also the organizations or groups that disseminate them it is possible to examine the confluence of intersecting processes and relationships that in turn shape health at the sites where health care is administered.

In addition, many anthropologists who study reproduction tend to focus on women's reproduction and issues surrounding conception, pregnancy, and birth within broader social contexts rather than male reproduction or reproductive concerns across the life course (Gutmann 2007; Lock 1993; and Lock and Kaufert 2001 are notable exceptions). On the ground, reproductive health can encompass a spectrum of health needs from birth to death and include men and transgender individuals as well as women. In examining reproductive health as a whole in particular sites, without defining it beforehand, it is possible to see where different individuals and organizations or institutions draw the boundaries around reproductive health and delineate its role and scope in these sites. Such an examination may reveal the social relationships and dynamics at work in different contexts that contribute to constructions of the meaning of reproductive health, how and what kind of reproductive health services are provided, and, by extension, individual health outcomes.

Finally, very little anthropological work has been done on reproduction using Planned Parenthood, and independent clinics with a similar mission, as an ethnographic

site. Faye Ginsburg studied the politicization of abortion and reproductive rights around a regional abortion center and mentions Planned Parenthood in her work, but many anthropologists who examine reproduction at the institutional level use hospitals and regional clinics as their study sites (Ginsburg 1989). Planned Parenthood clinics provide a potentially unique site through which to explore reproduction because they are not purely medical facilities. While their clinical operations do make up a portion of their services, Planned Parenthood lies somewhat outside of the medical institution and occupies a middle ground between medical treatment, education, and advocacy. Examining reproduction and reproductive bodies and the ways these are constructed in such a site can add depth to medical anthropology research, extending an understanding of reproduction in the institutional setting and among individuals to also include mid-level providers. In addition, Planned Parenthood can be an effective site to study how specific contexts and meaning-making processes affect reproductive health care service provision. This is because each health center is bound between national and local influences; each facility is locally based even though their philosophy and service protocols are supposed to be national. This dialogue between the national and the local within the clinic setting can illuminate facets of the health care delivery process and the social factors that shape it.

Reproductive health does not have an inherent meaning. Instead, its meaning is politicized and continually contested within different sites and through different social interactions and relationships. An exploration of how reproductive health is defined in different contexts, such as a Planned Parenthood clinic in Lexington, can reveal underlying social and structural forces that have physical bearing on individual bodies in



the ways these forces shape health care delivery. For different communities or individuals a variety of variables can make up the meaning of reproductive health or what reproductive health entails on the ground. In the context of Planned Parenthood, these variables can include support from the national federation and local community, and they shape how reproductive health services are structured and delivered. In addition, these variables shape action and the interpretation of relationships with others operating with similar or dissimilar constructions of reproductive health. From an anthropological standpoint, understanding how people define or construct reproductive health meanings goes beyond generic or overt definitions of reproductive health to also encompass the implicit or explicit associations actors make with reproductive health based on their daily experiences and interactions with it. For instance, while security may be an issue that is associated with reproductive health for Planned Parenthood staff, this may not be an association a local OBGYN or even patients of Planned Parenthood would have as part of their understanding of reproductive health.

Perception on the part of organizations and individuals can play a role in shaping understandings of reproductive health and its associated meanings. By perception (or perceptions) I refer specifically to an organization's interpretation of its social location and the relationships or interactions it has with other organizations and the individuals it serves. While perhaps wielding a certain degree of power within social contexts, health care facilities and health practitioners are also caught up with spheres of influence on different scales from the local to the national contexts in which they operate. Planned Parenthood in Lexington is a small organization that both impacts and is impacted by other multi-level spheres of influence, from the national Planned Parenthood federation to

the clinic's local Lexington patient base and from Kentucky state funding bodies to the Fayette county school board. These spheres of influence may reaffirm or complicate the ways in which health care practices, and the meanings of these practices, are enacted on the ground at the patient level. The staff at Planned Parenthood interpret or perceive their relationships with these multi-leveled spheres of influence and reshape their understanding of reproductive health and reproductive health needs in Lexington according to their shifting interactions with these groups. With the newsletters the Lexington clinic staff receives from the national Planned Parenthood federation, the invitations to participate in community health fairs, and the negotiations to work with Lexington teens through the local school board come reassessments and reevaluations of what delivering reproductive health services means as a Planned Parenthood clinic operating in Lexington, KY.

Anthropologically, an exploration of the meanings of reproductive health within local sites as parts of wider and multi-leveled relational networks and the ways actors within these sites interpret and negotiate their positions within these networks highlights the role of social forces in shaping meaning and action around reproductive health. There is a dialectic process and a discourse that takes place through the social relationships organizations like Planned Parenthood have with other organizational bodies and communities of individuals. These dialectic relationships in turn shape the health of the communities where they are located by influencing their interpretation of health needs and the most effective ways to address them. Placing organizations like Planned Parenthood within broader networks of relationships also reveals the ways in which medical service providers can be both freed or constrained in their ability to deliver

health services to their patient and community bases. These networks of relationships consist of political, legal, economic, and social dynamics and hierarchies that also must be continually negotiated and assessed. An analysis of these dynamics lends itself to a broader understanding of how reproductive health is constructed in certain sites, the role social factors play in these constructions, and the ways these constructions shape action.

### *Thesis Overview*

The primary goal in conducting this thesis project was to examine anthropologically the ways in which reproductive health can act as a site of intervention and how it is represented within community health clinics like Planned Parenthood. The primary question driving this research project was: How do the meanings of reproductive health influence reproductive health interventions in specific contexts? More specifically, this research aimed to explore how Planned Parenthood employee's personal understandings of reproductive health shape the reproductive health services and community health initiatives that Planned Parenthood provides in the Lexington community. This research also sought to explore how the services offered by Planned Parenthood are shaped by the interconnected contexts in which it operates and how these contexts, in turn, shape meaning.

### *Site Description*

Planned Parenthood of Kentucky's Bluegrass Health Center is located in an out-of-the-way side street in downtown Lexington. There is an interesting mix of inhabitants on this street, with the Planned Parenthood clinic situated near many restored historic homes, several locally owned shops and cafes, one of the Lexington housing authority's low-income apartment facilities, and two churches. The clinic itself is housed in one of

the historic homes, which was converted from its original two-story Victorian domicile to a fully operational medical facility with a reception area and examination rooms on the first floor and administrative offices and a large multipurpose conference room occupying the second. The staff members often express ambivalent feelings about the clinic facility because while they like the location, the age and placement of the house make it impossible to expand the space and expensive or difficult to maintain.

The door to the clinic remains permanently locked according to Planned Parenthood safety protocols; patients must ring the front bell and be buzzed in by a staff member working at the front desk. The steady noises of the clinic day – the music from the radio behind the reception desk, low conversation from patients in the waiting room, and the shuffling of charts and forms - are constantly punctuated with the sounds of this doorbell. Inside, the clinic is decorated with brightly colored informational posters. Some are glossy and professional and probably come from the federation while others, done in marker and construction paper cutouts, are the creation of the staff and volunteers. Suggestion boxes, made out of old tissue holders, and bowls of condoms are placed sporadically throughout the waiting and reception areas. A corkboard with old newspaper clippings about historic events or people associated with the clinic hangs in the hall for visitors' viewing pleasure.

The staff at the Lexington Planned Parenthood clinic consists of seven members: two nurse practitioners, two patient service specialists, and a clinic director, lab technician, and volunteer coordinator/community educator. Though each staff member has a specific job title, coordinating the clinic's activities is often a mutual effort. Everyone helps where help is needed, with the exception of actually giving medical

consultation or performing medical procedures. The staff is also a fairly close-knit group, with many of them often getting together outside of the clinic on weekends and after work.

Clinic days usually start early for the staff members. By 7:45 most of the staff begin to arrive in preparation for the first appointments, which start at 8:30. Appointment lists are checked, charts are pulled for the day, the radio is turned on, and staff members spend a moment or two catching up before filing off to their respective posts: nurses to the exam areas and everyone else to the reception area or administrative offices. The clinic is only open from 8:30 – 4:30 three days a week due to financial constraints. As a result, the facility becomes brisk with activity as people come in slowly but steadily for exams, treatment, and information. The staff members spend most of their time checking in patients, conducting financial assessments, filling out paperwork, and performing examinations.

There are often many patients to attend to, and tensions can run high among the staff when charts or prescriptions are misplaced or a patient becomes particularly troublesome or uncooperative. However, the staff members are quick to help one another and their daily interaction can be fun. For instance, either Alex or Danielle, two of the staff members, always has new videos or websites to share on recent advocacy events or sexual health awareness and Brittany sometimes brings in homemade penis-shaped sugar cookies to share. Overall, weathering the sometimes-frantic pace of clinic together contributes to an environment of staff camaraderie and mutual respect.

## *Methodology*

The ethnographic research for this thesis was conducted during summer 2010 over the course of 8 weeks at the Lexington, KY Planned Parenthood of Kentucky Bluegrass Health Center. Research methods consisted of semi-structured interviews with Planned Parenthood staff and participant observation of the day-to-day activities of the clinic.

I chose to use a semi-structured, or open-ended, interview format for one-on-one interviews with Planned Parenthood staff so that I could see the directions my interviewees would take with my questions. By the end of the research study, I conducted semi-structured interviews with 8 Planned Parenthood staff members. These individuals included clinic administrators, medical practitioners, and education and outreach staff. The demographics of this population, including age, race, and gender, were constrained by the organizational demographics of the Planned Parenthood staff. I conducted the initial interviews only after I informed all of the staff members of the project's goals, methods, and standards for protecting human subjects. I used one list of interview questions for all staff interviews. This set of questions investigated staff roles and responsibilities; how staff defined reproductive rights and reproductive health; how they situated the Lexington community politically, demographically, economically, and medically; how they perceived Planned Parenthood's relationship with the Lexington community and why; and how they viewed their relationship with other Planned Parenthood organizations including the Louisville, KY clinic and the national Planned Parenthood federation. An audio recording device was used during individual interviews with the consent of the interviewee, and detailed field notes of interviews were also

taken. All of the field notes and audio recordings from interviews were transcribed and coded. No patients were interviewed for this project.

The research also consisted of weekly participant observation of the daily administrative and outreach activities conducted by Planned Parenthood staff. Participant observation refers to the qualitative research strategy of engaging directly with the individuals or populations being studied and recording one's interactions and experiences. This research strategy is a useful tool for anthropological research because it allows for the collection of data that would not be possible without the rapport and trust built through continual interaction and it enables researchers to better interpret the meaning of the things their informants do or say through a personal knowledge of their informants' context. Some of the activities I observed included office and managerial work, interaction with patients within the reception area, and community health fairs the Planned Parenthood clinic was invited to attend. Detailed field notes of these activities were taken over the course of the project. I did not observe any patient appointments at Planned Parenthood as part of the participant observation process.

Before research commenced, initial contact was made with Planned Parenthood concerning the feasibility of conducting a research project with the Lexington, KY clinic. The clinic director and director of community outreach gave me permission to pursue this project. I also received an official letter of permission from the national Planned Parenthood federation with the understanding that my research materials would be made available to the federation upon request. The project design and purpose were presented to Planned Parenthood employees during a staff meeting. Following that meeting, all staff

members signed consent forms and agreed to be interviewed and observed as part of the research study.

For the most part, the research process was smooth, though there was one incident towards the beginning of the summer that challenged my ability to build trust among some of the staff members. Earlier in the spring of 2010 an undercover video of the Louisville EMW abortion clinic was recorded by a pro-life student group called Live Action.

Live Action was begun by a UCLA student named Lila Rose, and the organization targets clinics like Planned Parenthood that offer abortions or abortion referrals. All Live Action videos are staged by members of the organization posing as young women seeking abortions or information about abortion services. Interactions between abortion clinic staff and the “pregnant” young women are taped covertly through the use of hidden voice recorders and video cameras and then posted to the organization’s web site. In many instances, Live Action members also present their videos to state government and congressional members in an effort to promote abortion clinic reform and, ultimately, state and national elimination of abortion procedures.

Until the early spring of 2010, no Live Action videos had been recorded at any reproductive health clinic in Kentucky. The Louisville EMW clinic itself is not a Planned Parenthood clinic. However, both of the Kentucky Planned Parenthood clinics refer patients who would like an abortion to the EMW clinic because none of the Kentucky Planned Parenthoods perform abortions within their clinics. Thus, while the video was not shot in an actual Planned Parenthood facility, it still had strong connections to the Kentucky Planned Parenthood affiliate because it targeted a place where KYPPFA



sends the bulk of their abortion referrals. In this particular video (shot as a series with clinics in other states), the Live Action organization document what they deem to be the miseducation of young women about abortion and the failure of abortion clinics to report abuses such as statutory rape. Following the posting on the Live Action website, Live Action members submitted their video to the Kentucky government in early June.

As could be expected, the video put the members of the Kentucky Planned Parenthood affiliate on their guard after it was discovered on the Live Action website. I was informed by a couple of staff members toward the end of my fieldwork that Planned Parenthood staff in both the Louisville and Lexington clinics were encouraged by the affiliate's administration to be more aware of "suspicious" patient activity. This included patients' use of cell phones or other potential recording devices in the examination and consultation rooms as well as patients' requests to bring friends in to their consultations.

I began fieldwork in early July, tape recorder and notebook in hand, without any knowledge that any of this had occurred.

One of the first things I noticed as I began my fieldwork was the probing questions I received from some of the clinic staff as to the nature of my research and what it was going to be used for. In fact, on the day that I introduced my project to clinic staff, I received a pretty thorough questioning from one of the nurses. She wanted to know what individual or institution was behind my research, why I wanted to conduct research at Planned Parenthood specifically, what I was "looking for," and what I planned to do with my research once I finished. At the time I was more than happy to answer her questions about my intentions and the purpose or goal of my research, though I came away from the conversation feeling a bit defensive. As I began to conduct interviews with staff and

observe their activities around the clinic I also began to sense some unease. For instance, during interviews I was never asked to stop the recorder, but some of the staff would respond to questions or interrupt themselves saying things like “I’m not sure if I can tell you that,” “Could you tell me again what your research is for?,” and “Is anyone else going to hear these recordings or see your field notes?” Some even told me explicitly that the tape recorder made them nervous, though they did not want me to put it away after I offered to do so. I also noticed that even though staff were in no way unwelcoming or hostile, interaction during participant observation was sometimes difficult. For instance, I was repeatedly asked “Are you taking field notes on this?” and it was clear that my presence scribbling furiously in the corner made some of the staff a bit uncomfortable or at least unable to forget that I was taking notes. Not all of the staff had such reactions and everyone was on the whole incredibly generous, kind, and polite. However, I was very concerned about how the staff viewed my research.

It was not until two weeks into my fieldwork that I found out about the Live Action video that had been filmed only a few months before. The subject actually came up in an interview with one of the staff members, and afterward I tried to find out more about it from the staff during my participant observation sessions. Though I was not entirely sure if this was the cause of some of the staff’s discomfort, I took several methodological measures to try to alleviate it. First, I began going over the IRB consent form and project overview again before interviews to remind staff of their right to tell me to turn off the tape recorder as well as my intentions for the project. Second, I stopped taking field notes during my participant observation sessions. Instead, I would take breaks on the hour to record things I heard or saw in the privacy of my car. I would also sit down to enhance

these notes with more detail as soon as I got home from the clinic each day. Third, I began using a method for participant observation that I came to call “reciprocal participation.” Instead of simply observing and participating through verbal interaction, I also offered to do small things to help around the clinic, like fill folic acid bags, fold brochures, make copies of information flyers, and stuff new patient folders. As a whole, I believe these measures helped in conducting fieldwork at the clinic because after the first three weeks staff members had fewer questions about my research intentions and included me more often in conversations around the clinic. However, I also believe that this experience could have initially influenced the direction I was able to take in examining what the staff members’ definition of reproductive health was, what processes contribute to the construction of this definition, and the implications for reproductive health service provision and delivery.

### *Chapter Overview*

In the chapters that follow I analyze the Lexington Planned Parenthood’s model of reproductive health with particular emphasis on how this model is constructed through the clinic’s interactions with national, state, and local actors and enacted through the clinic’s manner of health care service delivery. In Chapter 2, I begin by explaining what reproductive health means to the staff at the Lexington Planned Parenthood and why they believe it is worthwhile to use reproductive health as a site of health intervention. Chapter 3 explores how the greater Planned Parenthood federation and the Kentucky Planned Parenthood affiliate administration in Louisville, KY affect the Lexington Planned Parenthood’s understanding of reproductive health and how reproductive health services should be deployed at the community level. Misperception is a strong theme in this

chapter because the staff's understanding of patient perceptions of Planned Parenthood and reproductive health and the staff's own misperception of patients seemed to be a result of the negotiation between federation guidelines or goals and staff's personal experience with the Lexington community. Finally, in Chapter 4 I examine how community support as well as local funding and legislation affects the Lexington staff's understanding of reproductive health and, to a larger extent, the ways in which it is able to provide services to the Lexington community. This also highlights some of the limitations Planned Parenthood staff must mediate at the community level and how this mediation shapes their services, perception of the community, and understanding of how reproductive health interventions work in Lexington.

## **Chapter 2**

### **The Planned Parenthood Clinic and Reproductive Health Discourse Among Staff**

#### *How Staff Construct the Meaning of Reproductive Health*

One of the primary goals of conducting an ethnographic research project with Planned Parenthood was to explore anthropologically how staff members at the Lexington Planned Parenthood clinic define reproductive health and the ways in which that definition shapes their particular brand of health care services and their style of reproductive health care delivery. In this chapter I sketch out the reproductive health model employed by the staff at the Planned Parenthood Bluegrass Health Center and connect it to some of the services that the clinic provided. This section is relevant to the larger goals of the thesis because it is important to know what reproductive health means to staff members in the context of the Planned Parenthood clinic in order to understand *how* that specific meaning is constructed in this site and connected to a larger network of social interactions of which the clinic and its staff are a part.

I was able to get a better idea of what reproductive health entails for Planned Parenthood staff members and the clinic as a whole based on interviews and on informal conversations I had with staff members while observing at the clinic. During these interactions I asked staff members directly how they personally define reproductive health. There were some specific characteristics that ran through all or nearly all of the staff responses, creating a similar model of reproductive health care that the clinic attempted to follow. These characteristics included the idea that reproductive health affects and is affected by more than just physical factors in an individual's life; that reproductive health has a stake in community dynamics; that reproductive health and reproductive bodies are sites for education and raising awareness; and, finally, that

reproductive health is inherently tied to political issues surrounding access to reproductive health services.

First, most staff members did not construe reproductive health as something that was solely physical or bound in the body. Instead, they noted that reproductive health, or issues that fell within the domain of reproductive health, were much more comprehensive and complex than simply categories of disease or medical conditions. Alex, a staff member, and I had a conversation about this aspect of reproductive health during her interview. The clinic was buzzing with activity when I came in to do Alex's official interview. A line of female patients was queued at the reception desk and every seat in the waiting room was taken. Danielle greeted me with a quick "Hello" as she came into the reception area with an armload of charts and Jane rushed in from the exam area wearing scrubs and looking harried as she bit her lip and scanned through a clipboard with patient names to determine who needed to be taken back to the exam area for their appointment next. She groaned as she saw another patient come to the outer clinic door and push the doorbell to be buzzed in. "Please tell me this is the last one!," she said to Sarah, who was so busy signing patients in that she had not noticed that either Jane or I had come into the reception area. As I went upstairs to Alex's office I expected some of the hustle and bustle to die down, but two of the upstairs offices were just as busy as the clinic below. Six female students from VOX, a campus organization that focused on reproductive rights, were making posters, flyers, and a "Reproductive Health Jeopardy" game for a regional meeting that would be taking place at the end of the month. The windows were open, packages of flavored condoms and scraps of colored paper littered the room, and the VOX members sat on the floor writing their organization's logo on

poster board with Sharpie pens as Alex sat at her desk scrolling through a website on her computer. A radio sat in the window tuned to a station playing 80's and 90's hits, and the several of the VOX members were singing along with a Backstreet Boys song using their pens as make-believe microphones. Alex allowed the VOX members to use some of the upstairs office space when it was not in use by the clinic and served as mentor for the group. She smiled when she saw me and motioned to one of the VOX members to turn the radio down so that we could begin the interview. Alex has been working with Planned Parenthood for 2 years and seems to gain enthusiasm for her job every time I see her. She knew Planned Parenthood was a place she wanted to work during college, and actually began working for the clinic a week after she graduated with her Master's degree in Women's Studies. She talks confidently about the clinic and its mission during the interview, supplementing her answers to my questions with current events that have bearing on reproductive health issues and her own personal experiences while working for the Lexington clinic. In Alex's opinion:

“[reproductive health] is a pretty broad term. I think about reproductive health in terms of how much of an impact it has and how much all the other things in our lives impact our reproductive health, so anything as it relates to obviously the anatomy, the reproductive organs, but also thinking about sexuality, gender identity, understanding how the world perceives those things and working to build a world that's more inclusive and understanding of people regardless of those things.”

Here reproductive health extends beyond a purely bodily, medical understanding to highlight a relationship between reproductive health, environment, lifestyle, and society. Reproductive health involves both a healthy body in terms of the absence of harmful diseases or disabling conditions as well as in terms of a strong sense of self and the ability to recognize the interconnectedness of one's health behavior. The way in which

staff members at Planned Parenthood know about reproductive health in a social as well as biological way is similar to the way in which pregnant women constructed the delivery process in Craven's study of the way homebirth mothers negotiate the politics of the medical institution (Craven 2005). Both parties recognize that reproductive health or giving birth are physical phenomena, but also that they involve a sense of personhood and have implications beyond individual bodies.

Most staff members also highlighted the fact that reproductive health status did not just affect individuals, but also communities and societies. While I was observing in the clinic Danielle and I got into a conversation about STI's in Lexington. According to the clinic's estimates for 2009, almost 34% of the Lexington clinic's patients come to be tested or treated for STI's. Danielle worked closely with patients to conduct financial assessments and answer questions. She asserted that, "We would never turn anyone away that feels like they've been exposed [to an STI]. That's a HUGE community health issue! It's not just about you and your boyfriend, it can have wide repercussions." This social nature of reproductive health was also referred to with regard to pregnancy. While discussing her definition and understanding of reproductive health during her interview Alex explained:

"When we help people to be more in control of their reproductive health, when and how they have children, I think it really helps people to live up to their own potential. And so I think that that is the thing we really do ourselves a disservice when we don't help people to do that. Not only does it hurt them, but it hurts everybody because they're less able to commit themselves to the things they want. So I think it's one of those things that you get back far more in terms of the payoff for society."

In both of these statements, which effectively sum up all of the staff members' sentiments, reproductive health and the absence of reproductive health problems in the



individual also work toward the greater good of the community in which they live. Fewer individuals with STI's contributes to fewer sites where the infections can be spread and the reduction of the community's STI rate more broadly. When women are given more options or control in having children, they tend to complete their education, get better jobs, and become productive contributors to the larger society. All of these things, in turn, contribute to a much higher quality of life.

Conversations with Planned Parenthood staff about the meaning of reproductive health also led to corollary conversations about community/patient reproductive health education. This was particularly true during my interview with Brittany. I did not get to see Brittany often during clinic hours, so we met for her interview on a Tuesday when the clinic is typically closed to patients. Since we had not had very many opportunities to interact before the interview, she had always seemed to be a bit more reserved than the other staff members. She usually worked quietly at a computer in the reception area when she was not sorting patients into exam rooms or reviewing patient charts. She completely surprised me during our interview. Instead of the stiff scrubs she usually donned in the clinic, she arrived wearing a long loose skirt and a red t-shirt with a picture of a cartoon pig that said "Don't eat me, I'm cute." During our interview, she was talkative, needing little prompting from me to expound on her answers to my questions, and she was quick to share information about herself. She laughed as she explained the somewhat unusual path that led her to Planned Parenthood. Even though her background is in horticulture and engineering, she has been working in the clinic for two and half years after deciding to follow her interest in Planned Parenthood's reproductive rights mission. For her, a major part of that mission is education, and she became even more animated, leaning

forward across the table that held my tape recorder and punctuating her words with jabs of her finger, as she explained why she thought education was a vital part of health care, particularly reproductive health care. According to Brittany:

“When I think of reproductive health I think of people being educated about how to even maintain their reproductive health. So coming in [to the clinic] and just being aware that they need to get PAP’s and knowing what the PAP is screening for; being aware that there might not be any symptoms of Chlamydia and gonorrhea, so they should get tested; being aware of different birth control methods; being aware of all the options that are out there and feeling able to make one’s decision about their health.”

Brittany also added in a later conversation we were able to have briefly during her lunch break that, “I think it all *starts* with educating people...you know, just educating people empowers them to make responsible choices and take care of themselves.” As seen here, for staff there are strong connections between reproductive health and education about reproductive health issues. This indicates a more complex and nuanced meaning of reproductive health for Planned Parenthood staff because it also entails the idea that reproductive health provides an opportunity for education, and the growth and development of knowledgeable patients who can make informed decisions.

Finally, there was also a political dimension to the Lexington Planned Parenthood staff member’s understanding of reproductive health. Staff asserted that in order to achieve and maintain healthy reproductive bodies individuals not only had to be informed about reproductive health issues but they also had to have access to reproductive health services. Josephine a staff member who had worked for the Planned Parenthood clinic part-time for the past three years, felt particularly strongly about the political aspect of reproductive health access. Josephine is soft-spoken, but not in a timid or shy sort of way. Instead, her calm demeanor and terse, to-the-point responses and explanations command

the attention of patients and staff members alike. During her interview in the nurse's station at the back of the clinic she told me that she has had quite a bit of experience in many types of medical facilities, and has worked for doctor's offices and health departments in the past. She compared these facilities to the Planned Parenthood clinic, citing the types of services Planned Parenthood was willing to offer to its patients as an important difference. She believed it was crucial to provide patients with access to the medical care they wanted regardless of her own personal religious or political affiliations.

According to Josephine:

“I think access is really what it [reproductive health] is about. The ready access to what we need is important, whether it's access to prenatal care if we want to have a child, access to contraceptive methods if we don't, access to health screenings for STI's and treatment for those STI's, access to sterilization. Just access to good health check-ups. Because that's taking care of reproductive health even if you're not sexually active.”

Access to such services was not only needed for maintaining reproductive health, but reproductive health services (and medical services in general) were perceived by the staff to be a right, akin to the other civil rights. Danielle argued during a conversation we had after her interview that:

“I would kind of put it [reproductive health] with reproductive rights, which is in the same arena as civil rights. It's not something that you have to earn access to, it should be something that's just guaranteed to you because you were born, therefore you should be allotted the right to make sure that you can obtain health services that will allow to you to stay well and allow your family to be healthy.”

Access could be controversial, though, particularly with regard to abortion and even birth control, making reproductive health and reproductive health services topics that were not just a concern to medical practitioners but also to religious groups and political activists. However, staff held that the right to access such

services overshadowed the other political or moral concerns, and that health care providers should make these services accessible, regardless of their potentially controversial status.

The clinic staff attempted to provide such access to reproductive health services in a variety of ways, though this could be difficult to do since the financial resources for such projects were not always available. For instance, some of the individuals who arrived at the clinic on days when it was open were not there for appointments, but wanted to stop by to pick up a “brown bag.” The brown bags are bags filled with condoms and instructions for how to use a condom correctly that people can pick up for free. I was not aware that the clinic provided this service until one day when I was observing behind the reception counter with Sarah and Danielle. There was a lull in the stream of patients and no one was waiting at the reception desk when an African American woman who looked to be in her 30’s arrived at the clinic, stood in the entryway for few moments, and then rang the bell on the inner door to be let into the clinic. After Sarah buzzed her in, the woman motioned to Sarah to lean over the counter so that she could ask her a question. The woman put both of her hands flat on the counter and spoke rather softly, asking if there were any brown bags available. Danielle must have known what the woman was coming for because before the woman had even finished her question Danielle produced an unmarked, brown paper bag from a box underneath the reception counter and gave it to the woman. The woman tucked the paper bag into the oversize tote purse she was carrying and asked why the bags were no longer in the clinic entryway. Danielle responded that finding money for the condoms was a little tight at the moment and quipped “This is a non-profit, we’re always broke.” The woman “tsk”-ed,

smiled, and thanked Danielle for the bag. After the woman had departed I found that the clinic always provides free condoms to anyone who comes in and requests them. In the past, though, the brown bags with the condoms were just placed on a round side table in the clinic entryway and people could drop in and pick them up without being buzzed into the clinic. According to Danielle, this was supposed to make people “feel less awkward about asking for condoms.” The staff members had hoped that people would feel more comfortable picking the condoms up - and using them - if there was minimal observation by other people in the clinic. The clinic typically received some funding from the Fayette County health department, and they used this money to pay for the condoms in the brown bags. However, this funding had recently been cut, due to larger budget cuts within the health department, and the clinic was now paying for the condoms out of pocket so that they could still provide them to the public. Danielle explained that the clinic was trying to “spread the resources further” by taking the condoms out of the entryway since the staff members could ensure that people who came in for condoms were only taking one bag at a time. This compromised the original premise to ensure minimal interference with people who were trying to obtain condoms, though, and Danielle worried that “people might just not bother asking and leave without any” when they saw that the condoms were not in the entryway anymore.

In sum, Planned Parenthood staff members have a complex and nuanced understanding of reproductive health. Their definitions do incorporate the idea that the physical absence of reproductive health conditions, such as STI’s and cervical cancer or the prevention of reproductive health issues, such as unwanted pregnancy, contribute to healthy reproductive bodies and healthy lives. However, their understanding of

reproductive health also extends beyond the immediate individual body to also address what they perceive to be the factors, beyond bacteria, viruses, or cancers, that allow such reproductive health issues to arise and the wider repercussions negative reproductive health can have on a community. They have a more holistic and systemic understanding that is reflected in their personal definitions, incorporating the dialectic nature of the reproductive body and its physical and social environment as well as the importance of patient education and access to services.

*Meaning in Action: Services Offered at the Lexington Planned Parenthood Clinic*

On the ground, in the day-to-day activities of the clinic, the meaning of reproductive health to Planned Parenthood staff was translated into community services in specific ways. For service providers, reproductive health and the reproductive body are not just sites for medical treatment and intervention. Instead they are also sites for the dissemination of information and opportunities to educate, empower, and advocate for patients. This understanding of reproductive health and the reproductive body is in keeping with the findings of other anthropological researchers who have highlighted the various ways that reproduction and the reproductive body are not solely concerns for pregnant mothers and their physicians. Instead they can be used in a variety of ways to serve a multitude of political, institutional, ideological, economic, and pedagogical purposes outside the purview of medicine and family (Davis-Floyd 1992; Jordan 1997; Root 2001). In line with this more holistic mentality, the Lexington Planned Parenthood clinic uses a multi-pronged approach to the services they provide, including clinical services and educational outreach. While the national Planned Parenthood federation also officially includes a third prong, patient and women's advocacy work, the Lexington

Planned Parenthood clinic was unable to get involved in advocacy directly because of their status as a 501C3 organization. 501C3 status offers important tax exemptions for non-profit organizations like the Lexington Planned Parenthood but also restricts them from any kind of political lobbying. Many of the staff believed strongly in the importance of advocacy work, though, and participated in pro-choice rallies, wrote to government officials to support the pro-choice agenda and patient rights to all medical services, or found other ways to participate in advocacy activities without officially going through the Lexington clinic.

The Lexington Planned Parenthood clinic offers a wide variety of clinical services. These include STI testing and treatment (except for syphilis), pregnancy testing, unbiased pregnancy counseling including abortion referral, prenatal counseling (for couples trying to become pregnant), all forms of contraception (including insertion services for IUD's and diaphragm fittings), HIV testing, annual gynecological exams (including PAP smears), breast exams, Gardasil vaccinations, and UTI screening and treatment. According to the staff the major services patients come to the clinic to receive are STI testing and birth control in various forms. Clearly, the services are more heavily focused on prevention and diagnostic measures, though the clinic does provide treatment for some conditions patients may arrive at the clinic with, such as STI's. More often if patients sought treatment for larger issues they would be referred to a specialist or physician at another medical facility. For instance, individuals with positive PAP tests (indicating the presence of cervical cancer) would be sent to an OBGYN or the cancer centers at UK and individuals seeking abortion procedures would be referred to the EMW women's clinic in Louisville. This means that the clinic's focus and the staff members'

interest was on catching reproductive health problems before they began so that treatment or invasive surgical procedures would not be needed in the first place. The “ounce of prevention is worth a pound of cure” mentality is clearly displayed by the Lexington Planned Parenthood clinic’s medical service repertoire.

To fulfill the perceived importance of education and patient awareness in reproductive health, the Lexington Planned Parenthood clinic also provided a variety of services. The 7-person staff actually consisted of one individual hired as a “community educator” whose responsibility was to design, organize, and implement educational outreach initiatives for the community and patient populations. Some of these initiatives included: participation in local health fairs, a teenReach peer educator program, sexual health classes at various local facilities, a “Let’s Talk” forum for parents and children to discuss reproductive health topics; free STI testing drives during STI awareness month, free fact sheets and educational packets for patients, and talks on developing healthy relationships, building self-esteem, and understanding one’s sexual identity. Given the size of the staff the variety of educational initiatives is impressive, and many of the staff often chipped in to aid the community educator when she needed an extra pair of hands to prepare for an event. These educational services are also reflective of the more holistic view the Planned Parenthood clinic has of reproductive health. While the bulk of these services involved information about the importance of getting tested annually or the ways to effectively prevent reproductive health problems, they also included basic information for a healthy lifestyle in terms of relationships with others and confidence in one’s self.

The Lexington Planned Parenthood clinic’s patient base is predominantly made up of females, aged 20-40, who reside in the Lexington area. Based on 2009 data, the



staff members estimate that most of their patients visit the clinic to obtain contraceptive devices and medication (40%) or to receive STI testing and treatment (34%). The clinic can generally see up to 35 patients per day on the three days of the week that it is open, which keeps the staff members busy signing patients in, conducting financial assessments and physical exams, and scheduling new appointments. Most of these patients fall in the middle to low income bracket, but 35% of the clinic's patient base is fully covered by an insurance plan provided by a place of employment or purchased individually. The staff members estimate that roughly 50% of their patients have insurance through Medicaid. Men are present in the clinic often, accompanying girlfriends or wives, but they rarely visit the clinic to obtain services for themselves. Staff members report that they only see about 5-10 males a month, and 90% of the time it is for STI testing and treatment.

For the staff members at the Lexington Planned Parenthood clinic, reproductive health has meanings and connotations that are specific to the context in which they operate and interact. In the examples presented in this chapter it is possible to see what aspects the employees delineate as particularly relevant toward an understanding of reproductive health and, by extension, why reproductive health is used as a site of intervention at this clinic. Staff members reiterated that it was important to understand that reproductive health is not purely physical, that it affects communities, that it can be used for didactic purposes, and that it is politically influenced, and they attempted to act on this holistic understanding by providing services according to a multi-prong model of reproductive health service provision that includes prevention, treatment, education, and advocacy. However, while the characteristics the staff members use in their understanding of reproductive health are clear, *how* do staff members construct this

understanding? What factors play a role in their decision to focus on or highlight these particular aspects of reproductive health and how does this interaction play out on the ground? In the following chapter I examine some of the national level interactions that influence how staff define reproductive health and offer reproductive health services, beginning with the clinic's relationship to the broader Planned Parenthood federation.

### **Chapter 3**

#### **Navigating Reproductive Health within a Federation Framework**

This chapter explores some of the broader structures and organizations that influence how Lexington Planned Parenthood employees determine what reproductive health means and how it should be promoted through clinic services. I was not able to directly interact with individuals at the federation level and I only had brief meetings with a couple of the staff members who work for the Louisville Planned Parenthood branch, where the Planned Parenthood of Kentucky is located. However, my analysis is focused on the way the Lexington Planned Parenthood interprets their interaction with these higher Planned Parenthood bodies and how that interpretation shapes meaning-making and action around reproductive health. Specifically, I discuss how Lexington staff's interaction within these larger, external structures as well as interactions with patients at the clinic level shaped how the Planned Parenthood employees negotiated reproductive health meanings. This chapter contributes to an understanding of how the context of social processes can shape ways of knowing about and handling reproductive health issues and services by highlighting how national level health politics, regulations, and interests are negotiated, contested, and translated before being enacted at the clinic and provider/patient levels.

#### *Negotiating the Meanings of Reproductive Health*

Danielle has the radio set to a smooth R&B station and is humming along to Smokey Robinson while filing patient charts when I come into the clinic to interview her. She grins as I enter the reception area and asks how everything is going. Danielle has been with Planned Parenthood for two years and is the only African American employee currently working there. She is quick to laugh as she recounts some of her experiences at

the clinic. While several of the staff members have been at Planned Parenthood just as long as Danielle, many of them come to bounce ideas off of her and get suggestions about how to take care of certain forms and protocols or handle various patient interactions. Recently, she has not been able to work at the clinic as much as she would like because she has started taking classes toward her nursing degree. She answers my questions enthusiastically, but begins gaining energy and gesturing expressively with her hands as she discusses Planned Parenthood's image in the local community specifically and in the United States more broadly:

“It's just so interesting because from street to street it seems like we receive a different kind of love. There are some people who are just flat out like, “We don't like you,” and I think that could be because they don't really understand what we do specifically. They might have an idea of what Planned Parenthood does here [in Lexington] or what we do nationally, like we just provide abortions and abort black babies, or whatever else people say. They're just using the brand and whatever they think they know about the brand instead of really looking in to what we do.”

One of the most prominent themes that came up in interviews and in my daily clinic interactions with Planned Parenthood staff was this theme of misperception, or a general misunderstanding about Planned Parenthood, that Danielle alludes to above. This included a misperception of Planned Parenthood activities specifically and reproductive health generally on the part of the Lexington Planned Parenthood patients or the Lexington community. It also involved, to a lesser extent, the misperception of patients or patient intentions on the part of the Lexington clinic's staff.<sup>2</sup> This theme proved

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<sup>2</sup> Due to the limits of this project's research design, I was unable to fully assess whether or not patients at Planned Parenthood actually did misperceive Planned Parenthood activities or reproductive health. Such an assessment would have required that I speak with or interview patients, which was beyond the scope of the project's IRB approval guidelines.

interesting because it reflected Planned Parenthood staff members' perceptions of their patients, the reasons patients sought the clinic's services, and what responsibility Planned Parenthood staff had to these patients. This theme reflects the beliefs and understandings of the staff with regard to the individuals they serve and the ways their interaction with these individuals contributes to the staff members' understanding of reproductive health.

One area of patient misperception that the Lexington Planned Parenthood staff members referred to dealt with Planned Parenthood itself and its mission, services, and goals. Many staff reported that they thought some people saw the Planned Parenthood staff as "femi-Nazi abortionists," whose reproductive health services were limited to providing abortions to low-income minority women and preaching radical feminist ideology. There was a general agreement among the staff that part of the reason people had misperceptions about Planned Parenthood could be attributed to an essentialized and stereotypical Planned Parenthood "brand." Within the news and popular culture, the name "Planned Parenthood" can be associated with many controversial topics, particularly abortion, and strong advocacy work, though these representations are more often a reflection of the federation level activities and a general pro-choice agenda rather than the ways individual clinics operate. This image of Planned Parenthood that is propagated by news media and popular culture is also a current reflection the history of violence associated with reproductive health and its proponents. This image reduces the clinic's mission to providing abortions and obscures the role they have played in making health education and care available to the community. According to Danielle, one could often mention Planned Parenthood to members of the general population and "their understanding of the brand [would cause] a collective eye-roll" and subsequent dismissal

of anything staff had to say. While I did not observe this misperception among the patients who visited the clinic while I was there (probably because they had a better understanding of Planned Parenthood in general since they utilized its services), I did notice this phenomenon to a certain degree in the general Lexington population while observing at local health fairs the Lexington clinic attended. I went to these fairs with Sarah, one of the more recent additions to the clinic staff. Though she had only been working at Planned Parenthood for a few months at the time, she had picked up on the daily rhythm of the clinic quickly and tried to help wherever she was needed. The clinic had been experiencing some staff shortages since the beginning of the year as more staff members went back to school or found other jobs, and many of the remaining staff members appreciated Sarah's willingness to go beyond her job description by manning the health fair booths. Sarah was a bit shy and she had been hesitant in our interview during the early weeks of my fieldwork, her responses to my questions spattered with "ums," "ers," and long pauses. I found out later that the tape recorder had made her nervous and she seemed to relax a lot more in the public venue of the health fair. She chatted willingly with me as we sat and observed the passers-by and was more responsive to my questions about her perspective on the clinic and its services.

As I sat with Sarah I noticed that many people would pass Planned Parenthood's brightly colored booth, realize what organization was represented there, and make comments such as "oh, that's not for me" or "I'm done having kids." Comments like these reflect the fact some individuals could be essentializing Planned Parenthood's purpose and may not actually be aware of Planned Parenthood's range of services or the wide population they were actually serving in Lexington, including men and women and

individuals who are old and young, poor and wealthy. Several staff mentioned that the generally recognized view Planned Parenthood could actually prove to be a weakness of for the clinic because of its automatically assumed association with controversial services like abortion and the morning after pill. Often staff members expressed their desire to be able to advertise and market themselves better in the Lexington community. During her interview, Alex spoke at length about how she thought the local community perceived Planned Parenthood and why this perception might exist:

“I think in many ways the public awareness about Planned Parenthood and what we do is something that we’re constantly trying to improve. Because sometimes we find that people don’t even know we’re here and don’t know what we do, and unlike a lot of organizations we don’t advertise. We can’t advertise, it’s not in our budget to advertise. So we have to find other ways to try to be sure that people in the community know that we’re here and know what we do.”

Since funds were not available for advertising the Lexington Planned Parenthood’s services, education and “raising awareness” became the clinic’s primary method to reform assumptions about the clinic’s services and the population that could benefit from them. Staff considered education to be one of two equally important prongs (along with clinical services) in promoting reproductive health, and they used some of their educational programs as opportunities to also remedy Planned Parenthood’s image and chip away at what they perceived to be a very negative stereotype.

Staff also thought that patients, or the general community, tended to have misperceptions about reproductive health. In particular, this included understanding how STI’s are transmitted and what their symptoms are, possessing a knowledge of the reproductive system and organs, and being aware of the variety of birth control options available for men and women. One day while I was observing at the clinic Danielle

received a phone call at the front desk from a woman who apparently had a condom stuck inside of her. Danielle listened on the phone quietly for a few moments and then proceeded to tell the woman that it was not necessary for her to come in to the clinic for an examination. Instead Danielle explained how to remove the condom and added that the condom would come out on its own in a few days regardless. After she got off the phone Danielle, half joking and half exasperated, remarked: “I swear, some women think they have a whale’s vagina. It is *not* that big and condoms are not that small. Come on people.” Danielle’s reaction to this particular phone call reflected the staff members’ attitude about answering these seemingly obvious questions.

Another event also illuminated the Planned Parenthood staff members’ perception that people generally do not have a broad knowledge of reproductive health. While I was conducting research the Lexington clinic held an activity at the clinic called “Let’s Talk.” The “Let’s Talk” event is held by Planned Parenthood health centers throughout the country and was developed in an effort to provide a comfortable and educational space where parents could talk to their adolescent children about puberty, sex, and healthy sexual practices. In Lexington, the staff members mediated the discussion by interjecting supplementary information (e.g. how to put on a condom correctly) and fielding more difficult or awkward questions that parents or their children felt more uncomfortable asking. During the event, Alex was highly amused and a little surprised by the some of people there who got into a discussion about what exactly oral sex was. Many of the staff felt that “Let’s Talk” was one of the most important educational events that the clinic organized because it remedied the information shortage that they perceived among the population and conveyed accurate information to kids and the parents so that they would



come away with a better understanding of reproductive health. Although I was unable to interview patients about their knowledge of reproductive health issues, it was clear that staff saw patients' misperception of reproductive health as an important challenge they faced. This understanding was mediated both by their own interaction with patients and Lexington community members at events like "Let's Talk" as well as by the federation's emphasis on education. The clinic staff, by federation expectations, should be up to date on current reproductive health knowledge and the clinic receives a lot of information about reproductive health issues in federation emails and newsletters that may not actually be common knowledge to the general public. This could widen the perception of the general population's lack of knowledge about reproductive health and sexual issues.

Finally, a few of the staff mentioned that they were concerned that they too held some misperceptions, particularly in relation to the patients they treated at the clinic. My interviews and discussions with Jane, in particular, clarified this staff sentiment. Jane always looked as though she was on a mission in the clinic. In fact it was sometimes difficult to catch up with her during clinic hours because she was always moving around from one area of the clinic to another. On any given day she could be found darting around the clinic on her phone with a Post-It note on each finger, answering phones in reception, checking clinic protocol updates and scheduling meetings in her office, or standing in as a nurse's assistant and ushering patients into exam rooms. Jane is a very serious worker, and she often listens more than she talks in her interactions with patients and other staff members. She has a clever under the radar wit, though, that comes out sometimes when the clinic is not gridlocked with patients. Most of her fellow staff members cited her as one of the Lexington clinic's biggest assets since she often gets in

earlier and leaves later to insure that all of the clinic business is taken care of. Jane is also a very strong supporter of prevention and patient advocacy, and in her two and half years working for the clinic she has tried to focus the clinic's services in that direction. She often told me and other staff members that "we give patients a voice," referring to the work of Planned Parenthood generally and the Lexington clinic specifically. In this light, it did not surprise me when Jane commented to me about her concern over the possibility that staff could be misunderstanding patients:

"I feel like having to be on our toes so much with security issues, you know, it's always a question of...we don't *want* it to by any means affect our patient care, but does it? I hope that it doesn't, but to a certain degree when you're always sharing stuff about security issues and somebody calls in and you have a suspicion that they might be an anti-choice person, and maybe they're not but you don't know, can you offer them pure compassionate services?"

Here it is clear that Jane thinks the staff member's heightened awareness of security issues, which come from places like the national federation and the Planned Parenthood of Kentucky affiliate, can be problematic because this awareness could potentially cause staff members to misperceive patient intentions at the clinic. Due to the recent occurrences in Louisville, KY with the LiveAction undercover recording of the EMW women's clinic it is unsurprising that security was a prominent issue at this time. As I continued to interview staff and interact with them in the clinic I asked about the incidence of security issues, such as attacks, suspicious phone calls, or protests near the Lexington clinic. However, it became clear that at the there had not been any major security issues in Lexington, at least within the time frame that the current staff had been working there. According to several staff members the most significant things that had happened were that they received some pamphlets in the mail from a pro-life

organization concerning the immorality of abortion and that there had been a peaceful protest with a couple of people carrying a cross who had stopped briefly at the clinic during Easter as part of a longer procession to visit pro-choice organizations. This heightened awareness about the importance of security is a reflection of the contention surrounding reproductive health and reproductive rights that is still tangible today and the staff members' positionality as employees of Planned Parenthood, an organization that has plays a major role in the fight for reproductive rights. The staff members' interaction with their affiliate's administration in Louisville and from the national Planned Parenthood federation shapes how reproductive health is made meaningful for them and what is at stake as reproductive health care providers. Jane mentioned that their monthly meetings with the Louisville affiliate had "taught us [staff members] to be so hypersensitive about security." Also, when reflecting on the connectedness between the federation and its health centers, nearly every staff member mentioned the distribution of new security protocols as one of the main types of information shared across the federation network. The Lexington clinic definitely takes these protocols seriously because patients have to be buzzed into the facility by the receptionist, there is an emergency button located under the receptionist's desk that summons the police, bomb safety instructions are located in all areas where staff work, and coded locks with key pads are located on the doors to the reception, clinic, and administrative areas. There were also a few instances when I observed this sensitivity to security issues in the staff members' interaction with patients at the clinic. On one occasion, I had arrived at the clinic just after it opened and assumed my usual position behind the reception counter with a box full of bottles of folic acid and a stack of information sheets on the importance

of prenatal nutrition, which I began putting into plastic baggies. Danielle was out for the day, and Alex had stepped in to help Sarah. There were not many patients yet and Sarah was doubled over laughing as Alex showed her a video of a foreign condom commercial involving balloon animals on YouTube. Jane was also behind the counter, sealing some envelopes that had to go out that afternoon. Two white girls who appeared to be in their late teens rang the doorbell and Sarah left Alex to buzz them into the clinic and find out what they needed. When Sarah asked how she could help them, one of the girls explained that she wanted to get a pregnancy test. Apparently, she was currently using Implanon, a contraceptive implant inserted into the upper arm, as a contraceptive method but had recently had unprotected sex and was a little late having her period. The girl was concerned that she could be pregnant and kept twisting her fingers together nervously as she spoke to Sarah. The girl was not a patient at Planned Parenthood, and had actually gotten her Implanon at a different clinic, but she had decided to come to Planned Parenthood because she thought it would be a cheaper option. She had insurance but did not want to use it because she did not want the pregnancy test to come up on a claim. I assumed that the girl might be on her parents' insurance in which case they could see that the girl had gotten a pregnancy test and perhaps would confront her about it. The other girl, who appeared to be her friend, did not say anything, and stood away from the reception counter, silently looking around the clinic with her hands in her jean short pockets. Sarah listened to girl, looking a bit confused and then asked, "Ok....um....which clinic did you get your Implanon at?" The girl did not give Sarah the name of the clinic, but simply replied that the clinic was not in the area. At this point, Jane had stopped sealing envelopes and was listening to the conversation with the patient and paying

particular attention to the girl's friend who was still pacing silently around the entry area of the clinic. Jane stood up, walked over to front desk, and cut into the interaction. With her arms folded across her chest she explained that the test probably would not be as cheap as the girl originally thought and that Implanon "works differently for different people" and a period that was a few days late on Implanon did not necessarily mean the girl was pregnant. She added that, regardless, the girl could not "just walk in" and would need to make an appointment. She also explained that anyone accompanying her to the appointment, including friends and family members, would need to remain in the waiting room on the other side of the building. The girl decided to think about it and then call back to make an appointment. I was initially shocked as I observed this exchange because Jane seemed unnecessarily, and uncharacteristically, stern with a young girl who appeared to be genuinely worried about being pregnant. However, Jane's response is more meaningful when examined in light of the security issues that were prominent for the Planned Parenthood Kentucky affiliate at the time. Jane's reaction was likely influenced by an incident in Louisville where an abortion clinic had been secretly videotaped by two girls, one posing as pregnant and the other posing as a friend accompanying her to the clinic. The staff members were briefed on this occurrence at several of their staff meetings with the Louisville affiliate administration over the summer, and were understandably suspicious of situations resembling the one that precipitated the filming of the Louisville clinic and more strict about enforcing the waiting room policy for family and friends.

These examples show that as staff members interpret reproductive health and provide reproductive care they are not only influenced by their daily interaction with

patients from the local community, but are also kept on their toes by outside spheres of influence in the form of the Planned Parenthood of Kentucky affiliate administration and the national Planned Parenthood federation. It was in their negotiation of their practical experience with the Lexington community and the guidelines and information they received from the broader Planned Parenthood network that staff felt they could potentially be misconstruing their patients in ways that may hinder “compassionate” service.

Each of these factors reflect how the provision of reproductive health care services and the construction of reproductive health are not shaped solely at the local level, but are also highly intertwined with and influenced by larger organizational frameworks, particularly the national Planned Parenthood federation and affiliate administration. In addition, it illuminates how the federation model is translated to local contexts and the influences it encounters there. These broader frameworks should be taken into consideration when exploring health care delivery to gain a more holistic, and potentially realistic, understanding of the health care operation in different contexts and the shaping of organizations’ perceptions of health.

## **Chapter 4**

### **Negotiating Reproductive Health within the Local Context**

The city of Lexington and the state of Kentucky as local contexts where the Lexington clinic operates make up another sphere of influence that affects the clinic's understanding of reproductive health and shapes reproductive health services. Though there are over one hundred Planned Parenthood affiliates and health centers all over the country, they probably each look slightly different from one another given the populations they serve and the varying local dynamics at work in individual states and cities. In this chapter I analyze how a variety of factors within the local context where the clinic exists shape the Lexington Planned Parenthood brand of health care and both challenge and enhance the staff members' ability to provide services to the Lexington community and surrounding areas. Such an analysis works toward the overall goal of the thesis to understand the fluid and context-specific ways of knowing about health by situating reproductive health's meaning and the action around it in the push-pull dialectic of local dynamics. The local contextual factors staff must mediate on an on-going basis directly affect the services offered, the staff's perceptions of the Lexington community, and the staff's understanding of how reproductive health interventions operate at the community level.

Interviews with and observations of Planned Parenthood staff highlighted three local factors that shaped the way Planned Parenthood operates and provides services in Lexington specifically. These are funding sources, Lexington community support for the clinic, and the clinic's relation to other health facilities in the community. Knowing the issues that the Lexington staff experienced and the ways these issues affect or influence the way their clinic works could be helpful for the Planned Parenthood federation in

general, because it may be that similar factors are at work, though in different ways, at each Planned Parenthood clinic. If these factors pose limitations, or even enhance clinic services, understanding the ways they affect individual clinics could allow the federation to potentially mediate them broadly, or at least take them into consideration when updating their organizational policies and disseminating information to individual clinics.

### *Funding*

One factor that shapes reproductive services at the Lexington Planned Parenthood is the clinic's funding sources. While I was observing at the clinic and conducting interviews the staff often expressed their belief that funding limits their ability to practice or operate the clinic as they wished. At first I always took this to mean that it was a lack of monetary support that was at issue because several staff had mentioned that they were frustrated by their inability to open the clinic more than three days a week or offer extended services, such as hiring a Spanish language interpreter, due to financial scarcity. However, as I came to understand later, the sentiment that funding limits the clinic's ability to practice also applied when funding *was* available, particularly in the form of Title X funding. Title X is a federal grant program that provides money for health facilities that offer family planning services to low-income individuals. In Lexington, Title X money is given to the local Fayette County health department and the Planned Parenthood clinic is sub-contracted through them in order to receive a portion of the funds. While this money is not offered solely in Lexington or solely to Planned Parenthood clinics, it does operate to influence the Lexington clinic in specific and important ways. I was able to get a much better sense of this during Ruth's interview. We met early in the morning, before clinic hours, so that she would not have to spend time



away from patients during the daily rush. The clinic was much quieter in the morning, though on this particular day, there were people working on the clinic building, including several pest control agents spraying for termites and an electrician rewiring one of the lights that had gone out in the reception area. The clinic's location in an old historic home made facility upkeep a continual challenge and workers had been in and out, mixed with a steady stream of patients, all week. I was waiting behind the reception counter and talking with Josephine when Ruth arrived at the clinic complaining of the pest control truck driver's parking job in front of the building. She stepped behind the door of the reception area to hang up her purse and noticed an unwrapped Paraguard IUD sitting on the reception desk. "What's this doing here?," she asked as she headed back for a cup of coffee. "Oh you know," Jo said jokingly as she picked up the IUD, "these things are just falling out of people right and left." The clinic has many patients who come in for IUD insertions and some of them return to have the strings checked to ensure that the device is still in place. Ruth raised her eyebrows skeptically and Josephine laughed, explaining that she had opened one of the packages to show patients who were considering an IUD as a birth control option what the device looked like and how it worked. Ruth smiled and headed out of the reception area toward the nurses' station in the far side of the clinic, waving me to follow her. Ruth has been a Planned Parenthood employee for over 10 years, and I was repeatedly referred to her when other staff members were unsure how to answer my questions about the clinic's service trajectory or guideline changes. Each time I spoke with her she thought over my questions seriously for a few moments before responding, speaking slowly and matter-of-factly as she explained her perspective on Planned Parenthood. Specifically, Ruth described to me how the availability of funding

like Title X can actually make achieving clinic goals and providing clinic services more difficult:

“Funding, well the policies can be both a strength and a weakness. . . . For example, we receive Title X funding at this clinic but not at the EKU clinic [another smaller clinic within the Planned Parenthood of Kentucky affiliate]. So after three months of being on the pill we have to make patients come back here [to the Lexington clinic] and get a weight and blood pressure check before they can get more pills. Often they don't come back at that three months, or they're off the pill a couple of months because they can't get back in to see us. And I can think of several occasions where women have gotten pregnant when they've run out at that three months but didn't make it back in to get more pills. At our EKU clinic, because we don't have Title 10 funding, I can see them and they can get their whole year's supply of pills at that very same visit. And you don't worry about them not making it back in and stopping their birth control pills for a while. So funding often limits how we would practice.”

Funding from sources like Title X is important because it allows the clinic to offer its services on a sliding scale, but as Ruth shows here the guidelines for how services are to be administered in order to receive funding can actually inhibit the efficacy of those services. Based on Ruth's statement she prefers EKU's method of delivery and finds it to be more effective. Funding sources may also have guidelines or standards that actually compete with the Planned Parenthood federation protocols that the Lexington clinic is supposed to follow. For instance right before I began conducting research the national Planned Parenthood federation changed its guidelines for PAP smears. Under the new protocol no one under 21 needed to have a PAP smear in order to receive birth control regardless of sexual activity. According to the staff, rates of cervical cancer, which the PAP's screen for, are very low in women under 21 and even when a PAP smear comes back as abnormal for someone in that age group medical practitioners typically wait year and refer the individual for another PAP smear because it can fluctuate. However, the Title X guidelines still required PAP smears at three years after first sexual activity or age

21, whichever came first, meaning that someone under 21 could still require a PAP smear if they became sexually active at a young age. The staff at the Lexington clinic opted to follow the Title X guidelines over the federation's because "they [Title X] were the more conservative of the two." In cases like this, the Planned Parenthood staff must constantly negotiate the different sets of guidelines because they are a non-profit organization and cannot remain open without outside funding. This negotiation of funding guidelines affects the Lexington Planned Parenthood's services and influences patient outcomes in very important ways as reflected in Ruth's example comparing the Lexington clinic's and the ECU clinic's ability to provide birth control to patients. With different guidelines it is impossible for Planned Parenthood services to be universal, since, depending on the clinic and its funding sources, the types of services and manner in which they are delivered can vary, even within an affiliate like the Lexington Planned Parenthood and the ECU Planned Parenthood. Also, there is always the potential for changes to the clinic's service delivery based on the changing policies of funders and the federation that require a reassessment of their preferred prevention methods. In these ways funding very directly affects the ways the clinic is able to practice.

### *Community Support*

Another factor that affects clinical services and staff understandings of reproductive health is the support the Lexington community shows for the Planned Parenthood clinic. Many of the staff members commented during their interviews that they perceived the Lexington community to be a "pretty mixed bag" that was "demographically different" and "split pretty evenly politically and economically." According to the staff, support for Planned Parenthood in Lexington, while

predominantly favorable, is also rather mixed. During the summer there were several instances of community support from the Lexington population that I observed or was informed of by staff. For instance, the clinic was invited to set up booths at two local health fairs hosted by local organizations. Alex and Sarah worked many of the booths, and they provided pamphlets and informational packets about the various services their clinic offered, STI prevention, and forms of birth control to passersby. They also discretely distributed “brown bags,” or bags with condoms in them, to the people who asked for them. While I was there, a slow trickle of people ventured to the Planned Parenthood table and I observed that not everyone knew about all that Planned Parenthood had to offer. Several people, particularly men, expressed surprise at the list of services displayed on the table. It was clear, though, that the parties organizing the health fairs valued the information Planned Parenthood could provide. Alex and Sarah were greeted warmly by the fair officiants and invited to partake in the opening activities for the fairs. One fair official even discussed the tentative plans for next year’s health fair with Sarah and asked, “You guys will be there, right? We definitely want you to come back again.” Besides the health fairs, staff reported that they were regularly invited to provide educational and clinical services to local organizations such as the Chrysalis House, a drug rehabilitation center for women, and the Hope Center’s Privett Recovery Center, a recovery program for homeless men, particularly those who suffer from drug and alcohol addiction. Some of the individuals using the services of these organizations later become patients at the Planned Parenthood clinic since it offers affordable reproductive health care and they are familiar with members of the staff. In these cases, as with the health fairs, the services and information that the Lexington clinic provides

are obviously important to the organizations that ask Planned Parenthood staff to visit their facilities and reveal another important source of community support. These examples of community support typically involved educational initiatives for lower-income sectors of the population, though the clinic staff did report that they had begun holding a well-attended annual fundraiser, called “Birds and Bees in the Bluegrass,” that was held at the former mayor of Lexington’s home and represented community support from a different sector of the Lexington population. All of these instances of community support had a direct effect on Planned Parenthood staff and services. These events constituted a major part of the clinic’s educational outreach method, providing important preventative information to the community, but were also an avenue to advertise Planned Parenthood and its mission to different groups, highlighting services or characteristics of the organization that might be of interest.

There were other instances in which community support was more difficult to obtain or altogether lacking. One of these concerned the clinic’s attempts to teach comprehensive sex education, STI prevention, and birth control methods in the Fayette County school system. On one occasion shortly after I had started the research project I was observing at the clinic and ventured upstairs to Alex’s office to see if she had come in. It was one of the few days I saw all summer where only a handful of patients actually came into the clinic for an appointment, but the phones had been ringing off the hook with people scheduling future appointments and inquiring about birth control and STI testing, which kept Danielle and Sarah busy despite the low patient volume. I had been helping to stuff folic acid bags in the reception area for the better part of the morning and Alex had not been there. Alex’s office is in a sunny room on the second floor of the clinic

and is typically strewn with colorful information pamphlets and half-finished teenReach posters lying amidst piles of markers, tape, and packages of condoms. When I found her, she was sitting at her computer looking thoroughly disgusted. She had just received an email from one of the local high schools informing her that Planned Parenthood would no longer be able to hold teenReach peer educator recruitment sessions and meetings or provide educational classes at the school anymore due to “program restrictions.” Alex sat back in her chair and tapped a pencil back and forth angrily against her desk as she shared her suspicion that there had been “some interference from above” because the youth services coordinator at this particular high school had previously been supportive of Planned Parenthood’s activities there. “What a loss. She [the youth coordinator] was really enthusiastic about having us there last year.” Alex explained to me. Over the course of the summer I found that Alex had to deal with this issue often and she explained what had been happening in more detail during her interview:

“I’ve been contacted on multiple occasions by school counselors, youth service coordinators, you know, folks that work on the ground and see kids coming into their office with questions about sex or questions like ‘I think I’m pregnant what do I do?’ or they see teens walking around pregnant in their school. And so they call us and they’re like ‘What can you offer? Do you have brochures? Can you come teach classes? What can you do?’ But as they sort of go up the ladder they realize they have to retract their request. They’re not allowed to have us come and speak to their students. It’s something that we haven’t yet been able to figure out, where that push back is coming from because from our perspective it’s *not* coming from the people on the ground. I think it’s coming from farther up the administrative or bureaucratic ladder, so we’re working on that.”

As Alex’s statement suggests, there can also be an interesting dichotomy with regard to community support. While certain people, such as teachers and guidance counselors, may value the information the Lexington Planned Parenthood clinic can provide to teens and support the staff’s presence in the schools as reproductive health educators, their wishes

are overshadowed by a presence “somewhere up the ladder” that finds it inappropriate or at least problematic for Planned Parenthood staff to teach in the schools. According to many of the staff this “push back” from the school system was also an example of misperception on the part of some members of the Lexington community in two ways. The first is simply a misconception of Planned Parenthood as organization and a classic use of the stereotyped Planned Parenthood brand to portray the clinic’s sole function as providing abortion and abortion referrals. The second regard Kentucky state law. Until recently, the only funding available for sex education programs was for abstinence only education. However, funding has now become available for teen pregnancy prevention programs in schools that include comprehensive sex education. Some staff surmised that school officials may not be aware of the change and so would not permit Planned Parenthood (who teach comprehensive sex education) to come. Ironically, it still reflects a misperception of the Planned Parenthood clinic since organizations requesting educational services from the clinic are not required to pay anything for those services, making the concern with a funding a moot point. Either way, the clinic’s inability to provide preventative education in the school system influenced them to find new, unique ways to provide reproductive health information to the younger demographic in Lexington. The teenReach peer educator program that recruited volunteers from among local high school students is one important avenue to reach youth. The “Let’s Talk” event was also a way to reach youth by encouraging communication about reproductive health and sex between parents and teens. In addition, the push back from the local schools seemed to reaffirm the staff’s understanding of reproductive health as politically charged. The speculated mistrust of Planned Parenthood from powerful higher ups and

negotiations with state funding for sex education all solidify the staff's perception that the importance of reproductive health is not relegated to individual bodies or to the clinic alone. It has meaning and different levels of value outside those contexts as well.

### *The Clinic's Relation to Other Health Care Providers*

Finally, the Lexington Planned Parenthood clinic's relation to other health care providers shape the clinic's services and staff understandings of reproductive health at the local level. Within Lexington there are a variety of health facilities that provide reproductive health services. Some of these include private practice OBGYN's, OBGYN's working through university health services, and the public health department. Often, when staff discussed their understanding reproductive health or related their perception of Planned Parenthood's role in the Lexington community references to these other health facilities were nearly always brought up. This typically took the form of staff defending their understanding of reproductive health or defining their organization in terms of the services they provide, and the manner of service provision, that other facilities did not have. (These facilities are not necessarily in competition with one another for a patient base since they all vary slightly.) Some of these included the financial accessibility of Planned Parenthood services. For instance, Sarah discussed this issue in her interview, explaining that:

“Family planning is for everyone, you know, and we *see* everyone. Insurance is so expensive right now people can't afford going to a normal doctor and it's really fulfilling because we're able to quote a person [on the sliding payment scale] with how much they make and them be so excited because they actually get to have their annual exam done.”

In this statement Sarah contrasts the expense of a “normal” doctor, meaning a general practitioner or gynecologist in the area, with the Planned Parenthood clinic's financially



available services. Danielle also compared Planned Parenthood's financial accessibility to other medical service providers during her interview saying:

“When you think of health care and when you think of going to the doctor or going to the hospital and getting medications like birth control you immediately think ‘Ooh, this is going to cost me a lot of money.’ But here [at Planned Parenthood] we’re seeing people who are maybe on the poverty scale or reach the poverty scale all the way to people who you may consider middle class but still don’t have insurance or need services that are not really within their scope of affording it at the time.”

Again, in Danielle's statement, the financial accommodation of the Planned Parenthood clinic is placed in immediate comparison with local providers. Danielle also directly refers to the socioeconomic statuses of a large portion of the clinic's patient base, of which roughly 60% are not insured by a health plan. She suggests that Planned Parenthood is their most viable option to obtain reproductive health care. The staff put forth quite an effort in making services affordable for the patients who came in. While in the clinic I observed that the two staff members at the Lexington clinic who were client service specialists spent at least a third of their day conducting household financial assessments with new and returning patients in order to determine the amount they were exempt from paying on the sliding scale. On one occasion, Danielle shepherded a female graduate student from the University of Kentucky who wanted an annual exam and an IUD into one of the smaller exam rooms and spent nearly an hour with her, conducting a rigorous financial assessment in order to work out a payment plan that would work for the student's budget. Sarah and Alex stepped in to work the reception desk so that Danielle could work personally with this new patient. This kind of lengthy interaction supports the staff members' emphasis on the importance of the financial accessibility of

reproductive health services and contextualizes their efforts to make this accessibility a reality for their patients.

The other way Planned Parenthood staff located themselves somewhat in opposition to other health care providers was in reference to the provider-patient relationship. Ruth was very vocal about this point during her interview, and discussed the clinic's rapport with its patients at length:

“People come to Planned Parenthood because they know that we are unbiased and we have information to offer that other doctors don't or on topics that often they may not be comfortable bringing up with their primary care provider, like being screened [for STI's]. We often get clients that say they already have a primary care provider or they have their OBGYN's they go to once a year, but they wanted to come see us this visit because there's a sense of security and they know we won't be judgmental.”

In this statement, Ruth suggests that the information and assurance of anonymity or security patients receive at the clinic sets Planned Parenthood apart from providers who may not offer comprehensive reproductive and sexual health information or with whom patients do not feel they can discuss such topics. Brittany also reflected on the service encounter at Planned Parenthood and the clinic's goals in providing educational information during her interview as we discussed Planned Parenthood's role in the Lexington community. In her opinion:

“We present all options. I mean we really do try to have a dialogue with the patients and try to let them decide what they think is the best route. Depending on your doctor, if you have a doctor that you would go to for a pregnancy test or something, you may or may not get unbiased options depending on if your doctor is pro-choice or anti-choice or what. ... And when people go to the doctor they're bombarded with people talking at them and they get home and it's just a blur and they can't remember what they were told, but we give them literature. I think I mentioned the fact sheets, we seriously have a hundred of them that we give out, so that they can go home afterwards and be like 'Well, I can't really remember what

they said when I was *in* the clinic, but I have all these papers I can look through and get more information.”

Here, Brittany directly compares the service encounter at Planned Parenthood, where patients engage in a “dialogue” with providers and receive educational materials for future reference, to the service encounter at a doctor’s office, where patients may feel more unsure or confused about the information they received. In addition, Brittany points to Planned Parenthood’s efforts to remain “unbiased” and offer a full spectrum of reproductive services as a characteristic that sets the clinic apart from other service providers who may let anti-choice sentiment determine service provision. Though I was not able to observe other health care facilities or the Lexington Planned Parenthood’s interaction with them directly, references like Ruth, Sarah, Danielle, and Brittany’s came up in nearly every interview and in participant observation at the Planned Parenthood clinic. It is clear that these perceived distinctions between Planned Parenthood and other facilities affect the Lexington clinic’s services because based on the staff’s repeated references to them they are keenly aware of a gap that their services are filling and they are working to continue filling it by offering things like the sliding payment scale that affords accessibility to reproductive health care to anyone who needs it, comprehensive and unbiased pregnancy options counseling, and free information in the form of fact sheets and packets that every patient receives during their visit. On a different level, though, these references and comparisons to other health care providers are reflective of the ways in which the Lexington Planned Parenthood staff members construct their understanding of what reproductive health and effective reproductive health care is. Planned Parenthood stands apart and is different because at base it has a slightly different mission. For staff members, reproductive health is achieved through prevention and

education in addition to medicine and should be accessible to all. Rather than simply prescribing birth control or screening for STI's, Planned Parenthood staff see their position in relation to facilities that already provide these services as also creating informed and aware individuals. In this way the staff's perceptions of other local health care providers shape their particular style of reproductive health because it is a response to a perceived void in the reproductive health model these other facilities employ in the services they provide to the community. Planned Parenthood staff members' model of reproductive health is set in comparison and works to fill that void in its Lexington community services.

In all of these ways, with regard to funding, community support, and the clinic's position in comparison to other facilities, factors that are unique to the Lexington context shape what Planned Parenthood of Kentucky's Bluegrass Health Center is, how it looks and operates, in this community. There is a dialectic process between how staff members perceive reproductive health and the way it is achieved or maintained and the realities of operating a clinic in Lexington, KY. In some cases this dialectic reaffirms the staff's mission and supports their model of reproductive health and reproductive health care as in instances where the Lexington community shows that it values Planned Parenthood's services or when staff feel they fill a gap left by other facilities. In other cases, particularly with regard to funding and the situation with the Fayette County school system, the clinic does not have the power to follow their reproductive health model and dispense services as they wish. Instead they must negotiate and mediate the circumstances to best achieve their desired outcomes.

## Chapter 5 Conclusion

Context and culture shape ways of knowing about, incidence of, and experience with health and health issues. It does so through a dialectic negotiation between the individuals or organizations within specific contexts and the social structures, relationships, and philosophies they encounter and interact with in relation to health. Thus, sociocultural processes and interactions work in unison with the biology of the human body to influence individual health and community health services. The case of Planned Parenthood illuminates the sociocultural processes and networks the staff members participate in, including the national federation model of reproductive health, federation guidelines, relationships within the local community, and state funding all shape the meaning of reproductive health and the actual mode of reproductive health care service used at the clinic. The services offered by the Lexington Planned Parenthood (what staff members choose to include or omit) and the manner in which they are delivered are a direct result of these multi-scalar social and organizational interactions, and staff members at this local health center are the nexus of the negotiations between them.

This thesis project has attempted to examine the *how*, or the processes through which individuals or organizations know about reproductive health and manage reproductive health issues. The services offered at the Lexington Planned Parenthood health facility can be readily observed, but understanding *how* they come to look that way and the role context plays may be less obvious. To do so, connections need to be explored between sociocultural interactions or structures that make up the context in which these services are offered to the Lexington community and the clinic's patient base. Planned

Parenthood's brand or manner of service delivery does not exist because it is inherently "right" or even because it is the most effective and efficient way to provide reproductive health care to this community. Instead, it stems from the negotiations and reassessments made in everyday clinic practice and the interaction staff members have with multi-scalar influences, from the national to the local, outside of the clinic setting. This does not mean that Planned Parenthood staff members are doing a poor job or failing to offer care that is relevant to the reproductive health needs of the Lexington community, but it calls attention to the underlying social structures, organizational hierarchies, and outside interests they face.

This thesis contributes to larger anthropological discussions of reproductive health and the ways it is given meaning in two important ways. First, the focus of this thesis has been meaning making around reproductive health at the level of the health service provider. While studying the recipients of healthcare services is important, it is also productive to examine the individuals and organizations that disseminate these services to examine the intersecting social processes affecting the sites where health care is administered. Planned Parenthood staff members occupy the intersection between reproductive health discourse and policies and the individual patients they serve. In this space providers play an important role in shaping health care service delivery because their negotiation of reproductive health care meanings affect what reproductive health care looks like on the ground and what it entails for patients. The staff members' positionality within a Planned Parenthood health center that is part of the Kentucky Planned Parenthood affiliate and their relationships with actors such as other reproductive health service providers and the Fayette County school system that are mediated by this

positionality provide an important lens on what is at stake for providers as reproductive health is conceptualized and defined.

In relation to this positionality, this project also contributes to a broader anthropological understanding of reproductive health meaning-making by using a Planned Parenthood clinic as an ethnographic site to study the production and enactment of reproductive health discourse. Very little anthropological work has been done on Planned Parenthood, but it is a unique space to examine how reproductive health is made meaningful because it embodies not only clinical services, but also education and advocacy in its reproductive health mission. This three-pronged approach shapes providers' understandings of reproductive health in ways that are very different from those of other medical facilities or health care delivery sites. In addition, the history of Planned Parenthood's past and continuing efforts in the struggle for reproductive rights colors staff members' conceptualization of reproductive health and the meaning and action around reproductive bodies. This Planned Parenthood perspective adds an important dimension to the medical anthropological literature on how reproductive health is made meaningful in different contexts and how this process manifests in reproductive health services.

The process of conducting research at Planned Parenthood as a site of reproductive health negotiation has opened several potential lines of inquiry that would be productive to pursue further. First, gaining a more comprehensive perspective on the Lexington community members' views of Planned Parenthood and the role it plays in their personal experiences with reproductive health would add much more depth to an understanding of the negotiation of reproductive health meaning in the patient-provider

relationship. The community interaction with Planned Parenthood as a space for reproductive clinical services, education, and advocacy and the community members' reception to Planned Parenthood reproductive health discourse needs to be explored as an important factor in the network of relationships that contextualizes reproductive health.

Another line of inquiry that would be interesting to follow would be how the current debates around health care and health care reform influence meaning making around reproductive health specifically and impact individual Planned Parenthood clinics over time. This type of follow-up could provide important insights into the shape reproductive health services will take in the future and its effect on reproductive health outcomes.

While this thesis does try to explore how reproductive health is made meaningful in the context of a Planned Parenthood clinic in Lexington, KY there are some aspects that are left unexplained. For instance, this thesis cannot address community perceptions of reproductive health or actual community perceptions of Planned Parenthood. The focus of this thesis was on the ways Planned Parenthood staff members make meaning of reproductive health and shape reproductive health care delivery rather than the Lexington community's negotiation of reproductive health. Also, while this thesis examines the dynamics of meaning-making in one clinic, the specific results can not necessarily be generalized to Planned Parenthood clinics in other contexts. It seems likely that similar processes may be at work when mediating definitions of reproductive health, given the national Planned Parenthood coordinating body and a shared history in the struggle for reproductive rights. However, these processes should be examined specifically in the contexts in which they occur and should not be assumed to fit a fixed model.



Asking what role context and sociocultural process and relationships play in reproductive health service provision and delivery could be important, particularly in attempts to evaluate or improve reproductive health care and reproductive health outcomes. Ways of knowing about reproductive health and the actions organizations like Planned Parenthood take around reproductive health and health services are fluid and influenced by sociocultural factors in the form of interactions with national, state, and local dynamics. By not reducing reproductive health, or health and health related issues in general, to biology or medical examination a more holistic and realistic picture of reproductive health in the United States may emerge.

**Appendix A**  
**Lexington Planned Parenthood Clinic Staff Demographics**

<b>Staff Member</b>	<b>Race</b>	<b>Age</b>	<b>Time Worked at Clinic</b>	<b>Educational Attainment</b>
Alex	White	25	2 years	M.A.
Brittney	White	24	2 years	B.S.
Danielle	African American	25	2 years	B.A.
Jane	White	39	2 years	M.P.H.
Josephine	White	58	3 years	M.S./ RN
Ruth	White	53	13 years	Family Nurse Practitioner
Sarah	White	23	3 months	B.S.

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