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**"A BARRIER WITH ROSES GROWING OUT OF IT": AN INTERROGATION OF
THE RELATIONSHIP BETWEEN A SERVICE-BASED NONPROFIT
ORGANIZATION AND ITS CLIENTS**

by

DEBORAH D. SELNOW-RICHMOND

DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

2016

MAJOR: COMMUNICATION

Approved By:

Advisor

Date

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DEDICATION

For Betty, my partner in crime throughout these graduate pursuits.

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I must begin my acknowledgements by thanking the women who shared their experiences with me for this study. I never expected to be able to gather the richness and detail of these very personal experiences. This study is only as meaningful as the experiences I was able to include, and the candidness and openness of all of the woman who participated in this study made the experience so meaningful. Thank you for sharing all that you did.

By the time you reach the point of pursuing a doctoral degree, you've done a lot of schooling. There's a lot more than school to the doctorate, though, and many more folks have been involved in my successes here than any of my previous accomplishments. I'd first like to recognize those influences from my time at the University of Arkansas Clinton School of Public Service, where I made the decision to continue my education and pursue a doctorate. To my academic dean during those years, Dr. Mike Hemphill, when I came frustrated with my service work asking questions about how things could be more egalitarian, it was Dr. Hemphill who suggested I go on to study those questions for myself. Dr. Christy Standerfer and Dr. Arvind Singhal provided the nudge and understanding I needed to figure out where my doctorate would be housed, and helped me to identify my next academic home. I cannot imagine having pursued a doctorate in communication were it not for the influence of these change makers. Thank you for guiding me here.

I cannot imagine having pursued a doctorate in communication without these folks because I was raised by two strong, successful professors in the discipline. Mom and dad, I still sometimes find myself wondering how I landed where I did after so many years of resistance, but I'm glad things aligned this way. I've had two of the best role models as I've taken on this endeavor, and hope to refine my skills and thinking over time to match yours.

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CHAPTER 1 INTRODUCTION, LITERATURE REVIEW, AND RESEARCH QUESTIONS

Introduction

Women require reproductive healthcare. In optimum circumstances, they should have the agency to decide where, when, to what degree, and from what organization to seek care. When faced with poverty, women experience constraints starting with healthcare access. In the United States, “The relationships between women's poverty, health insurance coverage, and health status imply that those with the greatest health care needs are least likely to have financial access to care” (Braveman, Oliva, Miller, Schaaf, & Reiter, 1988). When healthcare access is constrained for women, they are left with limited choice.

When women make the decision about where to receive care, they enter into a relationship with that organization. The decision and the relationship are both communicatively constructed, either interpersonally with employees of the organization or through greater public relations efforts that engage women who generally need reproductive healthcare. Yet, the extent to which women are voicing their needs, engaging in dialogue and reflexivity, and participating in collaborative decisions and services with the organization as well as helping to define the organization is unclear. Examining women’s experience is the first step in understanding the efficacy and role of organizations developed to meet their needs.

This study aims to understand women’s decisions to visit a specific healthcare site and the relationship they develop with their reproductive healthcare organizations. Focusing on women’s decision to choose a healthcare organization that focuses solely on reproductive healthcare and access to care, regardless of socioeconomic status, emphasizes the unique relationship women, particularly women of marginalized status, have with reproductive care in the United States. Importantly, these experiences provide the means to examine the broader

context of women's reproductive healthcare access among marginalized communities and the role of nonprofit organizations.

Entangled with this phenomenon is the role of nonprofit organizations that exist to fulfill the needs that are otherwise left unmet in society. Nonprofits are the third largest employment sector in the United States (or was in 2010), trailing only behind retail trade and manufacturing (Salamon, Sokolowski, & Geller, 2012 via Sisco, Pressgrove, & Collins, 2013). Moreover, Sisco and colleagues argue that, "The viability of nonprofit organizations hinges on organizational credibility and on successfully engaging with a wide array of constituencies, including contributors, volunteers, staff members, the population being served, the media, and the public at large" (p. 282). This, in fact, mirrors the organizational structure of the private sector, suggesting that nonprofit organizations may not be all that different from their for-profit counterparts. While critiques of nongovernmental organizations (NGOs) argue that civil society agents tend to promote personal and neoliberal agendas (e.g., Dutta, 2008), de Souza (2009) suggests that "civil society organizations such as NGOs are not inherently antithetical to community programs, but only insofar as they silence community voices" (p. 694).

It is important to understand, from the clients' perspectives, the relationship they have with nonprofit organizations. Criticism of NGOs and civil society organizations cannot be ignored. Dutta-Bergman (2005) argues that "in civil societies it is fundamentally the capital that drives social organizations such as welfare agencies, NGOs, hospitals, and churches" and moreover that "It is only by participating in the generation of greater capital for the United States that NGOs generate the capital for their survival" (p. 279). Of interest, then, is whether women perceive these clinics as traditional, capitalist organizations, or if, by contrast, they feel they

enter into a relationship based on shared ideals and goals, wherein their voice is effectively incorporated and understood.

Planned Parenthood a nonprofit, offers a point of entry to understand the position of socioeconomically disadvantaged women and their relationship with an organization dedicated to their reproductive health. Dutta-Bergman (2005) notes that nonprofit organizations must engage with a number of groups and organizations beyond the population they seek to serve. These organizations must focus on funding through private donors and government agencies in order to sustain the delivery of their services while also responding to external threats (e.g., religious and/or activist groups in disagreement with the organization's mission). As such, the relationship that socioeconomically marginalized women have with their reproductive healthcare center deserves interrogation.

This study inquires about the role of clients in assessing the ability of a nonprofit organization to meet their articulated needs, emphasizing the need for marginalized clients to maintain agency in the nonprofit organizational relationship. This chapter begins with a history of Planned Parenthood. Next, it provides a review of literature on nonprofit organizations and women's healthcare access. Then, the theoretical grounding used in conceptualizing the study, stakeholder theory and the culture-centered approach, are discussed. Finally, the research questions guiding this investigation are proffered.

A History of Planned Parenthood and Reproductive Health/care in the United States

Since its inception as the Birth Control League, the Planned Parenthood organization has faced political resistance and attack. The movement for birth control began in the mid 19th century with the slogan "voluntary motherhood." Margret Sanger created the Birth Control League in 1916 amid a climate of hostility toward women's reproductive choice and family

planning. Birth control was heavily restricted at the time under the Comstock Law of 1873, which made contraception illegal (Primrose, 2012). The American Medical Association's stance toward birth control and abortion was a large contributing factor in these restrictions, grounding objections to abortion in the role termination of a pregnancy would play in a woman's ability to fulfill her marriage contract. Though not socially acceptable, women did use birth control and abortion during this time, and infanticide was fairly common.

Though statistics on abortion use are unavailable for that time, the *New York Times* published an article in 1871 suggesting that there were at least 200 full-time abortion providers in New York City alone. The passage of the Comstock Law in 1873 criminalized mailing contraceptives or information about them, including how to find them. It banned birth control and related information on the grounds that these materials were obscene. One result of the law is illustrated in a 1917 survey of immigrants in Manhattan's Lower East Side, which revealed that a third of respondents were naïve to any birth control methods besides abortion. A subsequent Stanford University study conducted in 1921 indicated that one in every 1.7 to 2.3 pregnancies was terminated (Primrose, 2012).

Sanger championed the modern birth control movement beginning in 1915, having worked as a nurse in Manhattan's Lower East Side with immigrant families, noting class injustice that affected lower income women both because of a lack of preventive care options and an inability to afford abortion services, and making them more likely to use riskier at-home options. Making it her mission to help women access contraceptives, Sanger began her own newspaper, "the Woman Rebel," in 1914, where she openly discussed contraception. She was arrested under the Comstock Law for mailing obscenity. She fled to England before being prosecuted, during which time Anthony Comstock (the Comstock Law's namesake) died,

prompting Sanger's return to the United States where the charges against her and the newspaper were dropped. Witnessing birth control clinics in Europe, she returned to the United States with the intent to go beyond print in the fight for women's birth control. She opened the first contraceptive clinic in the United States in Brooklyn in 1916, though it was shut down after ten days. Sanger and her two partners in the clinic were arrested for providing contraceptive information to women. In 1936, the Comstock Law was relaxed under the ruling that the birth control was no longer obscene. By 1937, the American Medical Association recognized birth control as a fundamental part of medical care.

By the end of World War II, there were around 800 birth control clinics in the United States. In 1942, the American Birth Control League changed its name to Planned Parenthood. Sanger opposed the name change and ideology, which shifted the focus from women's liberation to family planning. This shift made the organization appear more socially acceptable and less gender-focused. Three years prior, men dominated leadership roles within the organization for the first time (McCann, 1998). By 1942, many of the longtime women working for the American Birth Control League had resigned their positions with dissatisfaction for the shift toward masculine leadership. The shift in leadership and name change decreased the commitment to women's reproductive self-determination as well as activities in the African American community.

The Federal Drug Administration approved the first birth control pill in 1960, though 28 states still prevented married couples from using contraception at the time (Primrose, 2012). The birth control pill gained popularity as legal restrictions on contraceptives loosened, though abortion remained illegal, disproportionately affecting low-income women. The National Organization for Women (NOW) was founded in 1966 to advocate for opportunities for women

outside the home and to challenge gendered images of men and women, and in 1967, NOW drafted a resolution calling for the repeal of criminal prohibitions on abortion. The organization eventually partnered with Planned Parenthood to institute a new campaign for women's reproductive rights.

In 1965, the Supreme Court ruled on *Griswold v. Connecticut*, recognizing a married couple's right to make contraception decisions. During the mid-1960s, President Johnson advocated for federal legislation supporting contraceptives for the poor, an effort that continued into the Nixon administration and the onset of Title X of the Public Health Services Act, authorizing grants to establish voluntary family planning projects. In 1973, the Supreme Court issued their decision on *Roe v. Wade*, providing women with the right to choose to terminate a pregnancy legally under the right to privacy (Primrose, 2012). The legalization of birth control and abortion revitalized Planned Parenthood in the 1970s, with women's perspectives central to organizational decision-making (McCann, 1998).

Planned Parenthood of Southeastern Pennsylvania v. Casey was brought to the Supreme Court questioning a state's rights to impose provisions on a woman's right to choose to terminate a pregnancy. It was decided in 1992 and reaffirmed a right to abortion. The ruling noted the affect that the right to reproductive freedom had on women's ability to participate equally in economic and social life (Primrose, 2012). In 2003, Congress passed the Partial-Birth Abortion Ban Act of 2003, which criminalized knowingly performing a partial-birth abortion (Lockett, 2008). In 2007, the Supreme Court decided two consolidated cases, *Gonzales v. Carhart* and *Gonzalez v. Planned Parenthood Federation of America*, which challenged the validity of the Partial Birth Abortion Ban Act. The Court upheld the constitutionality of the act.

Recent attacks on women's health in the 21st century have fostered a new generation of women's rights activists and increased investment in Planned Parenthood (Laguens, 2013). A bill introduced in the House of Representatives in 2011 was written to entirely defund Planned Parenthood and cut Title X. The bill passed in the House of Representatives, but was defeated on the Senate floor (Primrose, 2012). Family values-oriented campaigns have expanded their attack on abortion to contraceptive choice more broadly. Primrose (2012) notes that the pro-life and pro-choice camps were in general agreement on the benefit of preventing unwanted pregnancy through contraceptives until recently, with contraceptives having been understood to prevent the need for abortion. This marks a shift from an education- and contraception-based approach to sex to an abstinence- and chastity-based approach that keeps sex within the confines of marriage.

In September of 2011, The House Energy and Commerce Committee began an investigation of Planned Parenthood requesting audits of the organization, abortion-funding records, and reports on the organization's sexual abuse policy. The investigation was grounded in the \$363 million in taxpayer funding they receive annually. The committee noted concerns over Planned Parenthood's abortion funding practices. The organization is barred from using federal funding to support abortion services. However, opposition was grounded in the argument that an organization that provides abortions in any way, even if federal funding does not finance that procedure, effectively underwrites it. Additional concerns questioned Planned Parenthood's obedience of state sexual assault and child abuse reporting laws. Another bill was proposed to forbid any federal spending for Title X of the Public Health Services Act (the government's primary family planning program). The bill prohibited any funding to Planned Parenthood until they cease to provide abortion services, despite the legality of abortion services in the United States. As Primrose (2012) notes, "The majority of Planned Parenthood's centers are supported

by Title X grants meant to assist low-income women” (p. 200). In addition to federal-level efforts, individual states have also attempted to defund Planned Parenthood.

Laguens (2013) notes that young adults no longer identify as “pro-choice” or “pro-life” yet a 2012 poll found that two-thirds of Americans supported *Roe v. Wade*; 41-54 percent of respondents identified as pro-choice, and 38-50 percent as pro-life. She argues that the framing is divisive, but

We know that most people agree that abortion must remain safe and legal, that women must have access to birth control, and that politicians should stay out of personal healthcare decisions. It’s more important than ever that we maintain and intensify this support, not least because attacks on women’s health are more ferocious than ever, and we know that opponents of safe, legal abortion won’t let public opinion get in the way of their agenda (pp. 189-190).

The conversation, she argues, needs to embrace empathy and resist the divisive pro- and anti-camps.

To date, over five million people access healthcare education through Planned Parenthood; the organization now runs about eight hundred health care centers, and has a presence in all fifty states (Primrose, 2012). The organization offers a variety of women’s health services, including pap smears, cervical cancer screenings, breast exams, a range of contraceptives, testing for sexually transmitted diseases and pregnancy, along with abortion services at some centers. Founded to provide women with reproductive autonomy, the organization currently asserts, “For nearly 100 years, Planned Parenthood has promoted a commonsense approach to women’s health and well-being, based on respect for each individual’s right to make informed, independent decisions about health, sex, and family planning (Planned Parenthood, 2016). Planned Parenthood provides services largely to women experiencing financial constraints, with three-quarters of centers servicing individuals with incomes at 150 percent of the poverty line. While middle and upper class women also require

contraception, they are typically able to access services more easily than lower income women. This illustrates Planned Parenthood's efforts to provide women's healthcare access to socioeconomically marginalized women. Moreover, Primrose (2012) notes that three-quarters of American women who terminate a pregnancy do so because they cannot afford to raise a child, further illustrating the economic disparities present in women's access to reliable contraception and reproductive healthcare.

Statistics show that Planned Parenthood prevents 579,000 unintended pregnancies, and provides more than 270,000 pap tests, 360,000 breast exams, and 4.2 million tests and treatments for sexually transmitted infections, including more than 650,000 HIV tests a year (Planned Parenthood, 2016). Providing women's reproductive health services to low-income women remains a primary part of the Planned Parenthood mission a century after the inception of the American Birth Control League. Though Planned Parenthood faces continued threats to their funding, their size and scope are markers of the success the nonprofit organization has had. Next, a review of literature on the nature and role of the nonprofit organization, a legal identity that includes Planned Parenthood, is provided.

The Role of Nonprofit Organizations

The third sector, nonprofit sector, or civil society has been recognized as an important area of scholarly inquiry, and thus received the attention of academics over recent decades (e.g., Bush, 1992; Salamon & Anheier, 1997; Dees & Anderson, 2003; Sanders, 2012). According to the Urban Institute's publication of *The Nonprofit Sector in Brief 2015*, the nonprofit sector has seen a 2.8 percent increase since 2003 and contributed approximately \$905.9 billion to the US economy in 2013, which equaled 5.4 percent of the country's gross domestic product. Additionally, over a quarter of adults in the United States volunteered with such an organization

in 2014 (McKeever, 2015). With growth and impact, this sector has become increasingly powerful. Salamon and Anheier (1997) note that:

despite the rise of the modern welfare state, the civil society turns out to be a major social and economic force. It accounts for a far larger share of national employment and recent employment growth than is widely assumed, and has become a pervasive mechanism through which individuals and societies pursue a wide assortment of public and private purposes (p. 61).

Because of the significant impact the nonprofit sector has in the economic and political arenas, it deserves scholarly attention. The communication discipline has recently begun to focus on this sector and the centrality of communication within nonprofit organizations to the activities in which they engage as well as their impacts on the broader economic and political spheres.

Communication Scholarship and Nonprofit Organizations

While the scholarship devoted to nonprofit organizations across disciplines has provided tremendous insights into the unique tensions philanthropic and socially progressive work pose, Koschmann, Isbell and Sanders (2015) argue, “Communication is central to nonprofit organizations and the activities of the nonprofit sector. Fundraising and donor relations, client relationships and service delivery, volunteer management and board governance, collaboration and cross-sector partnerships—all involve dynamic processes of human interaction” (p. 201). Nonprofit organizations function and sustain their existence through communicative processes—internally and with their publics; as such, communication scholars ought to begin/increase engaged scholarship to push the nonprofit agenda by helping to convene the nonprofit community to share ideas, resources, and lessons learned, to identify those nonprofit organizations that are succeeding and document their best practices, and to stimulate thought and research about what these organizations could be (Lewis, 2012).

As of 2015, Koschmann et al. found only fifty communication articles devoted strictly to the study of nonprofit organizations. Though other communication scholarship may have incorporated nonprofit organizations, they were not the specific focus of inquiry. Of course, substantial research from other disciplines highlighted the role of communication within nonprofits when evaluating them from alternative perspectives. Koschmann and colleagues found that this existing communication scholarship focused on seven overarching themes: membership, structure, legitimacy, differentiation, stakeholders, communication strategies, and linkages. However, they contend that the majority of nonprofit theorizing takes an economic perspective to explain how and why nonprofit organizations function in the market economy. This perspective is valuable and necessary, but “assuming the primacy of the market economy to develop theoretical explanations has notable limitations” (p. 211).

Taking a communication perspective to nonprofits allows scholars to think about these organizations with a more nuanced typology in mind. Expanding communication scholarship into these organizations “will not only allow us to more fully describe the field of organizational types (corporate, government, nonprofit) and their communicative characteristics and dynamics but also will provide a wealth of opportunities to validate and/or question our current theoretical assumptions that have largely been based on the empirical picture presented in corporate organizations” (Lewis, 2012, p. 262). Whereas the economic perspective provides valuable insights into the existence of nonprofit organizations, privileging the financial and economic status of organizations over other aspects can lead scholars to miss understandings of the lived experiences of people involved and a nuanced, constitutive understanding of the organization (Koschmann et al., 2015, p. 215). In fact, Koschmann and colleagues argue:

few people experience nonprofit organizations as financial entities, and the most fundamental aspects of the nonprofit sector cannot be reduced to legal abstractions. For

most people what constitutes their experience of a nonprofit organization is fundamentally social, relational, interactive, and meaningful—in short communicative (p. 214).

A communication approach to nonprofits could offer just that—an emphasis on lived experience within these organizations. Koschmann (2012) argues that this approach “should therefore lead us to think about nonprofits in more *phenomenological* ways that understand nonprofits based on the *lived experiences* [emphasis original] of relevant stakeholders, not just the status of nonprofits as legal or financial entities” (p. 141). This approach allows us to consider the life-worlds of nonprofit organizations as they are comprised of the lived space, body, and human relationships, and temporality.

The role of nonprofit organizations extends beyond the organization and its immediate work, as they also exist to impact social systems and public policy. When larger nonprofits become more dependent on government funding, threats to that funding ultimately threaten the existence of the organization. When the Istook amendment was proposed in the mid-1990s to restrict lobbying efforts by nonprofit organizations, Cox and McCloskey (1996) proclaimed the need for communication scholars to remain conscious of the impact of such efforts and our role in critically investigating the impact these proposals could have on public debate and first amendment rights.

Communication scholars ought to examine “the ‘structural repressions’ that the statutory restrictions of advocacy suggest for the discursive performance of nonprofit groups in their missions” (Cox & McCloskey, 1996, p. 287). Because advocacy is central to the work of nonprofit organizations, and is fundamentally a communicative practice, communication scholars interested in public discourse and representation ought to pay attention to and critically engage these discourses. They argue that “Without the right of unfettered expression by those

sources that often are the best able to speak for vulnerable populations, we risk becoming a society that fears what may be different, unpopular, or threatening to powerful interests” (p. 288). Efforts to silence any group derails the possibility of a democratic society, and therefore the responsibility extends beyond applied communication scholars to the collective social interest to nurture debate and diversity of voices, as well as the representation of underrepresented interests in public spaces.

This emphasis on the impact of nonprofit organizations on greater society and policy highlights the interconnectedness of nonprofits and government, which has become “increasingly intertwined in the last 35 [*sic*] years due to direct government funding and new government regulations as well as the increase in overall government policy activity” (Smith, 2003, p. 36). While government has a direct effect on nonprofit behavior, for example the ways in which nonprofit staffs choose priorities in part based on the actions of government, nonprofits also influence government policy as they mobilize citizen participation and engagement to influence policy. The widespread presence of these organizations suggests that developing relationships that are mutually beneficial between the nonprofit sector and the state, as well as with the business community, ought to be considered one of the highest priorities for the promotion of democracy and economic growth not only in the United States but throughout the world (Salamon & Anheier, 1997). Communication scholarship should contribute to the body of knowledge about nonprofit organizations as they are inherently communicative in nature, but also intertwined with the public and private sectors, advocating for underrepresented causes through communicative practice, ultimately influencing social structures and the lived experiences of individuals on a daily basis.

Principles of For-Profit versus Nonprofit Organizations

Arguably, a majority of research on nonprofit organizations to date focuses on the tensions or benefits of comparing nonprofit organizations to for-profit sector organizations. Organizations benefit from developing some strategy, and the most fully developed of these strategy models come from the for-profit sector, focusing on markets, customers, and competition (Moore, 2000). Because substantial research exists in this arena, it makes sense that scholarship would borrow these findings and apply them to the nonprofit sector. However, Moore (2000) notes some glaring omissions in this transfer. First, the value that nonprofit organizations produce lies in the achievement of social purposes as opposed to the generation of financial revenues, as in the for-profit sector. Second, nonprofit organizations receive financial revenues from sources outside of customer purchases (e.g., government and private grants; private donors). When nonprofit organizations become entangled with the for-profit sector, Young (2002) identifies several negative repercussions:

First, nonprofits face strong market pressures to engage with business for financial reasons. Second nonprofit leaders are tempted to cultivate business leaders by inviting them onto their boards, thus reinforcing the nonprofits' business orientations and possibly compromising their very accountability structures. Third, nonprofit leaders have few strong counterbalancing influences: They must rely on strong, internalized values and understanding of the mission to keep an appropriate path. Sometimes nonprofit leaders are not up to the task and may become even less so over time if the influence of business continues to grow (p. 8).

Nonprofits organize and exist around a social vision, which, when entangled with business enterprises, runs the risk of becoming secondary to the economic aspects of viability.

The economic theory of the nonprofit defines the nonprofit as a substitute for the demand for certain goods left unattainable within the public or private sectors. This perspective shifts attention from the policy needs informed by the nonprofit sector. Bush (1992) warned that

What is particularly disturbing is the extent to which the use of economic models to define the nonprofit world appears to be leading increasingly to the belief that the only valid principles for organizing and running the individual nonprofit agency are to be found in the transfer of profit strategies into the nonprofit sector (p. 399).

Bush (1992) adds to the list of concerns regarding the comparison of nonprofit organizations to a business environment that businesses seldom engage in information sharing about the organization's client and resource base. However, in nonprofit organizations, this resource sharing is vital to the work of the sector as a whole. He argued, "we must never lose sight of the fact that it is by working together that we can best construct a human service system in which the safety nets work and in which the multiple, complex human needs common in our society can be addressed with effectiveness, compassion and caring" (p. 408). Moreover, nonprofits may continue to be preferred over for-profits in this regard because of their access to private donations based on the perception that they are more trustworthy entities than their for-profit counterparts (James, 2003).

Concern exists in regard to Dees and Anderson's (2003) statement that the inclusion of for-profit players in the nonprofit realm could only be perceived negatively if the standards for service quality were significantly diminished. For example, Wirgau, Farley, and Jenson (2010) examined the business discourse surrounding the (PRODUCT) RED campaign. (PRODUCT) RED is a licensed brand that engages the for-profit sector in raising awareness and funds to eliminate HIV/AIDS in Africa. A number of for-profit companies partnered with the brand, including Starbucks, Nike, Gap, Hallmark, Apple, and Coca-Cola. Wirgau et al. argued that the campaign "illegitimately argues that benevolence is linked to consumption and erases the object of the campaign's charitable efforts, the African citizen, in favor of a discourse solely focused on the consumer" (p. 614). When the focus of social work shifts from being service-oriented to consumer-oriented, it impacts execution. This shift "misses the opportunity to promote civic

engagement with its audience but actively discourages that engagement in favor of strategies that lessen transparency and give corporations the power to decide which causes should be supported and to what degree” (p. 614). In this model, the campaign asks individuals to “fight AIDS in Africa through consumption alone, further divorcing itself from the notion of philanthropy as a means of societal transformation” (p. 627).

Nonprofits operate within a uniquely complex set of conditions as they work to secure financial resources in order to fulfill their social missions. Along with the growth of the nonprofit sector worldwide, the ability to finance collective goods has become increasingly difficult and competitive. In order to compete for resources to address pressing social issues, nonprofits are expected to be more business-like in their management of financial resources. When nonprofits do attempt to become more businesslike, oftentimes they lack the education and training across the staff to do so (Beck, Lengnick-Hall, & Lengnick-Hall, 2008). Worse, “business tools taken out of context have the potential to create dysfunctional momentum” (p. 166). Because nonprofits are cause- or issue-based, a cohesive organizational identity is less effective in building common ground among staff than in big businesses, because employees of these organizations tend already to be unified around the issue that is central to the work they do.

A primary reason for nonprofit organizations to be reluctant, or at least cautious, about adopting business strategies is reiterated by the incompatibility of values orientations—the altruistic nonprofit versus the competition-centered for-profit. As nonprofits function within a market economy, “the mission-market tension is a generative phenomenon in which contradictory elements are understood as interdependent” (Sanders, 2015). However, the emphasis that nonprofits need to become more businesslike in order to remain viable while pursuing their social mission can be considered a tension to be negotiated rather than a problem

to be resolved (Sanders & McClellan, 2013). This negotiation occurs through communication practices and locally shared meanings used to address those demands.

Communication is central to how nonprofit organizations understand the mission-market tension, as well as how these understandings influence day-to-day work. Sanders (2015) found that everyday communication among staff of a nonprofit embraced the tension as a normal part of the organization. Employees “explicitly framed the mission-market tension as inherent and productive and did not try to resolve it or frame one concern as more important than the other (p. 218). While tensions are inherent when the for-profit and nonprofit sectors are compared and business logics are transposed onto the service work of nonprofit organizations, recognizing these tensions and reiterating the centrality of service, not profit, to the nonprofit sector communicatively shifts these logics and has the potential to mediate some of the dysfunction that results with the ill-fitting business lexicon.

Of course, tensions exist in all forms of organizing. Sanders (2012) argues that “the nonprofit sector is guided by an *organizing tension* [emphasis original] that is an ontological feature of all organizations that are dedicated to fulfilling social missions and building civil society within market economies” (p. 183). In fact, “nonprofit organizations cannot function outside of the realities of the market economies in which they pursue their work” and must therefore organize their work around competing concerns (p. 181). For scholars, Sanders (2012) argues “organizational communication practices should engage this tension as productive and constitutive rather than destructive or disabling” (p. 183). Tensions between the for-profit and nonprofit sectors exist and ought to be acknowledged through scholarship and practice. However, while the nonprofit sector should be considered uniquely from for-profit entities, the tensions that exist are inherent as the two sectors coexist within the broader market economy.

Nonprofit organizations should be theorized as a unique organization type, while acknowledging the interconnectedness with the for-profit (and government) sector(s).

The Nonprofit Mission Statement

One defining feature of nonprofit organizations is the centrality of the mission and mission statement to the work these organizations conduct. The mission statement has become increasingly popular in corporate communication as well, serving as “the corporate version of an ego ideal, a standard by which the corporation is supposed to measure itself and emulate, and whose demand for perfection it should strive to fulfill (Fairhurst, Jordan, & Neuwirth, 1997, p. 243). According to Brown and Yoshioka (2003), the mission statement serves a number of purposes: it “identifies operational objectives, gives staff goals to direct its behavior, describes performance standards, and speaks to organizational survival and vision for the future” (p. 6). The mission statement also gives nonprofit organizations criteria upon which to evaluate their success.

Nonprofit organizations must go beyond bottom-line measures of financial accomplishments in determining their success. While it is important that the organization is financially sound, donors, funders, and volunteers also need to see that the nonprofit is effectively providing value to the community, meeting client needs, maintaining their values and image, and successfully solving social problems, however gradually (Lewis, 2012). Beyond these concerns, Lewis (2012) contends that, “The public seems to expect that such organizations will and should accomplish their missions without spending much on themselves” (p. 252). The mission statement also impacts internal audiences (e.g., employees; staff; volunteers). Brown and Yoshioka (2003) found that nonprofit employees expressed positive attitudes toward the organization’s mission, which related to employee satisfaction and their intent to stay with the

organization. However, dissatisfaction with pay tended to override mission attachment, which led to their departure from the nonprofit. The mission statement can serve to attract employees, though financial concerns are more powerful, and the mission statement itself is much less successful in retaining them.

The mission statement allows the nonprofit to communicate identity and tangible success to both external and internal audiences. Externally, the mission statement serves as the primary means through which the organization communicates its identity and purpose to the public. Under-communicating the mission statement can limit the opportunities the organization has to “communicate with itself about who it wants to be” (Fairhurst, Jordan, & Neuwirth, 1997, p. 245). This limits the ability of the nonprofit to use the mission statement to withstand negative remarks in a tumultuous environment, which can result in organizational crisis. This can be exacerbated when the mission statement is under-communicated, allowing others to reinterpret the mission in terms that are inconsistent or antithetical to the organization’s purpose and values. An unclear mission statement is also among the identified sources of mission drift (Jones, 2007).

Internally, the mission statement helps to provide goals and direction for nonprofit staff. Brown and Yoshioka (2003) identified three principles that influence employee attitudes toward the mission. First, the mission must be clear and salient in employees’ minds. Second, employees must agree with the values expressed by the organization. This is particularly important because nonprofit employees typically work for lower compensation than they would in the for-profit sector, so identification with nonprofit values and purpose is an important recruitment and retention concern. Third, employees need to be able to identify a connection between the work they are hired to do and the fulfillment of the organization’s mission. If the mission is under-

communicated, employees are also left unclear on the mission's boundaries (Fairhurst, Jordan & Neuwirth, 1997).

Organization leadership is important in managing the meaning of a mission. The clarity of this communication is just as, if not more, important as the active communication of the mission statement. Fairhurst, Jordan and Neuwirth (1997) found that those in leadership actively manage the meaning of a mission, but that often "they communicate missions, visions, and values in clinically framed terms, marginalizing others' concerns over relevance or importance" (p. 245). Trust in the management that interprets the mission for the organization is important for the meaning of the mission statement to be effectively and consistently communicated. When organizations become large, the upper management typically tasked with mission interpretation and communication can become a faceless entity, making this trust more difficult to achieve. The cohesive communication of the mission statement impacts the satisfaction of employees, the ability for the organization to effectively work toward consistent goals, and provides a tool for measuring the success of the organization in meeting their values and purpose goals to external publics.

Public Interest and Social Impact

As noted above, nonprofit organizations work toward social missions, but simultaneously advocate for causes within the political sphere. The work these organizations undertake is then highly public, which contributes to the necessity of a clearly defined mission statement. Nonprofit organizations work as advocacy organizations, which involves pleading for causes and lobbying government to influence votes in favor of policy change that supports the nonprofit's stance on the issue (Jenkins, 2006). Many nonprofit organizations rely on financial support from various levels of government, corporate donations, and foundations. However, a common public

misconception is that these organizations run on donations and volunteer hours, with little need to fund themselves. Of course, not all nonprofit organizations use volunteers, and few are able to rely solely on volunteer hours (Carson, 2002).

Because employees of nonprofit organizations are invested in the mission and work of the organization, and therefore the clients they serve, they often exceed the expectations of the work, increasing their emotional labor (Eschenfelder, 2012). Nonprofit organizations tend to work with underserved populations, providing resources and services not attainable to them through traditional outlets. “It is this *service* [emphasis original] requirement that makes emotional labor so prevalent in nonprofit organizations” (p. 175).

When it comes to measures of effectiveness in nonprofit organizations, it is always a matter of comparison—either to the same organization at earlier times, similar organizations, or to an implicit or explicit ideal (Herman & Renz, 2008; Sowa, Selden & Sandfort, 2004). The need or desire to study effectiveness in nonprofit organizations resonates with academics. For example, Sowa, Selden, and Sandfort (2004) constructed a model to measure nonprofit organizational effectiveness empirically. Central to understanding nonprofit organizational identity is the recognition that organizational effectiveness is multidimensional, making models that measure or emphasize a single criterion poor assessment tools (Herman & Renz, 2008). For example, measuring the impact of the board of directors in terms of effectiveness provides valuable insights, but tends to negate areas such as volunteer training and/or retention, or consistency of donor support. Moreover, the level of importance placed on assessments tools like program outcomes reports is socially constructed. Depending on the stakeholder group, some will find one assessment measure more important than another, and currently there is no commonly accepted basis for determining nonprofit effectiveness.

Among suggested criteria for assessing the effectiveness of nonprofit organizations are the impact and efficiency of the board of directors, responsiveness to resolving differing judgments of various stakeholder groups (Herman & Renz, 2008), management effectiveness, and program effectiveness (Sowa, Selden & Sandfort, 2004). Herman and Renz (2008) argue that a universally accepted and applicable set of best practices for nonprofit organizations is unlikely, and prefer the term promising practices “to refer to practices that nonprofit leaders should examine because there is promising evidence of potential value” (p. 405). Arguably, these organizations must also consider the effectiveness of their public relations messaging. As discussed above, a cohesively articulated mission statement is important to nonprofit organizations’ credibility and internal effectiveness. Because the public has set expectations for the nonprofit sector that do not necessarily account for the program assessment measures these organizations undertake, internal organizational assessment must be communicated effectively to reach a broader audience. Nonprofit organizations must have well-developed public relations practice and staff dedicated to this (Dyer, Buell, Harrison & Weber, 2002). Nonprofit organizations engage numerous organizational parties and stakeholder groups in affecting their mission. Their communication strategies must be well developed, and measures of effectiveness must go beyond the internal work of the organization and extend to the external stakeholder groups that also affect and are affected by the work the organization undertakes.

In line with evaluations of effectiveness, nonprofit organizations are often held accountable for their work by a number of parties including the community, stakeholders, donors, government, and of course the people they serve (Young, 2002; Ospina, Diaz, & O’Sullivan, 2002). Nonprofit organizations “are dependent on markets to sell services; on donors to provide gifts and grants; and on government for contract revenues, tax benefits, and legal

oversight” (Young, 2002, p. 4). These organizations are also responsible to those they serve, who “come closest to personifying the mission” (p. 4), but those interests are not necessarily in line with those who fund or govern the nonprofit. In addition to these groups, nonprofits are held accountable for upholding the norms and values of their staff and volunteers, those who constitute their workforce. From a management perspective, managers of identity-based nonprofits experience and achieve negotiated accountability, which requires communication with the organization’s primary constituency to drive priorities and help managers to negotiate needs among others stakeholders to whom they are also accountable (Ospina, Diaz, & O’Sullivan, 2002). In order to balance their accountability across parties, nonprofits must ensure that appointed board members understand the mission of the organization, promote transparency, include employees in decision making processes, and develop guidelines for accountability, particularly as they negotiate the world of business-nonprofit relations (Young, 2002).

Nonprofit organizations work with multiple stakeholder groups, including clients/consumers, paid staff, and volunteers. These groups may experience the organization differently from one another. Stakeholders of nonprofit organizations may have greater importance than stakeholders of private enterprises as they work to achieve specific social goals (Knox & Gruar, 2007). Nonprofit organizations working with marginalized groups have the opportunity to empower clients. These organizations also have the opportunity to empower volunteers and staff. Ashcraft and Kedrowicz (2002) suggest that empowerment within organizational structures differs among internal stakeholder groups. Social support among peers may be as (or more) important as enabling individuals to fully participate and in the organizational structure and activities for volunteers in the organization, and a more important factor in maintaining the relationship.

Because nonprofit organizations do negotiate a wide array of stakeholder interests, public relations efforts deserve focus. One unclear area of nonprofit employee responsibilities is the role of fundraising. Kelly (1993) argued that, in the arena of fundraising, public relations professionals face encroachment, when professionals from outside public relations are tasked with managing the public relations function. She argued that, “The role enacted determines whether public relations is regarded as a primary or secondary function in the organization” and that “Encroachment occurs when the function is perceived as secondary and when organizational turbulence and marketing imperialism are present” (p. 351). When encroachment of the public relations practitioner’s role occurs, the value of that role within the organization is diminished and is displaced by the functional goals of management. This can contribute to greater concerns, as “Other organizational goals and the critical publics related to them are ignored and the organization becomes vulnerable to crises involving those publics and eventual loss of autonomy” (p. 363).

Often, due to structural inequalities, many groups are unable to represent themselves in the public sphere. This serves as a basis for nongovernmental organizations to step in and play the role of publicizing social problems and conceptualizing and advocating for their solutions. However, “The images and discourses produced by advocacy NGOs have significant impacts on the communities who are the targets of their aid; images of people and their needs attract and propel funding and make political interventions more or less likely” (Dempsey, 2009, p. 328). These images and discourses are often not initiated or managed by the local interest, but are generated by external groups situated outside the culture of the represented group. In the transnational context, these “NGO representations are a product of communicative labor, a term describing forms of work primarily oriented around representing and speaking on behalf of

marginalized groups” and which is “structured by the historical and geographical advantages of imperialism, colonialism, and capitalism” (p. 328). However, when these constructions are taken as direct reflections of local groups, the problematic nature of their formation are obscured. While nongovernmental organizations are values-based and work to address important social problems, providing much needed aid across the globe, they are incredibly powerful economic and communicative actors. Rarely has the personnel whose work it is to speak and advocate on behalf of the marginalized group been elected from within this group to represent their interests. Through the process of attempting to improve circumstances for a marginalized group, NGOs may reinforce Western forms of knowledge and prevent these groups from being able to eventual speak on their own behalf.

Trethewey (1997) studied a human service organization, arguing that these organizations serve marginalized clients, and that these marginalized voices often challenge dominant organizational discourses through moments of resistance. Clients of human service organizations demonstrate resistance in a number of ways. For example, they “may accommodate their social workers’ demands and willingly submit themselves to a variety of objectifying practices to secure vital resources and/or services which they later share with undeserving others or use in ways that are not sanctioned by the organization” (p. 284). These clients may also work to politicize their needs by speaking publicly about them and communicating resistance by redefining their own needs in order resist to the bureaucratically imposed definitions of their needs. Within these organizations, clients may also pick and choose services to further challenge the bureaucratic definitions of their needs, which inherently omits their own agency. These forms of resistance “empower women and set the stage for empowering the larger community of

clients” (p. 296). The next section looks more deeply at women’s healthcare, and ways in which gender and access to care impact their approach to the healthcare system.

Women’s Healthcare Access

Healthcare access is generally constrained among underrepresented groups. Women make up one such group in the healthcare system, and when examined further based on racial and socioeconomic status, these disparities grow wider (Bird & Rieker, 2008). The gendered nature of the healthcare system contributes to the ways in which women experience health disparities in the United States medical system. Health disparities research further illuminates the ways in which traditionally marginalized groups face increased health inequity. Policy initiatives, nonprofit organizations, and academic scholarship all work from different angles to address health disparities and those that affect women specifically.

Gendered Bodies, Gendered Healthcare

Gender is ultimately a socially constructed system that is reinforced through interactions with existing social constructs and restraints. Lorber and Moore (2011) offer a comprehensive definition of gender as:

Legal status as a woman or man, usually based on sex assigned at birth, but may be legally changed. Gender status produced patterns of social expectations for bodies, behavior, emotions, family and work roles. Gendered expectations can change over time both on individual and social levels. There is an assumed congruence between sex and gender although the actual biological evidence of sex is often limited. Rather, we assume that when we know someone’s gender (their embodied behavior and presentation), we also know their sex (their physiological and biological status) (p. 5).

This is a useful starting point for discussing the sociocultural construction of gender, particularly in regard to women’s health. To begin, it is useful to discuss the ways in which the body is constructed differently across genders.

Lorber and Moore (2011) argue that women's bodies are culturally defined. This contributes to efforts or desires of women to assert power by defining their own body. The ideal beauty has become increasingly narrow, contributing to the increased medicalization of appearance. What began as an effort to "pass" among Whites for devalued ethnic groups has evolved into a social norm. However, the target for cosmetic alterations by women has expanded to counter the natural effects of aging (e.g., face lifts to eliminate wrinkles) or childbirth (e.g., liposuction or the removal of stretch marks developed during pregnancy) (Pitts-Taylor, 2011).

Similarly, the social construction of feminine beauty emphasizes the desirability of slim bodies, which can result in disordered eating. Connell (2012) points out that the *DSM-IV* entry on anorexia nervosa describes the eating disorder, leaving mention of the statistics of sufferers (90% of those affected are women, and it overwhelmingly begins in adolescence) until the end of the entry. Connell argues that "This is an age when a particular form of social embodiment, heterosexual attractiveness, is a vital issue for most young women in metropolitan society" and "makes women more dependent on their desirability to men than men are dependent on their desirability to women" (p. 1678). Lorber and Moore (2011) discuss ways in which efforts to control body size differ across cultural groups. For example, heterosexual women experience pressures from media and men in their lives to be thin in order to maintain sexual attractiveness, while women tend also to police other women's body size. Lesbian women tend to be heavier than comparable straight women and express greater satisfaction with their bodies. Women of marginalized groups report bingeing and purging as a means to cope with traumas in their lives. The ways in which women interact with one another, men, media and society impacts the ways in which they perceive and value physical manifestations of beauty.

Gender does not solely reflect the sociocultural impacts on women's identity. Men, too, are subjected to the social expectations of gender. Lorber and Moore (2011) explain that, "the ideal male body is constructed by dominant social institutions and depicted through frequently reproduced images" much in the way the female body is constructed, as outlined above (p. 89). In the ways that women are subjected to ideals of feminine beauty, images of young, able-bodied men dominant popular media images. Dominant men have both social and cultural power (hegemony). Lorber and Moore describe hegemonic men as "economically successful, from racially and ethnically privileged groups, and visibly heterosexual; they are well educated or excel in their careers and work in the most prestigious and lucrative occupations" (p. 96). If these men are of working-class roots, they have overcome this status, and their hegemonic status is legitimated through Whiteness, wealth, social position, and heterosexuality.

Sexuality and sexual performance are pivotal to a man's identity and social power. Western culture is argued to be phallogocentric, "focused on men and their sexual performance" (p. 101). The phallus "refers to imagery and symbolism that celebrates male generative power, often to the exclusion or denigration of female generative power" (p. 101). Pharmaceutical companies now produce medications in order to *treat* the *impaired* penis, as the central construct of male sexuality, without which, a man's identity – his masculinity – is jeopardized. Lorber and Moore point out that in advertisements for these products, it is not sensuality and closeness in a sexual relationship that is the desired outcome of using the product, but "a way to achieve otherwise unattainable standards of the perfectly functioning penis and the always successful sexual performance," standards that are reified through sociocultural pressures and expectations (p. 102).

These systemic norms extend into the way women and men experience health (from a Western perspective) as well. For instance, Lorber and Moore (2011) describe the social importance of breasts in Western societies, noting that in terms of cosmetic surgery, breast augmentation and reduction have increased significantly over the past 20 years. This is indicative of the social significance breasts, as part of the female body, have on a woman's gender identity. However, they also note that breast cancer is the second most common form of cancer in the United States, and the second most common cause of cancer death in White, Black, Asian/Pacific Islander, and American Indian/Alaska Native women. For Latina women, breast cancer is the leading cause of cancer deaths. Given the treatment options for the disease (radiation, hormonal therapy, chemotherapy, breast-conserving surgery, and mastectomy), the designated treatment option would logically depend on medical issues. However, in reality the choice of treatment deals more with body image, with breast-conserving surgery being chosen most commonly among "younger, wealthier, urban women treated in larger teaching hospitals, with lower use by African Americans" (p. 71). Regardless of the efficacy of treatment options for the specific stage of cancer, women express deep attachment to their breasts and what they express about a woman's feminine identity.

Beyond the realm of individual-level health (though health implications are inescapable), the division of labor is a gendered reality. Chafetz (1997) describes the division of labor and the impact it has on women specifically (which stems from the bodily difference described above):

Because of women's reproductive functions in birth and lactation, and the gendered division of labor within the household and broader society that are typically constructed based on them, women become more identified with 'nature' and domesticity, men with 'culture' and the public sphere. In turn, culture and the public sphere are more highly valued socially and, therefore, the more strongly differentiated and segregated the two spheres, the greater the level of gender inequality (p. 107).

Many of the themes that arise in discussion of gendered differences between men and women are intertwined with the division labor, wherein women are identified through their femininity and encounter social expectations to tend to the domestic (an expectation of their gender identity) whereas men's identity is defined through their involvement outside of this space, in the public, cultural sphere.

Feminist theory argues that gender itself is a social construction developed and reinforced through a gendered social system. For example, capitalism is an inherently masculinist construct in which "the division of labor by gender makes women responsible for the unwaged maintenance and reproduction of the current and future labor force" while "The nonwaged work done by women is crucial and profitable for capitalists, who get its benefits for free, and, therefore, such labor is exploitative and oppressive for women" (Chafetz, 1997, p. 105). This gendered division of the work force, regardless of women's movement into the public sphere, leaves women responsible for insurmountable unpaid labor at the same time. In Chafetz's words, "working class men derive advantages both within the household (free domestic services and subservience from their wives, resulting from their economic dependence) and in the labor force (better paying jobs are reserved for men)" (p. 105). The individual-level embodiment of gender and the societal division of role expectations illustrate the ways in which gender is a sociocultural construct.

Chafetz (1997) argues that, "gender as an ongoing accomplishment that emerges during interaction processes, both between and within the sexes" (p. 111-112). Here, she asserts the notion that gender is not something that can be understood as an immutable construct. Rather, gender is something that individuals perform, develop, enact, and alter through interaction. Bird and Rieker (2008) explain that "current models of racial/ethnic and socioeconomic inequality do

not adequately explain observed gender differences in health” and how gender enactment has an integral role in the social aspects of health (p. 54). Gender cannot be conceptualized as a static variable. Rather, it is constantly evolving and redeveloping through interactions in social life.

Bird and Rieker (2008) address shortcomings of current models of social determinants of health. They explain that, “We cannot simply substitute gender for race/ethnicity or socioeconomic status (SES) in existing models because they are not constructed to capture the complex ways in which men and women are advantaged and disadvantaged” (p. 57). In reality, gender is something that is negotiated and renegotiated through our social interactions. In the context of child rearing, for example, Bird and Rieker suggest that the division of child care at home, household labor, and/or decisions about who will work outside the home and to what extent are gendered issues that are continuously negotiated through relationships with others.

The meanings individuals attach to events or roles have important gendered implications. For example, while men and women both share the meanings of social roles, including spouse or parent, the benefits or costs of these roles are significantly gendered. Where a man may be expected to provide for the family outside the home, he is equally expected to perform his role as spouse and/or father. Alternatively, a woman who provides for the family outside the home may be in conflict with her role as spouse and/or parent, as “mothers are more likely to feel stressed and guilty both about not being able to be with a sick child and being distracted at work” as a result of the social expectations of her simultaneously occurring roles (Bird and Rieker, 2008, p. 72). What is more, “The meaning attached to changes in circumstances or status that have the greatest impact on central components of one’s identity or sense of self is most likely to lead to a reformulation of priorities” (p. 72).

Gender expectations pervade the lives of women and men throughout everyday life. In many ways, women's and men's lives are constrained by gender expectations. Bird and Rieker explain "Work and family relations display and re-create gender roles in the division of labor and the expectations that are held for men and women over the life cycle" (p. 149). In terms of self-presentation, "rather than simply enacting internalized social norms, we are actively responding to some degree of social constraints as we select our clothing, care for our families, choose particular jobs, or even express dissatisfaction or disagreement" (p. 159-160). Gender in social life is not only pervasive but something that individuals perform in response to the social structures with which they interact.

West and Zimmerman (1987) argue that "the 'doing' of gender is undertaken by women and men whose competence as members of society is hostage to its production" (p. 126). Here, they expand on the notion that gender is an evolving character that is performed rather than a static component of one's being in society, arguing that "gender is not a set of traits, nor a variable, nor a role, but the product of social doings" (p. 129). While gender might be assumed to be a natural component of existence, they argue that it is produced through the ways in which society is organized. Members of society, in fact, hold one another accountable for performing gender in the expected way, and in this way police each other's behavior in order to maintain a consistent understanding of gender identity.

West and Zimmerman argue, with regard to creating gender differences, that, "Once the differences have been constructed, they are used to reinforce the 'essentialness' of gender" by way of "institutionalized frameworks" through which sex-based gender can be enacted (p. 137). Individuals enact multiple social identities that can be presented individually based on context. Therefore, depending on which social construct an individual is engaging with, the gender

identity will shift to match expectations. Ultimately, “sex category and gender are managed properties of conduct that are contrived with respect to the fact that others will judge and respond to us in particular ways” (p. 140). Gender permeates the social institutions individuals interact with daily. Gender “produces, reproduces, and legitimates the choices and limits that are predicated on sex category” (p. 147). Gender is not only pertinent to social life, but constructed, constituted, and reinforced through the social structures in place. Furthermore, gendered and biological differences both contribute to the unique set of health needs women face and the care they must be able to access.

Access to Healthcare

Health and healthcare disparities are “deeply rooted within a history of low socioeconomics and social injustice among different groups and populations” (Schiavo, 2015, p. 163). Health disparities refer to the different health conditions and diseases that discriminate and are more common among underserved groups. *Healthcare* disparities refer to differences in both the access to and use of healthcare, quality of care, cost of care, and hospitalization rates that impact patient outcomes. Health disparities affect a number of different populations, including women, children, individuals of gender identities and sexual orientation that fall outside the hegemonic gender binary, people with disabilities, individuals of lower socioeconomic status, residents of rural areas, people of marginalized race and ethnicity, and the elderly. Addressing health inequities has grown in concern across the United States and many other countries in the developed and developing world (Cameron, 2013).

While healthcare consumers have some choice in where and when they receive care, that choice is inherently constrained, particularly among marginalized groups. Constrained consumption, grounded in consumer vulnerability, “may result from constraints imposed by

illness, health care choices, or health care financing...it may stem from information asymmetry between health care providers and patients” (Mittelstaedt, Duke, & Mittelstaedt, 2009, p. 97). Consumption may also be constrained through legal, cultural, personal, or systemic barriers and may be real or perceived. Consumption within the healthcare system is constrained by access, particularly when private health insurance (or public access through the Affordable Care Act) leave most households dependent upon employer options when it comes to the healthcare they are able to receive.

Health literacy has been identified as an important indicator for the use of preventive medicine and management of chronic conditions. Levy and Janke (2016) found that individuals with low health literacy were more likely to forgo or delay necessary medical care, or to report difficulty finding a provider for care when controlling for health insurance coverage, employment, race, ethnicity, and socioeconomic status. Low health literacy increases the risk for misuse of medication through misinterpretation of drug label instructions, incorrect identification of medication, and difficulty understanding warnings on drug labels (Osborn, Cavinaugh, Wallston, Kripalani, Elasy, & Rothman, 2011). Patients who do have low health literacy tend to be more reliant upon verbal instructions about their medication, but experience inadequate provider communication. Health literacy inquiries must look at both sides of the healthcare conversation—the literacy skills of patients as well as the communication skills of providers. Health literacy conversations must also involve the policy related constraints or facilitators put in place by healthcare institutions through practice (Rudd, 2015).

Public policy and opinions can have an impact on healthcare access. The Patient Protection and Affordable Care Act, initially signed into law in 2010 (with provisions still being phased in through 2020) is demonstrative of the role policy can have on access to care,

particularly among low-income individuals and families. In 2010, the Commonwealth Fund predicted that by 2019 32 million uninsured Americans would be covered under healthcare reform, increasing the insured proportion of the population to 94 percent (Commonwealth, 2010). However, Mittelstaedt and colleagues (2009) point out the unlikelihood that universal coverage and choice in provider could be maximized without sacrificing cost containment, as costs would likely increase with either of these. In order to alleviate health disparities, population-based approaches to delivery via nonprofits and philanthropic organizations may be useful, but “For many nonprofits and philanthropies, the legal constraints of nonprofit status reinforce widespread unease with advocacy and engagement in the policy arena” (Treadwell, 2008, p. 31S). Accountability to the population served is vital, but government support is necessary in mandating the collection of health information and the revision of statutes and laws that are discriminatory toward marginalized groups.

Access to healthcare is also influenced by the type of messages and information patients receive outside of the healthcare system. In the context of health disparities, Rasmussen (2014) found that press coverage addressing health disparities during the passage of the Affordable Care Act were marked with ambiguity regarding the causes of those disparities and what type of interventions were necessary. Mainstream presses were particularly hesitant to explain causal links when compared to Black presses. Lundell, Niederdeppe and Clarke (2013) further explored public views about health disparities across political liberals and conservatives and found that people tended to begin by attributing health to individual behavior and responsibility. Their findings “rest on the assumptions that health is predominantly determined by behaviors and changing health behaviors cannot (or should not) occur without conscious thought and motivation” (p. 1126). Their findings resonate with the individualistic nature of the American

Dream often inherent in policy beliefs. As might be expected, public opinion is more supportive of initiatives like school-based efforts to prevent obesity in children or health education for adults than for government regulation. The systemic nature of health disparities is oft overlooked or misunderstood in public presses and policy discourse among citizens.

Springer, Hankivsky and Bates (2012) assert that research on gender (and/or sex) and health centers chiefly on two points: “empirical examinations of trends and explanations for sex differences in disease incidence and mortality” and “sex-specific disease patterns and corresponding, often differential, investments of research and policy attention to ‘men’s health’ and ‘women’s health’ needs” (p. 1661). A review of recent women’s reproductive health campaigns demonstrates the immense impact the dominant, masculinist/expert-driven approach has in this area. To illustrate, an initial search of women’s reproductive health campaigns across the communication, sociology, and public health disciplines since 2005 yielded 46 studies. Twenty-eight of these studies used experimental design or questionnaire data as a methodological approach which, by their very nature, decontextualize lived experience through the reduction to variables and expert-driven testing. Within the United States, health disparities research shows that women of lower socioeconomic status and racial and ethnic minorities are disproportionately affected by poor reproductive health (Matsaganis & Golden, 2015; Matsaganis, Golden, & Scott, 2014). Transportation issues, lack of available providers, insufficient communication about reproductive healthcare recommendations, and confidentiality about services received in small communities have been identified as contributors to reproductive health disparities (Matsaganis & Golden, 2015).

Ellingson (2010) offers optimism in the future of women’s health research, outlining four feminist accomplishments she forecasts will be met over the course of this decade in the

context of women's health. First, she suggests, "researchers will increasingly emphasize intersections of gender with other critical identities, such as sexual orientation, age, disability, race/ethnicity, and nationality as they pertain to health communication" (p. 95). Her argument here is that health communication scholarship, much like the dominant sociological research trajectory Chafetz (1997) critiqued is dominated by a white, middle class standpoint located in the West. Second, feminist scholars will interweave feminist methodological values into health communication work in the mainstream, in which the post-positivism and quantitative research that dominates this domain will be met with increasingly participatory and feminist methods that illuminate localized experiences. Third, the medical system reinforces a "hierarchy of disciplinary power...reinforcing physician power as natural and inevitable while marginalizing members of less powerful, feminized disciplines" (p. 96). Feminist scholars will question these taken-for-granted norms of the medical system to "illuminate the complexities of communication, revealing manifestations of power and offering alternatives to top-down power structures" (p. 96). Finally, Ellingson predicts an increase in the variety of venues that will be incorporated to present feminist scholarship – including narratives, performance, or street theater – that will "both enhance validity with multiple truths and destabilize hegemonic claims of objective 'Truth'" (p. 97).

This section has provided a review of extant literature on the role of the nonprofit organization as a means of filling gaps left by the government and for-profit sectors. It also provided a review of literature on gendered healthcare and the impact of constrained access to healthcare among socioeconomically marginalized women. The next section provides the theoretical grounding used to conceptualize this study.

Theoretical Grounding

In conceptualizing this investigation, two theoretical frameworks were useful in determining the research questions and course of inquiry. The first was stakeholder theory. Stakeholder theory was used to conceptualize the role of clients within the organization, and the ways in which women identified themselves as a part of Planned Parenthood upon entering into a relationship with the healthcare organization. Stakeholder theory was particularly useful due to its complex understanding of primary and secondary level stakeholders. Here, women are positioned as primary stakeholders who are directly affected by, but also directly affect, the success of the organization. Within the nonprofit organization, clients serve an important role in sustaining the work of the organization, and their direct experience with the organization should be considered as the organization evaluates its successes and failures.

The second theoretical framework used to conceptualize this dissertation was the culture-centered approach. This approach provides a critique of top-down logics found in a majority of health communication campaigns. It understands three concepts – culture, structure, and agency – to be interlaced and acknowledges barriers to health that extend beyond the individual level. The critique of top-down logics of health campaigns was extended in conceptualizing this study to interrogate the nonprofit organization and the extent to which women who use these sites are empowered or subjected to expert-driven logics that silence underserved voices and understandings of health and healthcare. Taken together, these two theories inform the approach used in conducting this study, positing that women have the agency to decide when, where, and to what extent they require healthcare, even if that means forgoing care altogether. As such, nonprofit organizations have the opportunity to empower women through the process of

accessing care, but the extent to which they effectively do so is unclear. Grounding this research in the perspectives of women clients, this relationship is interrogated and better understood.

Stakeholders and Stakeholder Theory

Stakeholder theory was developed within organizational studies in contrast with the predominant shareholder framework, arguing for a two-tiered approach (Freeman, 2010/1984). The first tier consists of primary stakeholders (e.g. financiers, suppliers, employees, customers, communities) whereas the second tier consists of secondary stakeholders (e.g. competitors, government, media, special-interest groups, consumer advocate groups). Freeman, Harrison and Wicks (2007) argue that

Business can be understood as a set of relationships among groups that have a stake in the activities that make up the business. Business is about how customers, suppliers, employees, financiers...communities, and managers interact and create value. To understand a business is to know how these relationships work (p. 3).

Freeman (2010) defines a stakeholder as “any group or individual who can affect or is affected by the achievement of the firm’s objectives” (p. 25).

Freeman (2010) offers the stakeholder concept in order to address the environment of the firm, accounting for changes that consider all of these groups or individuals that affect/are affected by the accomplishments of the organization’s purpose. It draws upon a number of theoretical frameworks, including corporate planning, systems theory, corporate social responsibility, and organization theory. Ultimately, the stakeholder concept argues that there are numerous factors that contribute to the success of the organization, requiring organizations to look beyond shareholders for financial securities and into both the internal environment (how actors working within the organization create to value and uphold the mission) and external environment (how policy makers, activist groups, consumers, and so on contribute to the direction of the organization by exerting pressures to which the organization must respond).

Donaldson and Preston (1995) argue, “stakeholder theory is ‘managerial’ and recommends the attitudes, structures, and practices that, taken together, constitute a *stakeholder* [emphasis original] management philosophy” (p. 87). There are a number of influences on an organization. Freeman’s normative core suggests that “there should be a ‘fit’ between stakeholders, values, social issues, and the society within which managers operate” with which managers should engage to “monitor performance and keep score with stakeholders over time” (Freeman, Harrison, Wicks, Parmar, & de Colle, 2010, p. 214). Parmar, Freeman, and Harrison (2010) provide two fundamental questions here: “what is the purpose of the firm?” and “to whom does the management have an obligation?” (p. 409).

To map stakeholders from a rational perspective, Freeman (2010) argues there are three steps. The first is to identify the stakeholders in the organization and their perceived stakes. This means that an organization must consider who is affected by or affects the organization’s ability to uphold its mission from a comprehensive level. Second is the process of understanding the organization’s relationships with identified stakeholders to develop a stakeholder map, which can in turn be analyzed for transactions that occur between the organization and stakeholders, as well as across stakeholder groups, for fit with the organization’s goals.

Stakeholder theory is built to suit business efficacy within capitalist restraints and opportunities. To understand the relationship between business and capitalism, stakeholder theory posits that businesses are successful when they create value for, at the very least, customers, employees, suppliers, communities and financiers. They are sustainable when they have a purpose alongside profitability. Further, businesses need to understand the complexity of people and that rather than focusing on self- versus other-interest, ethics and responsibility are

consistently relevant. Ultimately, managers need to understand the interconnectedness of these components in order to successfully exist within the constructs of capitalism (Freeman, 2009).

Though stakeholder theory was conceptualized and developed within organizational studies, the theory has clear communication applications, which have been adopted and explored by organizational communication scholars. Bundy, Shropshire, and Buchholtz (2013) argue that in understanding stakeholder concerns, issue salience is a distinct construct driven by cognitive interpretations of the issue that can be modeled as “the key antecedent of firm responsiveness to stakeholder concerns” (p. 369). This notion can provide a useful avenue for informing current public relations research from within the communication discipline. If, under the stakeholder framework, an organization is to consider the needs and interests of numerous stakeholder groups, effective communication strategies are vital. Stakeholder investment can be strengthened or supported when organizational issues are clearly communicated. Public relations scholarship is key in understanding how this communication is or is not successful.

One way in which public relations scholars address the role of stakeholders is to identify which stakeholder groups are acknowledged and/or understood in public opinion research. Stakeholder theory offers a framework for understanding numerous stakeholders that contribute to the potential success of the organization. Luoma-aho and Vos (2009) argue that stakeholder theory is particularly applicable for public relations research, “as it concentrates on the long-term social networks and relationships organizations have” (p. 120). When an issue of interest (in their case, nuclear power) is presented, the timeliness with which an organization addresses it increases the role they have in the communication sphere. They argue that in the context of public relations, rather than defining stakeholders, practitioners ought to identify issues arenas in order to speak first and be heard most markedly. To that end, Moon and Hyun (2009) argue that,

while stakeholder theory emphasizes that an organization's responsibility is to numerous stakeholders, beyond shareholders, public relations practitioners and journalists continue to cater to the interests of shareholders above other stakeholder groups. Considering stakeholder theory from this perspective suggests a need for a cross-disciplinary understanding of stakeholders versus shareholders and the implications for limiting the scope of stakeholder considerations.

Organizational communication scholars have built upon this theory in a number of ways. It is particularly pertinent, in terms of the present study, to understand how communication scholars have applied stakeholder theory in the context of NGOs and nonprofit organizations. For instance, Shumate and O'Connor (2010) offer the Symbiotic Sustainability Model as "a macrolevel communication-based explanation of NGO-corporate alliances" (p. 578). They argue that the macrolevel model sheds light on issues including the popularizing of social issues and alliances and the implications therein of NGO-corporate alliance communication for both economic and social issue industries, as well as draws attention toward communication patterns that shape the organizational landscape. They highlight the centrality of communication with stakeholders in constituting these alliances, drawing explicitly on Freeman's (2010/1984) broad understanding of stakeholders. They use the model to explain the network of alliances across industries, stemming from Freeman's argument that an organization's stakeholder needs are oft intertwined and must all receive attention if the firm is to succeed in carrying out its goals.

Shumate and O'Connor argue that stakeholder theory is applicable to organizational communication particularly in cross-sector alliance formation as it "is motivated by a corporation's desire to mollify stakeholders" (p. 580). Moreover, they acknowledge that stakeholder management theory is dominated by corporate-centered literature, and that from this perspective "NGOs are a broad stakeholder category that includes activist groups" but overlooks

the possibility that NGOs and corporations, among other stakeholder groups, are mutually influential (p. 580). They couple stakeholder theory with collaboration theory (organizations will collaborate when they cannot solve a given problem independently) and transaction cost economics (specifically, the notion that transaction costs dictate the nature of relationships between NGOs and corporations) to address what they identify as missing components of cross-sector collaboration in their model. The relationships between NGOs and corporations are fundamentally communicative; it is important to acknowledge the ways in which NGOs and corporations co-construct these alliances.

Expanding on the need for scholarship to address nongovernmental organizations as unique entities in fields that focus predominantly on corporate organizations, Koschmann (2012) offers a communication theory of the nonprofit. Here, Koschmann argues that a theory of this sort ought to focus on the lived experience of stakeholders, moving beyond understandings of nonprofits as legal or financial entities. He argues that the latter limits nonprofits to economic theorizing, leaving scholars to study communication “as a phenomenon within these given organizational structures” when in fact “what we know and experience as ‘nonprofit’ is a socially constructed concept that is reinforced (or not) through continued patterns of communication” (p. 141). Koschmann urges scholars to consider language used to describe nonprofit organizations, and how these impact the social relationships and identities that result. To clarify, Koschmann argues that “By conceptualizing communication as the production (vs. merely the expression) of meaning, a communicative theory of the nonprofit “would provide valuable insights as to *how* important aspects of the nonprofits sector arise and evolve...versus merely explaining *that* [emphasis original] they exist” (p. 143). Further, it is necessary to consider the communicative constitution of organizations within the context of nonprofits, and the ways in which this can

“offer a conceptual foundation from which to advance communicative explanations of nonprofit organizing” (p. 145).

Corporate social responsibility is a fundamental component of stakeholder theory. Freeman et al. (2010) explain that, within this context, stakeholder theory suggests,

the managers of the corporations have a responsibility not simply (and vaguely) to serve the *general interests* of society (which society?)...but rather to serve the interests of the *corporation's stakeholders*—that is those specific individuals that *make* the firm...*contribute* to its success...and *bear* [emphasis original] the consequences of its activities (p. 260).

O'Connor and Shumate (2010) conducted a macro- and meso-level analysis of how corporations define the scope of corporate social responsibility (CSR), finding that “CSR communication gives primacy to ethical and philanthropic responsibilities,” though CSR remains limited within this scope (p. 547). Yet, they argue, “CSR communication presents universal values that are accessible only to those people and places fortunate enough to have munificent corporations in their communities” (p. 548). From the perspective of stakeholder theory, these findings illustrate the ways in which corporate entities likely focus primarily on financial stakeholders, offering lip-service to stakeholders such as customers and employees.

Stakeholder theory argues for a more comprehensive understanding of organization stakeholders. Koschmann (2013) extends this notion beyond the interconnectedness of the web of stakeholder relationships to the concept of collective identity. Whereas traditional organizational research treats collective identity as a cognitive construct, this perspective highlights the interorganizational context, “portray[ing] collective identity as a communicative phenomenon that is subject to continual alteration by organizational members” (p. 81-82). Organizations should consider the centrality of identity and shifting perspectives across stakeholder groups so that they can continue to evolve to fit stakeholder needs. There is room for

growth in the incorporation of stakeholder theory and multi-stakeholder perspectives in communication literature, but an intriguing and fruitful foundation exists for those conversations to continue and progress.

There has been substantial research with the intent to synthesize stakeholder theory and feminist theory. Freeman et al. (2010) suggest that, in the context of stakeholder theory, feminist theory can be a particularly applicable and powerful lens. Within this context, “the job of management is to extend care to stakeholders and maintain the web of cooperation that allows the firm to thrive and create value for stakeholders” (p. 215). Stakeholders are considered in terms of “a web of interconnected relationships...that reshape our conception of the firm” (p. 215). The central argument is that stakeholder theory accounts for diverse stakeholders—moving beyond the economic perspective that accounts predominantly for shareholder interests and negating other entities and individuals that share stake in the company—therefore catering to a collaborative, decentralized orientation toward business.

Wicks, Gilbert and Freeman (1994) counter claims that stakeholder theory retains masculinist assumptions from the dominant business literature. They focus on the centrality of language, outlining five dominant metaphors that shape understandings of organizations. Masculinist metaphors, according to these authors, dominate business perspectives of the organization. Masculinist assumptions include the following: corporations are autonomous entities, companies should enact and control their environment, the metaphors of conflict and competition best describe how firms should be managed, strategy formulation should be objective, and power and authority should be embedded in strict hierarchies.

A feminist reinterpretation, according to Wicks et al., flips these assumptions. They argue that a feminist reading of stakeholder theory “suggests that persons are inextricably embedded in

context” and that “persons are fundamentally connected with each other in a web of relationships” (p. 483). Therefore, corporations ought to be considered as “webs of relations among stakeholders” rather than considered individual entities that can avoid being affected by context. The multiple stakeholder perspective operates as a network, or web, of entities that interact with and give meaning to the firm. Interdependence is central to stakeholder theory, as well as a fundamental notion of feminist thought.

Secondarily, a masculinist understanding of environmental change considers such movement as threats that must be dealt with. When viewed through a feminist lens, Wicks et al. argue that stakeholder theory sees forces of change as opportunities for diversity and new opportunities. When multiple primary and secondary stakeholders of the firm are considered and relationships across these groups are considered as the organization develops, change provides progress rather than threats. This extends to the notion that competition and conflict, a masculinist metaphor, ought to be replaced with a more collaborative lens.

Feminist theory would argue that the metaphor of competition and conflict evokes violence and distrust that eliminates the possibility of win-win outcomes. Rather than making the hard choices, collaboration in the context of multiple stakeholders can in fact further the agenda and successes of all when given the space for cooperation and communication. In fact, “not only does collective action allow both individuals and groups to be a part of decision-making and implementation—forms of participation which are fulfilling and help build a sense of community—it brings together greater resources to address a given problem” (p. 488). The notion of participation, in this context, begins to speak to the culture-centered approach as well, arguing that communication and consideration of alternative voices increases avenues for participation and collaboration.

While a masculinist (dominant) perspective of business takes an objective approach, a feminist perspective is skeptical of science and empirical inquiry, which negates the unique relationships managers have with specific stakeholders. Wicks and Freeman (1998, via Freeman et al. 2010) criticize positivism, which they argue separates finding (scientific objectivity reveals truth) and making (human inquiry is informed by perspective, culture, and language). Rather than looking to science for “facts,” feminist inquiry would argue that “we should search through the rich tapestry of experience, language, and impression to construct a picture of both problems and solutions that is complex and reflects the variety of perceptions of the stakeholders involved” (Wicks, Gilbert & Freeman, 1994, p. 489). Instead of conceptualizing strategic direction through facts and statistics, solidarity and collaboration ought to be the starting point, wherein the multitude stakeholders are considered equitably.

To that end, feminist theory argues for decentralization, anti-hierarchy, and empowerment. Stakeholder theory argues that multiple stakeholders, not just shareholders, are considered in decision-making and business policy/ethics. This principle is in line with feminist theory, arguing that worker involvement—considering employees as stakeholders as stakeholder theory does—makes for a more meaningful work experience and empowerment, ultimately increasing organization effectiveness. In fact, “stakeholder management...is about creating value for an entire network of stakeholders by working to develop effective forms of cooperation, decentralizing power and authority, and building consensus among stakeholders through communication to generate strategic direction” (p. 493). A stakeholder approach has the potential to engage collaboration across groups and account for evolving contexts, offering space for stakeholder theory to synthesize and incorporate fundamentals of feminist thought.

Culture-Centered Approach

The culture-centered approach is grounded in subaltern studies and the recognition that “the subaltern voice is marked by its absence, by not having been noticed” (Dutta, 2007, p. 310). Subaltern studies scholarship problematizes these silences that occur within the dominant discourse and scholarship. Subaltern studies look for alternative ways of knowing and being in the world to open up discourse to traditionally marginalized voices. The culture-centered approach “offer[s] an alternative entry point for theorizing and practicing health communication by highlighting the absences and/or silences in current health communication theory and practice, and by presenting voices of the marginalized sectors through engagement in dialogue” (Dutta, 2007, p. 310).

In theorizing an alternative method for developing health campaigns, Dutta draws on Lupton (1994) and Airhihenbuwa (1995) to exemplify the need for a culture-centered approach to health communication. Lupton argued against the health promotion approach grounded in scientific rationality that centers on the individual while ignoring cultural contexts and remaining ignorant of sociocultural and socioeconomic contexts that situate health experiences. Airhihenbuwa extends this critique, providing further grounding for the culture-centered approach, arguing that health campaigns reflect an inherently Western, Eurocentric bias of individualism, further negating experiences unique to sociocultural and socioeconomic influence.

In fact, central to the culture-centered approach and building from Airhihenbuwa’s previous work is the notion that “health is a cultural construct and health theory and practice must be rooted in cultural codes and meanings, inherently tied to values” (Dutta, 2008, p. 19). Airhihenbuwa (2005, via Dutta, 2008) illustrates the need for a paradigm shift in the study of health communication campaigns:

It has become common practice in the field of public health and in the social and behavioral sciences to pay lip service to the importance of culture in the study and understanding of health behaviors, but culture has yet to be inscribed at the root of health promotion and disease prevention programs, at least in the manner that legitimates its centrality in public health praxis (Dutta, 2008, p. 18).

The culture-centered approach “provides an alternative entry point for theorizing about and practicing participatory health communication in marginalized spaces” (Dutta & Basu, 2008, p. 561).

Ultimately, the culture-centered approach draws predominantly from a few key theories. The culture-centered framework extends postcolonial theory by “providing an entry point for critiquing top-down logics of health campaigns” (p. 561). As aforementioned, the approach also draws on subaltern studies, serving as an approach that “demonstrates that members of marginalized spaces have historically participated in sociocultural and political processes in challenging, shaping, and coping with the structures that have encompassed their existence” (p. 561). The culture-centered approach operates around three central constructs: culture, structure, and agency. As such, it grapples with the dialectical tensions between structure and agency, drawing on structuration theory to do so. Culture, structure, and agency are interlaced in this approach, which acknowledges the barriers to health that extend beyond the individual level.

Integral to the culture-centered approach are the three previously mentioned concepts: culture, structure, and agency. That said, behavior change is not possible from the perspective of the culture-centered approach without addressing social change and the structural barriers to health. Still, there would be little purpose to a health promotion approach without indication of some level of health behavior change.

When promoting behavior change, the first step is to listen to the voices that are otherwise silenced. The dominant approach to health campaigns views message recipients as

passive vessels that must be informed, taught, or persuaded to change their behavior. In contrast, the culture-centered approach argues that these individuals are the true experts of their own lives, constraints, and beliefs. Therefore, discourse is the first step to understanding the problem(s). Through discourse, participants enact their agency, and in this way can begin to organize for themselves, finding meaningful avenues for addressing problems and implementing new behaviors (Basu & Dutta, 2009). Behavior change can only be desired and enacted through cultural beliefs and meanings, and highlighting the agency of marginalized groups.

Social change and behavior change are intertwined from the culture-centered perspective. Social change is dependent on the larger system in play and the place—socioculturally, socioeconomically, and socio-politically—of the marginalized group. Dutta (2014) argues that, “culturally centering social change also suggests that the impetus of the change is on engaging with the broader structures of silencing and oppression” (p. 70).

Culture is central to forming beliefs and ultimately behaviors. However, social structures heavily impact the ways in which individuals act. Dutta (2007) argues that, “the culture-centered approach emphasizes attempts at changing social structures surrounding health through dialogues with cultural members that create spaces for marginalized cultural voices” (305). Social structures directly affect the ways in which individuals act, particularly when they are located at the margins. Therefore, it would be fruitless to teach women in the margins of Nepal to use contraception if they feel devoid of meaning without motherhood. Social change must be considered at a broader level than the individual, family, or community level. Larger structures affect the ways individuals are able to enact their agency. Those living at the margins face unique stressors as a result of structural violence, but giving attention to these “create[s] alternative entry points for understanding meanings of health amid structural derivations, also

creating entry points for projects of social change that are driven by the localized narratives” (Jamil & Dutta, 2012, p. 378). The culture-centered approach understands social change through opening up dialogic spaces wherein marginalized groups can enact their agency and collaboratively address structural barriers from a culturally localized perspective.

In addition to health communication campaigns focusing on individual health behavior change, they also tend to be expert-driven, developed outside of the target group by a group of experts who develop messages to insert in the community deemed to be in need of intervention. This is illustrated through an examination of the most commonly used health campaign theories and models, for example the Health Belief Model, Theory of Reasoned Action, Theory of Planned Behavior, Integrated Behavioral Model, or the Extended Parallel Process Model. Glanz, Rimer, and Viswanath (2008) suggest, “health behavior theories and models *explain* behavior and suggest ways to achieve behavior *change* [emphasis original]” (p. 27). They distinguish between explanatory theory and change theory, arguing that explanatory theories help “describe and identify why a problem exists” and “predict behaviors under defined conditions and guide the search for modifiable factors like knowledge, attitudes, self-efficacy, social support, and lack of resources.” Change theories on the other hand, they argue, “guide the development of interventions” and form the basis for evaluation.” Further, “implementation theories are change theories that link theory specifically to a given problem, audience, and context” (p. 27-28).

Criticism of the Eurocentrism that pervades the dominant approach to health communication campaigns has led to the growth of a cultural sensitivity approach. This approach “seeks to modify the existing health communication practices to suit the characteristics of the culture, as opposed to the culture-centered approach that puts culture at the core of health practices” (Dutta, 2007, p. 304). Within the culturally sensitive approach, culture is considered

“a collection of shared values, beliefs, and practices that are contained within a clearly defined community” (p. 307). Here, values, beliefs, and practices are considered static variables that the health communicator can identify from within the defined community that can be incorporated into the delivery of health messages. A culturally sensitive program

(a) has clearly defined health objectives determined by the outside experts, (b) identifies relevant cultural characteristics and measures them (this is also expert driven), (c) develops health messages that are tailored to the characteristics of the culture, and (d) evaluates the health communication program on the basis of the objectives defined at the onset of the program (once again, by the external experts) (p. 309).

The culturally sensitive approach acknowledges the need to develop campaign approaches that are culturally and geographically relevant to the target group, doing so by incorporating cultural components as adjustable variables within the traditional, expert-driven framework.

The culture-centered approach posits that health cannot be understood without understanding culture. Dutta (2014) describes the culture-centered approach as follows:

Based on the understanding that subalternity is marked by erasure, which in turn is accomplished through the closing off of discursive sites of recognition and representation, the culture-centered approach offers a meta-theoretical framework for co-constructing discursive processes, spaces, rules and techniques in collaborations with subaltern communities, which in turn open up opportunities for the articulation of alternative discourses that challenge the oppressive frameworks of neoliberal governance (p. 70).

The orientation of the culture-centered approach is unique among the myriad approaches to health campaigns. At its core, the culture-centered approach seeks to understand health as it is situated among culture, structure, and agency.

Culture, from the culture-centered approach, is conceptualized as “the living framework of individuals and their collectives” through which knowledge is produced and within which individuals and social groups operate. Culture “emerges as the strongest determinant of life that shapes knowledge creation, sharing of meanings, and behavior changes” (Dutta & Basu, 2008, p.

561). Therefore, any health promotion program, from this perspective, will prove fruitless if the culture of the group—the ways in which knowledge and meanings are created—is inadequately addressed.

Structure refers to the institutional restraints that limit or constrain the resources available in marginalized spaces. Structures can be thought of as the sociopolitical, socioeconomic, or sociocultural barriers to positive livelihood and health. From this perspective, understanding health interventions from the individual level is thoughtless and unlikely to result in much success. Agency refers to “the fundamental human capacity to engage in actions” (p. 562). Culturally situated meanings provide the means for members of these marginalized groups to enact their agency amongst the “unhealthy structures that constitute their lives” (p. 562). The culture-centered approach, then, understands health and health campaigns from a more complex position than the majority of health communication approaches. The culture-centered approach considers the undeniably immense role that structures play on health and understands that marginalized groups, through dialogue, are able to enact their agency, making sense of health and the ways in which structures dictate much of their livelihood.

Listening is central to the culture-centered approach and to each of the three overarching components. According to Dutta (2014), “listening through inversion, incompleteness and imagination works in solidarity with the margins to co-construct theory rooted in the ontologies, epistemologies, and values of the margins” (p. 68). Structures pervade and often inhibit the lives of marginalized groups. However, through listening, alternative rationalities can be brought to light, and structural shifts may begin to occur through shifts in the structures of organizing. As discussed, culture provides the “constitutive framework for meanings” (p. 72). Co-construction of meanings of health can “guide the framework of listening to local articulations” which emerge

within discursive spaces (p. 72). This puts cultural voices at the fore of imagining and conceptualizing frameworks, processes, and possibilities. Finally, an emphasis on listening allows the enactment of agency to arise and provide directions for social change by interrogating the silencing nature of dominant structures. Agency “works through the mobilizing of cultural resources working in relation with structures to voice meanings from the margins” (p. 72). Listening allows for the interrogation of power structures that silence voices from the margins, and allows these voices to surface and reveal localized knowledge and meanings.

That said, the culture-centered approach takes a distinct and distinctly different approach to participation from traditional health campaign frameworks. First and foremost, the culture-centered approach recognizes the centrality of participation to “the articulation of health issues and as a primary step toward initiating change that is meaningful to community members” and works to “listen to and document participatory communication patterns emanating from marginalized spaces” (Basu & Dutta, 2009, p. 89). The researcher, from this perspective, shifts from expert to listener, engaging in dialogue with community members in order to highlight the ways in which members of marginalized groups enact agency through the meaning-making process. The expert role that permeates throughout the approaches outlined above is exchanged for one that appears more as a learner, highlighting the expertise of community members involved.

The culture-centered approach not only tackles health communication differently from the predominant health communication approaches, but looks more comprehensively at the lived experience than most. To illustrate, Basnyat and Dutta (2011) used the culture-centered approach to address family planning among Nepalese women. This piece illustrates the distinct differences between the culture-centered approach and the dominant approaches to health communication.

While family planning is a common campaign focus in the Third World, Basnyat and Dutta illustrate the ways in which women of the Third World are silenced, passive recipients of messages developed from top-down interventionists. So-called experts from the global West insert their messages among women with the goal of decreasing the average number of pregnancies with the objective of population control. They use the culture-centered approach “to challenge the dominant hegemony of health communication approaches that construct women living in poverty in the Third World as bodies to be worked over” as well as to open up a discursive entry point in which the stories of family planning, from the perspectives of the women, can be heard (p. 339). Of the utmost importance is the notion that no agenda can exist before interaction with the women occurs.

In conducting the study, the authors conducted in-depth interviews to “co-create locally situated meanings” that are negotiated in relation to health (p. 343). Through this approach, the authors found that motherhood offered a space of legitimacy for women who were otherwise very much devoid of agency and constrained by structural limitations. They also found that women, among this group, learn from other women. The meanings of family planning were negotiated within the relational and familial networks, making the biomedical approach emphasizing individual-level behaviors, which the authors argue commodifies subaltern women’s bodies, largely ineffective. Ultimately, this approach emphasizes the need for locally situated narratives and the need for new models of health promotion that center on these cultural implications rather than persisting with models based on the assumptions of the dominant approach.

The culture-centered approach contrasts the dominant approach to health promotion campaigns. This dominant approach foregrounds the vast majority of women’s reproductive

health interventions. Questionnaires (e.g., Abojobir & Seme, 2014; Tilahun, Mengistie, Egata & Reda, 2012; Egbert & Parrott, 2001) and experiments (e.g., Carcioppolo, Jenson, Wilson, Collins, Carrion & Linnemeier, 2013; Madeni, Horiuchi & Iida, 2011; Harvey, Kraft, West, Taylor, Pappas-DeLuca & Beckman, 2009) are favored approaches to these health interventions. As discussed above, listening and discourse are central to the culture-centered approach. These approaches severely limit the extent to which discourse can exist fruitfully.

A significant problem in the majority of health campaign research under the dominant approach is the notion that culturally sensitive campaigns can be generalizable beyond their means. In fact, Pillsbury and Mayer (2005) note that their approach (a particular initiative titled *Women Connect!*) “was carried out with 29 NGOs in Zimbabwe, Zambia, and Uganda, but the lessons learned apply also to women’s groups throughout Africa, Asia, and Latin America” (p. 362). The notion that a campaign implemented in Sub-Saharan Africa could extend across the content alone ignores the uniqueness of diverse cultures. An intervention grounded in the culture-centered approach could be useful in drawing out some issues that may resonate in other areas; these could be used to inform models implemented from this approach. However, the notion that an intervention could be transplanted across the country is often ill-informed.

Moreover, there are a plethora of NGOs focused on women’s reproductive health in various contexts. de Souza (2009) used the culture-centered approach to understand how NGO-facilitated HIV/AIDS prevention programs might look different from this perspective. She argues that though the culture-centered approach criticizes NGOs for implementing a top-down approach, there may be a way “to understand ways in which the ideal of civil society can be achieved through more ‘civil’ practices” within the NGO (p. 694). de Souza suggests that NGOs do play a vital role in training communities, and that the culture-centered approach may be

applied for cultural bridging, wherein members of the community learn sociocultural codes of dominant institutions to better execute the mission of the organization. She suggests that the primary role of the NGO ought to be one of communicative agents of change, “training marginalized communities to use their voices to bring about change and by creating spaces where communities can speak” (p. 701).

de Souza addresses an important tension between the culture-centered approach and campaign planners whose mission is to provide meaningful aid. This is an area of women’s reproductive health campaigns that could be better addressed with the culture-centered approach. A majority of women’s reproductive health campaigns globally are implemented or funded by NGOs or other aid organizations. As Basnyat and Dutta (2011) argue, “we must develop new models of health promotion that include cultural implications of health behaviors, rather than perpetuate models based on assumptions, theories, and frameworks of the dominant system” (p. 350). The culture-centered approach can understand and address the health issues women face in the context of reproductive health, which ought to be conducted in collaboration with those organizations that provide resources and work to develop more effective campaign strategies. The culture-centered approach can inform campaign planners and work with these organizations to implement more impactful campaigns with the hope of ultimately developing the models Basnyat and Dutta call for.

Research Questions

This dissertation used in-depth interviews with women who use Planned Parenthood of Mid and South Michigan as their primary women’s health organization to understand (a) beliefs, understandings, and motivators of health that impact a woman’s decision to receive health services through the nonprofit healthcare organization; (b) how women initiate and sustain the

relationship with the healthcare organization; (c) how women experience and negotiate the organizational relationship once it has been developed; and (d) how the needs of individual women and their relationship with the healthcare organization affect understandings of women's health and healthcare. More specifically, based on the phenomenon and literature outlined previously, this dissertation project proposed the following research questions:

RQ1: What beliefs, understandings, or motivators of health influence women's decision(s) to make initial contact with the organization?

RQ2: How do women initiate, develop, and sustain relationships with the health organization?

RQ3: How do women experience and negotiate the organizational relationships?

RQ4: How do the needs of individual women and the nature of their relationship with the organization contribute to understandings of women's health and healthcare?

The first research question sought to identify key beliefs, understandings, and motivators of health that women hold and impact the decision to seek out a healthcare organization for the first time. The decision to pursue healthcare from an organization is grounded in their understanding of health. Health is inherently tied to the values individuals hold (Dutta, 2008). When women decide to initiate a healthcare relationship with an organization, their decision is grounded in existing values and beliefs about the care they require. Moreover, when women do initiate contact with the organization, they are claiming a stake in the work that grounds that organization (Freeman, 2010). Therefore, this research question uncovered those key influences that brought women to the healthcare organization in the first place.

The second research question inquired about how women develop the ongoing relationship with their women's healthcare organization. Though women may initiate contact with the organization, there is no requirement that they continue the relationship in the future.

This study focused on women who consistently used Planned Parenthood for their reproductive and women's healthcare needs. Women's decisions to continue the relationship with the organization is grounded in the experiences they accumulate across visits to the site, the relationships they develop with employees, and the discourse surrounding the organization. This question identified those aspects of the organizational relationship that impacted women's decisions to continue to use the organization for their healthcare services.

The third research question expanded on upon the second, and inquired about how women experience the relationships with their healthcare organization, and how they negotiate their healthcare within that relationship. Once women enter into a relationship with the organization, they make communicative decisions about how best to address their needs. This question highlighted the extent to which women express their agency, and what steps they take in order to do so.

The final research question explored how the needs determined and expressed by women, embedded within the relationship with their healthcare organization, contribute to their overall understandings of women's health and healthcare. Women who use the nonprofit healthcare organization often do so amid barriers to alternative access points. When they do undertake a relationship with the organization, the organization and relationship contribute to the ways they experience and navigate healthcare. Throughout the relationship, this interaction continues to inform these understandings of health. As such, this question investigated how individual needs of women and the organizational relationship shaped overall understandings of women's healthcare.

Summary

This chapter presented the rationale for the study of nonprofit organizations from the client perspective. It emphasizes the role that nonprofit organizations play in meeting otherwise unmet social needs, but calls into question the extent to which these organizations work to preserve agency among clients. Nonprofit organizations serve an advocacy role in addition to providing services, but what these organizations advocate for is dependent on needs articulated by clients. Planned Parenthood fulfills both of these roles—the organization advocates for reproductive choice and provides access to reproductive care options, particularly among low-income women. The ways in which members of the organization enact its identity directly impacts the relationship women build with Planned Parenthood, and contribute to their continued use. Initial contact with the organization is marked by perceptions of the organization’s ability to fit with women’s beliefs about reproductive care. Women’s socioeconomic status and access to contraceptives and other women’s healthcare services highlights the need for an organization of this kind.

To better understand the role of the nonprofit women’s healthcare organization on women’s healthcare understandings and decisions, the voice of those women must be highlighted and incorporated within the greater understanding of the organization. While nonprofit organizations often exist to meet needs otherwise unmet through traditional social structures, the individuals they serve evaluate their work and choose whether or not to enter into and continue the relationship. Thus, the aim of this study was to use a qualitative approach to explore and describe the role of the organization in women’s efforts to have healthcare needs met and the ways in which that relationship impacts health and healthcare beliefs and decisions. This research can better inform the work nonprofit organizations conduct, and the extent to which

they highlight agency rather than restrict their clients, who oftentimes face marginalization within the broader social system.

CHAPTER 2 METHOD

This chapter discusses the qualitative methodology employed to answer the research questions, and provides justification for using in-depth interviews. This qualitative approach was used to gather a thick description of women's experience with their women's healthcare through the nonprofit organization. First, this chapter provides the justification for using qualitative methods to understand women's experiences with the nonprofit organization. Second, I provide my positionality as a researcher investigating this topic. Third, a rationale is provided for using in-depth interviews and follow-up interviews to gain an understanding of this lived experience, and a description of the interview approach employed. Fourth, an explanation of the organization as an appropriate point-of-entry is given. Fifth, the chapter discusses the data collection process of recruiting participants and collecting interviews. Finally, the procedures for data analysis and interpretation are described.

Qualitative Methodology

This study utilized qualitative methods for a number of reasons. First, this project targets a nonprofit organization that provides women's healthcare, providing access that may not otherwise exist for their clients. This type of applied research serves the purpose of working collaboratively with clients of the organization "to define problems, set goals, identify contributing factors, formulate strategies, and implement solutions" (Lindlof & Taylor, 2011, p. 18). Qualitative research is positioned to isolate the target group and provide a space for those whose experiences are the subject of inquiry to speak. This research is also situated within the health/care context. Within health communication research, qualitative methods "restore the integrity of patient subjectivity and agency in medical encounters" (p. 19). This is in contrast to quantitative methods in health communication research, which critics argue "can reproduce the

hierarchical authority of medical professionals over patients and obscure their experiences” (p. 19). Qualitative methods have proven useful in studying nontraditional organizational settings, such as nonprofit and nongovernmental organizations. Lastly, in the area of strategic communication, qualitative methods have seen a marked increase in application amid a “general shift of corporate sensibility in which organizations detached from traditional models of presumptuous, unilateral influence to engage in *dialogue* [emphasis original] with their stakeholders that permitted mutual curiosity, greater understanding of values and motives, and the discovery of opportunities for collaboration” (pp. 28-29).

The iterative approach to research was particularly fitting for this study, as it began with the previously discussed theoretical frameworks for inquiry, by left considerable space for the emergent qualitative data to respond to the research questions posed (Tracy, 2013). Throughout the data collection process, additional areas of interest were revealed and further researched to better illuminate the phenomena of interest. Qualitative research allows the researcher to abstain from predicting the outcome of a study, and requires constant reflexivity (Lindlof & Taylor, 2011). This allowed the research findings to emerge from the interviews with participants, providing flexibility in data analysis while seeking insight into the relationship women develop with the healthcare organization without pre-established themes or assumptions.

Positionality and Feminist Research

Prior to conducting this study, I outlined my positionality. England (1994) argues “fieldwork is intensely personal, in that the positionality...and biography of the researcher plays a central role in the research process, in the field as well as in the final text” (p. 241). She argues that,

research is a process not just a product. Part of this process involves reflecting on, and learning from past research experiences, being able to re-evaluate our research

critically...In short, I see research as an ongoing, intersubjective (or more broadly, a dialogic) activity (p. 244).

Ritchie, Zwi, Blignault, Bunde-Birouste and Silove (2009) found that transparency of positionality is exceptionally important when engaging in health-development research and practice. Transparency with participants allows both researchers and participants to understand the extent to which positionality influences interpretations of findings. Moreover, “responding to this transparency in a reflexive manner allowed reciprocity: not only did the participants give for our gain, but we learned, especially when we provided feedback at a community meeting and later at a national workshop, that they felt we had something to give them back for their benefit” (p. 111).

I approached this research from a feminist standpoint for several reasons. First, I personally identify as a feminist, and to exclude this stance would impart an ethical hindrance on the quality of the study. An emphasis on gender (in)equity in society marks my approach to research and social engagement. I am ideologically committed to a radical feminist perspective, asserting that inequality and oppression are products of systemic influences on gender roles and the ways in which the genders are valued or not; moreover, women can be defined as a social class, one which faces oppression through patriarchal social structures, and that liberation from gender oppression must be developed from women themselves (Rowland & Klein, 1996).

Second, women’s reproductive healthcare is uniquely gendered, and to attempt to remove a feminist understanding of the phenomenon would inevitably fall short. Systemic norms affect how women and men experience health through processes of receiving care and decisions about addressing health issues, such as prioritizing the conservation of the breasts among women with breast cancer as a means of preserving femininity (Lorber & Moore, 2011). Planned Parenthood, as an organization of interest, is dedicated to women’s reproductive health, and is rooted in

feminism and women's right to reproductive freedom. Reproductive services such as contraception and preventative screenings for cervical cancer pertain solely to women, which has been affirmed through a series of court rulings. As such, the study of women's reproductive healthcare is inherently marked by my feminist positionality.

Third, understanding the relationship women have with their reproductive healthcare organization is to understand both the lived experience of women themselves as they pursue health goals and the nature of an organization devoted to meeting uniquely gendered (feminist) healthcare needs. As such, the nature of this research design takes on a feminist slant. While socioeconomic and racial/ethnic inequality impact disparities in how individuals experience healthcare, gender influences the ways in which women and men prioritize health and make health-related decisions (Bird & Rieker, 2008). This study prioritizes women's experience with reproductive healthcare, which pertains solely to the female body, and highlights the ways in which women experience, prioritize, and negotiate their individual care, placing an emphasis on women's place in the healthcare system.

Fourth, understanding health, healthcare access, and the relationship with healthcare providers (the healthcare organization) interrogates access, power, and marginalization. Maintaining an understanding of power and hegemony in the healthcare system and the relationships women perceive through interactions with these organizations is bound to a radical feminist critique of social structure. This informs the intended methodological approach, wherein I seek collaboration and reciprocal gains with participants by better understanding the role of the organization in women's reproductive healthcare understandings and processes.

These justifications lead to my final rationale for incorporating a feminist positionality. Here, I aim to engage, through research and findings, potential social change initiatives to better

the health experience of women seeking reproductive care amid financial or other limitations to access. Ultimately, these perspectives informed my pre-data collection sensitization, and influence my decision to impart my feminist positionality.

In-Depth Interviews

In order to investigate the research questions, this project utilized qualitative interviewing. This project sought to understand the nature of the relationship women develop with their women's healthcare organization. In so doing, women who use Planned Parenthood as their primary women's healthcare site were recruited for in-depth interviews to better understand their reasons for selecting that organization for care, how that relationship develops over time and is experienced by women, and how the nature of that relationship contributes to women's understandings of health and healthcare.

In developing the interview approach for this study, Brinkmann and Kvale (2015) describe the phenomenological approach to the qualitative research interview as focused on "the experienced meanings of the subjects' life world" (p. 30). This approach accounts for the life world as it is experienced in daily encounters, pre-reflective of critique or analysis. It also accounts for the meaning that is central to the subject's experience in the life world, and is qualitative in nature and resists quantitative measurement. This type of interview asks interviewees to be as descriptive as possible in answering interview questions, emphasizes reflections on specific situations and events, and requires the interviewer to remain open to new and unexpected phenomena. This interview approach suits the openness and experience-based nature of the research questions proffered. As such, an iterative approach to qualitative interviewing was most appropriate for the study at hand.

Twenty women participated in this research study. Initial interviews lasted between 31 and 82 minutes, with 50 minutes being the average initial interview length. Four women agreed to participate in follow-up interviews. These lasted between 15 and 66 minutes, though the 66-minute interview was substantially longer than the others. The average length of follow up interviews was 28 minutes, though three of the four lasted only 15 to 17 minutes. A total of 18.4 hours of interview data was collected across the twenty participants.

The Organization: Planned Parenthood of Mid and South Michigan

This dissertation aimed to understand women's healthcare from the perspective of healthcare center clients. Specifically, the study aimed to understand how Planned Parenthood, as the most nationally recognizable women's healthcare organization, meets the needs (or does not) of clients who choose to receive care with them. Planned Parenthood served as a point of entry for the study as a nonprofit health organization with a wide presence, which focuses solely on women's healthcare issues and makes these services available primarily to low income populations.

Planned Parenthood is one of the innumerable nonprofit organizations that work to meet the needs of individuals unable to receive services in traditional settings. Whereas a culture-centered approach (see Dutta, 2008), grounded in subaltern studies, argues that NGOs and civil society agents tend to promote personal and neoliberal agendas, de Souza (2009) suggests that "civil society organizations such as NGOs are not inherently antithetical to community programs, but only insofar as they silence community voices" (p. 694). Planned Parenthood is a suitable site for this study, as it (1) is an inherently gendered organization, (2) upholds feminist political values, and (3) operates nationally, making critique of the organization's ability to engage localized clients worthy of investigation.

Planned Parenthood of Mid and South Michigan was chosen specifically to provide parameters on the participants recruited for the selection, ensuring that all participants were subjected to the same regulations on women's healthcare. Moreover, placing limits on a nationwide organization better allowed for experiences unique to the geographic area and culture to surface. Women in this study experienced Planned Parenthood under the same regional oversight and resided within a distinct geographic/cultural area. However, as a national organization, there may be some findings from this investigation that have the potential to transfer to the national organization and to other nonprofit health organizations. Still, the geographic parameters in which this study was conducted should be thoughtfully considered. Planned Parenthood's (2014) mission statement indicates that the organization works to "reflect [*sic*] the diverse communities within which we operate." Yet, there is no indication that the organization works *directly* with community members to develop services. This study engaged directly with clients of Planned Parenthood to understand the decision to seek reproductive healthcare services at this organization and the nature of that relationship.

Planned Parenthood provokes interest as an organization that continues to provide abortion services, which, though constitutionally legal, is consistently under political fire. This makes Planned Parenthood a complicated organization. In fact, in 2012, the Susan G. Komen Foundation opted to eliminate funding for breast cancer screenings conducted at Planned Parenthood for political reasons. The Komen Foundation did quickly revoke the decision, and continues to support Planned Parenthood, but separates themselves on the basis of abortion care services (Wallis, 2012).

It is important understand, from the clients' perspectives, the efficacy of nonprofit organizations. Criticism of NGOs and civil society organizations cannot be ignored. Dutta-

Bergman (2005) argues that “in civil societies it is fundamentally the capital that drives social organizations such as welfare agencies, NGOs, hospitals, and churches” and moreover that “It is only by participating in the generation of greater capital for the United States that NGOs generate the capital for their survival” (p. 279). Of interest, then, is whether or not Planned Parenthood functions as a traditional, capitalist organization, or if, by contrast, the organization remains steadfast to feminist ideals and feminist organizing practices that better incorporate the voices of those they seek to effectively serve.

Data Collection

This study used in-depth interviews and follow-up interviews from women who use Planned Parenthood of Mid and South Michigan as their primary women’s healthcare organization. Twenty initial interviews were collected. As transcription and analysis were underway, eleven women were approached about follow-up interviews. Of these women, four agreed and participated in follow-up interviews. These allowed a space for member reflection questions, wherein I was able to provide my understanding of the data collected thus far and allow the participant to reflect and comment upon it (Tracy, 2013). “Member reflections allow participants to give an opinion and shape the emerging analysis” (p. 150). Participant names were changed to preserve anonymity.

Participants

Twenty women were selected for participation in this investigation. This section begins by providing the criteria for participant selection. Second, a justification for the size of the sample is discussed. Third, the recruitment process is outlined. Fourth, the interview format is detailed. Finally, the interview procedure is specified.

Criteria. The eligibility criteria required that women use Planned Parenthood of Mid and South Michigan as their primary clinic for women's health. In determining the criteria for participation in qualitative research, the sample must also be appropriate to meet the goals of the study. Here, the goal was to understand the decision-making moment for women who identify a primary reproductive healthcare site, and to explore the relationship women have with this organization. As such, women needed to identify the organization as their primary women's healthcare site in order to understand client decisions to seek care at a clinic focused specifically on women's reproductive health.

It was vital that women be current clients of the organization. Women were first asked whether they use Planned Parenthood of Mid and South Michigan as their primary women's healthcare clinic. This study also required participants to be at least 18 years of age. They were then asked to respond to a list of services provided and select those that they had used. Women were able to select from the following services based on services outlined on the organization's website: birth control, permanent birth control, pelvic exam, prenatal programs, abortion services, emergency contraceptives, STD/STI testing, pregnancy testing, and other. Participants were also asked to report their race/ethnicity and income level; this demographic information did not affect eligibility or selection but was used for sample characteristic information if selected. Reporting this information was optional. The eligibility survey is included in Appendix E.

It was important not to deter participation by requiring participants to report their demographic information. However, this resulted in three participants declining to report race and ten, or half, of the participants declining to report income. Participants ranged from 18-40 years of age. Nine participants identified as White, six as African American, one as Native American, and one as White/Asian. Eight participants earned between \$15,000 and \$24,999, one

earned between \$25,000 and \$34,999, and one earned between \$10,000 and \$14,999 annually. A table providing services sought and the demographic characteristics collected is included in Appendix C.

Selection. In addition to the general criteria women were required to meet to participate in the study, maximum variation sampling was used in regard to services sought. For example, Planned Parenthood offers birth control services and STD/STI testing, but also offers breast cancer screenings, pelvic exams, or abortion services. It was ideal for women who agreed to participate in the study to have sought a variety of services through the organization to ensure the inclusion of data that may typically be marginalized (Tracy, 2013). This was a more significant criterion than age, for example, which is not directly included in the research questions/goals.

Approximately 50 responses were collected via the online survey, phone, and email. All participants who met the eligibility requirements were contacted for an interview, though not all initial respondents responded to the follow-up communication. Participants were required to report their age to ensure they were at least 18 years old and therefore eligible for participation. The goal of this study was to understand women's decisions to use Planned Parenthood of Mid and South Michigan as their primary women's healthcare organization as it reflects that Planned Parenthood jurisdiction, while understanding users' experiences across services offered by the organization. Therefore, the variety of services used was important.

Size. Whereas sample size is crucial in quantitative research, which is dependent on statistical calculation, life world research might consider sample size by the notion that "the more complex a phenomenon, the larger the group of informants" (Dahlberg, Dahlberg, & Nystrom, 2008, p. 175 via Vagle, 2014). In order to meet Tracy's (2010) criteria for credibility in

qualitative research, multivocality must be accessed through drawing from clients of more than one clinic site, engaging some diversity in demographic.

Though qualitative research eschews predetermined sample size, Lindlof and Taylor (2011) suggest, “The main factors to consider are the scope of the project, the complexity of the scene under study, and the researcher’s time and resources” (p. 177). Tracy (2013) echoes this, suggesting, “The answer to ‘how many’ depends on the richness of the data gathered from other sources, on budget, and on timeline” (p. 138). Tracy’s (2012) notion of rich rigor suggests that the amount of data must be enough to support significant claims, the sample must be appropriate given the goals of the study, the researcher must spend ample time gathering interesting and significant data, and the researcher must use appropriate data collection and analysis procedures. Theoretical saturation was kept as a goal for data collection, which “in effect, is the point at which no new insights are obtained, no new themes are identified, and no issues arise regarding a category of data” (Bowen, 2008, p. 140).

In this study, 20 women were interviewed. These women were contacted and interviewed after responding to the recruitment flyer by contacting the researcher directly or responding to the Qualtrics survey. While approximately 50 women responded to the call for participants, several indicate that their preferred contact method was email, but did not provide an email address in response to the survey. Multiple women inquired about participation having used Planned Parenthood in different states in the past, but never having used the organization in Michigan, thus excluding them from eligibility. Several women indicated interest, but when contacted by the researcher to set up an initial interview, did not answer or respond. This left the sample interviewed for this study much smaller than the number of women who initially indicated interest.

As data was collected and being transcribed and analyzed, eleven women were contacted and asked to participate in follow-up interviews. Of these, four women agreed to participate in follow-up interviews. Initial interviews were between 33 and 89 minutes in length, and averaged 48 minutes total. Follow-up interviews lasted between 15 and 86 minutes. Again, maximum variation sampling was used regarding services sought to ensure that women were using the organization for a variety of services offered. Of the initial interviews, 6 were conducted face-to-face, 13 were conducted over web-conferencing programs that allowed video, and one was done over the phone. All four of the follow-up interviews were done over web-conferencing programs that allowed video.

Recruitment. In order to understand the circumstances that influence a woman's decisions regarding women's healthcare, and the decision to use a nationwide organization specifically for that care, it was important to recruit from multiple healthcare sites. To recruit women solely from one site would likely influence the data by serving more as a community health organization as opposed to the nationwide service that Planned Parenthood provides. Women were recruited from the healthcare centers that fall under Planned Parenthood of Mid and South Michigan. This regional jurisdiction includes 19 healthcare clinics.

Women were recruited through a number of outlets. First, women were recruited using a flyer and in-class visits by the researcher in a number of undergraduate courses at Wayne State University. As a nonprofit healthcare organization that provides politically controversial services such as abortions and birth control, several users of Planned Parenthood indicated hesitation to disclose their healthcare site to others. Snowball sampling techniques are well suited to reach marginalized populations (Tracy 2013). As per the recruiting pitch, students were asked to follow the contact information provided in the flyer, or to notify friends or family who fit the

criteria. Second, the flyer and recruiting pitch was posted on the university-wide website. Again, participants were asked to share the study with others who may be interested. The study was subsequently shared via Facebook. Finally, the flyer and recruitment pitch were posted on Craigslist in cities encompassing the regional jurisdiction required. The researcher's contact information was provided on the flyer, as was a link to a Qualtrics survey that asked participants for a first name, demographic information, and eligibility. This information was verified over the phone or email if participants chose to inquire via those methods. The recruitment flyer is provided in Appendix B.

Participants were provided a Target gift card to compensate for their time and willingness to participate in the research endeavor. For initial interviews, women were provided a \$50 Target gift card, provided as either a plastic gift card or e-card, whichever they preferred. For participants who were asked to participate in follow-up interviews and consented, a \$25 Target gift card was provided in one of the two formats provided for initial interviews. Eleven women were contacted for follow-up interviews based upon lingering questions that arose during initial data immersion. Of these, four women agreed to participate in the follow-up interviews.

Interview Format. Methodologically, this study implemented in-depth interviews and follow-up interviews. The goal of the interview process here was to mine the experiences that already exist within participants, consistent with the phenomenological interview (Brinkmann & Kvale, 2015). Brinkmann and Kvale note that, while this type of interviewing may seem harmonious, there are inherent issues of power asymmetry between the researcher and the participant. The interview is not an everyday conversation, but rather was conceptualized by the researcher with a specific research purpose. The interview involves one-directional questioning, in which the interviewer poses specific questions for the interviewee to answer. Moreover, the

interviewer holds the monopoly of interpretation over the content the interviewee shares. The interviewee, though, has the power to withhold information or talk around particular subjects when the researcher poses questions, and ultimately has the power to withdraw from the interview entirely. I reckoned with this inherent power asymmetry throughout the data collection process. Participants were offered an opportunity to read the initial findings in order to alleviate the power discrepancy to some extent, allowing a small space for collaborative interpretation.

Data collection took place predominantly through in-depth interviews focused on the decision to seek reproductive healthcare services at a women's clinic specifically. Interviews were conducted in a mutually agreed upon setting, suggested by women, wherein comfort and privacy could be ensured. Interviews were conducted in-person and through mediated contexts. In the case of distance interviews, women determined the preferred modality among phone, Skype, FaceTime, and Google Hangouts. Originally, in-person interviews were preferred over distance interviews. However, I noted that the mediated context actually made the presence of the recording device less obtrusive in many instances. Still, on multiple interviews, the mediated format caused undesired pauses in the interviews when the internet connection on either end became choppy. Follow-up interviews were less structured than initial interviews, and only focused on one or two topics addressed in the participant's initial interview and a general discussion of emerging findings.

A semi-structured interview guide was used for initial interviews, as these "offer a more informal, flexible approach" (Lindlof & Taylor, 2011, p. 200). The interview guide used in this study can be found in Appendix A. This helped to ensure that interviews were being conducted in a way that would respond to the research questions, but allowed me flexibility as far as when and how those questions were asked. The "semistructured life world interview attempts to

understand themes of the lived everyday world from the subjects' own perspective" and "seeks to obtain descriptions of the interviewees' lived world with respect to interpretation of the meaning of the described phenomena" (Brinkmann & Kvale, 2015, p. 30). This type of interview resembles everyday conversation, but is purposeful and focuses on specific themes in line with the nature of the study. Questions were designed based upon the research questions, and in line with Brinkmann and Kvale's (2015) open-ended, phenomenological approach. First, women were asked to openly describe their women's health practices independently and when and why they chose to seek care. From here, women were asked about the meanings of their healthcare, as well as their rationale for using Planned Parenthood to have their healthcare needs met. A funnel-shaped questioning technique was implemented to gradually narrow down on the subject matter, "in order to obtain the interviewees' spontaneous views on a topic and to avoid leading them to specific answers" (p. 94).

Procedure. Once women agreed to participate in the study, the researcher worked with the participant collaboratively to identify a time and location/modality for the interview. Women were provided an information sheet via the Qualtrics survey, and acknowledged that clicking "submit" indicated their consent to participate. Women who did not fill out the Qualtrics survey were asked to sign an informed consent document. Prior to beginning the interview, I introduced myself and the project to the participant. Mayan (2009) considers this the first stage of the interview process, as "It centers on putting both the interviewer and the participant at ease through informal chat and by reviewing the topic and how you will use the participant's information" (p. 68). Once this information was clarified, women were asked to provide their oral consent to be audio recorded prior to beginning the recording, and once again after the recording began.

Once the interview began, the interview guide was used to ensure that the conversation spoke to the research questions. Women were asked to talk openly about their experiences, and a number of follow-up questions were posed to clarify experiences and meanings as the interview progressed. Women were provided the opportunity at the end of the interview to voice any additional experiences or concerns that did not arise in the questions to ensure that they had the opportunity to discuss everything they felt was important. Upon completion of the initial interview, women were compensated with the \$50 Target gift card.

Women were also asked about their availability and willingness to set up follow-up interviews as data was analyzed. Several women who agreed to this were contacted as the data was being transcribed and analyzed, and those who responded and agreed to participate scheduled a time to conduct the follow-up interview. At this point, women were more familiar with the project, but still engaged in pre-interview conversation. They again were asked to provide oral consent to the audio recording prior to beginning the recording, and again once the recording began. These interviews focused on clarifying findings that were emerging through data analysis. Participants were provided information about some general findings, and asked to reflect upon those. Upon completion of each follow-up interview, women were compensated with the \$25 Target gift card.

Data Analysis

Although data collection and analysis are discussed in separate sections of this dissertation, during the study they often occurred simultaneously. Tracy (2013) recommends that about three quarters of the way through data collection, “researchers submerge themselves in the entire breadth of the data by reading and re-reading them, listening to them, and thinking about them” (p. 188). This allows the researcher to become immersed in the data and consider a variety

of interpretations without making concrete judgments. With this process in mind, what follows is a description of the specific process of data analysis.

Data Management

Data management is the process of “Gaining some control over data that tend to grow rapidly in a project” (Lindlof & Taylor, 2011, p. 243). As discussed, interviews were audio recorded using a personal recording device. These recordings were uploaded to the researcher’s password secure laptop computer, and transcribed using Transcribe by Wreally Studios, a playback program that allows the pace of speech to be slowed. Once an interview was transcribed, the text was pasted into a Microsoft Word document, the participant was assigned a pseudonym, and the audio recording was permanently destroyed. At this stage, the transcript *becomes* the interview [emphasis original]” (p. 211). I also used analytic memos to keep track of literature that needed to be (re)visited as data was initially transcribed and analyzed. These also provided a space for conversations with myself about what might be surfacing from the data as the collection process was underway. These memos were also useful as a personal method-tracking device, used to keep track of methodological decisions throughout the data collection and analysis processes.

Qualitative data analysis software was also used to manage and organize data. Once interview data was converted to a Microsoft Word document, ATLAS.ti version 1.0.41 was used to import the documents and develop and assign codes to the data. Analytic memos were also organized in ATLAS.ti. The software allowed for quick retrieval of those codes while maintaining the ability to analyze the data within the larger context of the study. With data organized and managed, data reduction strategies were used to aid in data analysis.

Data Reduction

Data reduction strategies were employed to make sense of the organized data. Data reduction “means that the value of evidence is prioritized according to emerging schemes of interpretation” (Lindlof & Taylor, 2011, p. 243). Here, “data are ‘reduced’ by categories and codes that put you in touch with those parts of the material that can be used to construct claims” (p. 243). Throughout the data collection process, I took moments to reflect on methodological decisions, the interview process, and data. This allowed me to identify emerging themes or ideas that were appearing in the data, and consider ways of refining the interview approach. “Analytic memos are ‘sites of conversation with ourselves about our data [Clarke, 2005, p. 202] and a place to ‘dump your brain’ [Saldana, 2009, p. 32]” (Tracy, 2013, p. 2013, p. 196). These allowed for free writing where I was able to “write first and understand later” (p. 196). These allowed me to consider important concepts and remind me to (re)visit literature to further develop ideas and understandings of the emergent data.

In addition to the analytic memos, primary-cycle coding was used to make initial sense of the data. “Primary-cycle coding begins with an examination of the data and assigning words or phrases that capture their essence” (Tracy, 2013, p. 189). Because the phenomenological approach to qualitative interview research was used (Brinkmann & Kvale, 2015), incorporating the phenomenological approach to data analysis was useful. Phenomenological research has “a substantive commitment to a whole-part-whole analysis method” (Vagle, 2014, p. 97). More specifically, Vagle suggests that

we must always think about focal meanings (e.g., moments) in relation to the whole (e.g., broader context) from which they are situated—and once we begin to remove parts from one context and put them in dialogue with other parts, we end up creating new analytic wholes that have the particular meanings in relation to the phenomenon (p. 97).

Vagle goes on to describe the analysis processes in six steps. The first is the holistic reading of the entire text—all transcript data, notes, and descriptive writings. This is followed by a line-by-line reading, which generally leads to follow-up questions for participants. Following this, a second and third line-by-line reading help the researcher to focus on intentionality rather than subjective experience. Subsequent readings may also allow themes to arise across texts, with analytic asides and additional writing by the researcher continuing to illuminate the phenomenon.

This process mirrors Tracy's (2013) recommendation that near the end of data collection the researcher submerge herself in the data, reading and re-reading transcripts and notes to become fully immersed. This allows the researcher to have a strong sense of the data before engaging in primary-cycle coding. This process was helpful in immersing myself in the data for a holistic understanding of the interviews, followed by the line-by-line reading used to develop codes, and finally the overall interpretation to ensure that the analysis resonated with the interviews in full.

To emulate this process in this research study, I used primary-cycle coding in ATLAS.ti. During this phase, following a holistic read of the interview transcripts, I identified instances in which women discussed their women's healthcare beliefs and rationale. Primary-cycle codes were descriptive of the data, and required little interpretation (Tracy, 2013). I also identified instances where women discussed their experiences with Planned Parenthood, their reasons for using that organization, and instances of dissatisfaction with the organization. During this phase, I recognized that women were frequently discussing their preconceived notions about the organization prior to initially making an appointment, or information they received about the

organization from loved ones. This led me to investigate literature on reputation and branding among nonprofit organizations.

It was also during this phase that it became apparent that women were discussing the importance of trust in the organization, and the extent to which they felt the organization was in line with their personal beliefs. This led me to dig deeper into the literature on organizational trust and organizational identity. “Iteration is ‘not a repetitive mechanical task,’ but rather a reflexive process in which the researcher visits and revisits the data, connects them to emerging insights, and progressively refines his/her focus and understandings [Srivastava & Hopwood, 2009, p. 77]” (Tracy, 2013, p. 184). This phase also illuminated the role that Planned Parenthood had in providing access to women who had limited options due to insurance restrictions, which spoke to the literature on nonprofit organizations that meet needs not met through the government or private sectors, and broader literature on health disparities.

These initial findings, and returning to the literature, allowed me to undertake second-level coding, where the primary-cycle codes were synthesized and explained (Tracy, 2013). The literature described in the previous chapter provided grounding for my second-level codes. Here, I used the constant-comparative methods, wherein “Categories develop through an ongoing process of comparing units of data with each other (Lindlof & Taylor, 2011, p. 250). During this process, I compared statements both within interviews and across different interviews to gain a cohesive representation of the data (Charmaz, 2006 via Tracy, 2013). “Consistently reviewing your codes and their explanations and slightly modifying them or creating new ones along the way helps with avoiding ‘definitional drift’ as you code your data” (Tracy, 2013, p. 190). These analytic processes helped to reduce the data into manageable categories, which were then used for the final state of data analysis: interpretation.

Interpretation

The final step in the data analysis process was interpretation. “Interpretation involves the translation of an object of analysis from one frame of meaning to another” (Lindlof & Taylor, 2013, p. 266). During this step, the study moved from description through the use of codes to frames of meaning. Here, the literature became useful in making sense of the data, and positioned the data within the larger scholarly conversation. “This act of translation adds tremendous value to a study by using theories, other conceptual devices, and your own imagination to understand the data and their analytic categories in a new light” (p. 266).

One means of interpreting the data was through the use of exemplars, or examples extracted from the data that illustrate a number of the facets of the emerging analysis. Tracy (2013) explains,

Sometimes exemplars shine brilliantly only after several cycles of analysis, when various codes get layered one on top of the next and it becomes evident that a particular data segment is meaningfully saturated by different facets of the emerging examination. Other times, the researcher knows from the moment of data collection (in the field or in the interview) that she has just witnessed a situation or heard a quotation that beautifully sums up the analysis” (p. 207).

Exemplars were identified throughout the data analysis process, and helped to embody the emergent findings and argument developing around the study.

Another useful interpretation tool used in this study was the use of a table to organize findings and put them in conversation with one another. While ATLAS.ti was used to organize and manage the majority of the data, once the data interpretation phase was underway it became more useful to add a manual approach. I hand-wrote codes on paper and laid them out so that each paper was visible. Then, I began to think about the codes in relation to one another and to the research questions. At this point, I was able to develop a table to organize findings. “Tables...are instrumental for getting your head around the detail and expanse of the data”

(Tracy, 2013, p. 214). A table is useful in organizing existing data and highlighting missing data. A final iteration of this table is provided in Appendix D.

Quality Measures

Finally, this study incorporated quality measures to ensure an accurate read of the data was represented. One of these measures was the use of follow-up interviews to clarify emerging concepts with participants and make sure that they reflected the lived experience of the women (Tracy, 2013). Through follow-up interviews, I was able to assess the extent to which the initial coding and emergent analysis were on track. Four participants agreed to participate in follow-up interviews. Member reflections “allow for sharing and dialoguing with participants about the study’s findings, and providing opportunities for questions, critique, feedback, affirmation, and even collaboration” (Tracy, 2010, p. 844). Member reflections allow for collaboration with participants as well as what Tracy calls “reflexive elaboration.” Moreover, this process helps the researcher learn from participants whether initial findings are comprehensible and meaningful.

As the interpretation was drafted, it was important to reflect on multivocality. Multivocality “means analyzing social action from a variety of participants’ points of view and highlighting divergent or disagreeable standpoints” (Tracy, 2013, p. 237). Though the coding process allowed me to synthesize the dominant experience and highlight that in the findings, it was important to include instances of women having alternative, sometimes conflicting experiences and represent those in the text as well.

Tracy argues, “Writing a multivocal analysis can be facilitated through collaboration with research participants” (p. 238). Therefore, in addition to the follow-up interviews, participants were asked upon completion of initial interviews whether they would be interested in reviewing a draft of the findings to discuss the extent to which they felt that their experiences were being

accurately articulated. Participants who were willing to participate in member reflections were provided a draft of interview findings and asked to provide feedback on the extent to which representations resonated with their experience in order to ensure the quality of participant representations was sound. Nine women provided feedback on a completed draft of the study's findings. Member reflections differ from other member checking processes, as "member reflections suggest that participant feedback is valuable not as a measure of validity, but as a space for additional insight and credibility" (p. 238). These member reflections also allow the researcher to discover whether their findings are understandable and meaningful to participants who donated their time and shared their experiences for the project.

In summary, this chapter provided an overview of the study design, background on the organization that served as a point of entry for the study, data collection methods, and data analysis and interpretation procedures. In the next chapter, results of the data collection and analysis are discussed. Specifically, the results will describe the experiences of women navigating the nonprofit healthcare organization and the ways in which they manage and understand their health as they interact with the organization to have those needs met (or not).

CHAPTER 3 RESULTS

As discussed, nonprofit organizations function to meet needs unmet in the public or private sectors. In so doing, service-based nonprofits reach clients with few opportunities to access necessary services. Clients evaluate the ability of the nonprofit organization to meet the needs that they determine and identify. The Planned Parenthood mission statement opens saying, “Planned Parenthood believes in the fundamental right of each individual, throughout the world, to manage his or her fertility, regardless of the individual’s income, marital status, race, ethnicity, sexual orientation, age, national origin, or residence” (Planned Parenthood, 2016). This chapter describes how clients of Planned Parenthood evaluate the organization related to initiating contact for care. It then discusses how women develop and sustain their relationship overtime, once the relationship has been established. Next, this chapter explores how women experience and negotiate the organizational relationship. Finally, the organization’s contribution to understandings of women’s health and healthcare are discussed.

Making Contact

In order to enter into a healthcare relationship with the organization, women first need to make contact. Participants described a number of influences on their decision to make contact with Planned Parenthood for reproductive healthcare. Among them were financial constraints and becoming sexually active. They also discussed influences in their lives that led them to Planned Parenthood as an organization that would be able to meet their needs. Additionally, they discussed internal beliefs about the need for care that focused solely on the female body, as well as some conflicting beliefs that complicated their initial contact with the organization.

Making Contact				
Experiencing Financial Constraints	Being Sexually Active	Being Directed to Planned Parenthood	Recognizing the Uniqueness of Women's Bodies	Reconciling Conflicting Beliefs
<i>Unable to provide insurance</i>	<i>Became sexually active</i>	<i>Mom's role</i>	<i>Specialists are better for the female body</i>	<i>Religious upbringing</i>
<i>Require care offered at a reduced cost</i>	<i>Were young</i>	<i>Friends' or siblings' recommendation</i>	<i>Women need their own space</i>	<i>Political stance</i>
<i>Desire privacy from parents</i>	<i>Needed (new) birth control</i>	<i>Planned Parenthood's advertising and/or reputation</i>		
	<i>Experienced a pregnancy scare</i>	<i>Impact of upbringing and family life</i>		

Table 1: Motivators for initiating contact with Planned Parenthood.

Experiencing Financial Constraints

Nearly all of the women interviewed discussed Planned Parenthood's ability to meet their healthcare needs in spite of financial constraints. Planned Parenthood works with women who are unable to provide insurance to access services based upon their financial situation. Participants discussed a lack of insurance as a primary motivator for visiting Planned Parenthood, and acknowledged the sliding scale payment system the organization makes available to clients. Although some of the women discussed having insurance, they did not want the policyholder to be aware of their sexual activity and, therefore, did not want to use their insurance. Others discussed having previously gone without insurance, but gaining access through the Patient Protection and Affordable Care Act. While the Act provides increased access and choice, women discussed their comfort with Planned Parenthood and continued affordability of care through the organization once they had acquired insurance.

Unable to provide insurance. Several women discussed a lack of health insurance as a barrier to receiving necessary care. Often, women talked about conversations or word-of-mouth that led them to Planned Parenthood as an organization that would work with you even if you were unable to provide health insurance. Shonda¹'s interview highlights this when she explained,

At the time I didn't have insurance—reliable insurance, so I'd been recommended down through the years that, uh, that Planned Parenthood do like a pay scale and stuff like that. I was goin' to college actually and they were always outside. They were always outside passin' out condoms and information and stuff so Planned Parenthood was literally down the street from our school, and um, you know, that was like the go-to place basically everybody that was sexually active, on top of you could just go there if you didn't have insurance, and it was right down the street walkin' distance and if you didn't have any money you were always able to...donation or you could just go down there and that was like the best place to go.

Shonda discussed the reputation Planned Parenthood had as a place that would help sexually active women with no health insurance. In fact, she described the efforts on the part of the organization to initiate contact with women.

Ruth's interview discussed initiating contact with Planned Parenthood at a time when she was without health insurance. For Ruth, her needs were more explicit, and referred to additional financial concerns associated with not working and having to pay more than she could afford for birth control. Ruth explains,

I started going to Planned Parenthood when I—let me think. Might have been... [sigh] like the mid 2000s? I wanna say for sure... like 2005 or 2006. A period of time where I wasn't working and I didn't have any insurance and I actually was... sexually active. In all kinds of ways. I did, didn't... you know, like I wanted to be on the pill regularly. And I wanted to use that in conjunction with condoms for STI protection. And I just wanted like, where I knew I could go like, you can get your pills in the office at some of the offices. So it was really nice not to worry about a prescription cost.

Ruth goes on to describe the stress that accompanies accessing healthcare when income is tight.

She says, "It's like, you're only working part time and you don't have insurance, \$60 is a big

¹ Pseudonyms are used in place of participant names in order to preserve confidentiality.

difference, you know?” Lindsay discussed having health insurance, but facing setbacks trying to use it at her campus healthcare clinic. She made the switch to Planned Parenthood, and said “one of the perks is that Planned Parenthood does actually take my insurance, which is really nice.”

Although Planned Parenthood makes healthcare available to patients who don't have health insurance, a few women discussed still facing financial constraints. For example, Denise started using Planned Parenthood when she didn't have insurance. When she was able to obtain public health insurance, it actually made it more difficult for her to receive Planned Parenthood's services: “when I was on the state health insurance they took that differently so I didn't get any, like, the sliding scale then. It was all covered by the state, which was only a percentage so I had to pay the rest.” Prior to having state insurance, Denise was able to get her birth control for free, and says that, “when I went on the state plan it was like 30 bucks a pack. So I'm like, yeah, no, ok.” Denise's experience exemplifies the barriers that persist even when steps are implemented to make services available to more of the population.

Several participants discussed continuing with the organization after obtaining insurance. For example, Margo says “I never had insurance in my entire life until recently. But now that I actually have it, I feel like it's still a good place to use it.” Going without health insurance for most of her adult life, Margo found that Planned Parenthood was reliable and there for her despite her financial constraints, and considers continuing to use the organization and bill her insurance for the services as a way to continue to show support. Lynn reiterates this point in her interview, saying “even though I have health insurance, I will still go to Planned Parenthood, because I would prefer that they get the money that my, my health insurance would charge.” The impact of insurance in determining healthcare services was among the most important concerns for women using Planned Parenthood's services.

Require care offered at a reduced cost. In addition to health insurance obstacles to women’s reproductive healthcare, a number of women highlighted being able to receive services for free or on a sliding scale. Many of the women interviewed discussed having limited funds to spend on healthcare services and the need for a low-cost service provider in order to have those needs met. For example, Skylar discussed having used the health department where she went to college for free birth control. When she moved to the Detroit metro area after college, she had to identify a healthcare resource that would also be able to meet her financial needs. She said, “I moved to [the metro area] and that’s when I started going to Planned Parenthood for the first time. I went to a place in [a suburb of Detroit] and that’s the first Planned Parenthood I’d ever been to, again ‘cause it was free.”

Planned Parenthood also provided free care for Amanda based on her financial and life circumstances. She describes her financial background and how she was able to receive free care through Planned Parenthood:

Because I’m low-income or whatnot, I aged out of foster care. So I get free health care. Well... ehh... reasonably free healthcare with like, a provider like Planned Parenthood. So I didn’t have to pay for [the birth control implant]. It’s usually like \$300+ for the insertion and then you have to pay for the meeting and you also have to pay to take it out. But because I have, um, I think it’s called Blue Cross Complete—it’s not like the Blue Cross Blue Shield, but it’s through the state. I get it for free, so um, my next time, well m—it expires in 2017 in April ‘cause I called like a week ago to try to get it again. So next year I’m probably going to get it again and try to make it last another three years because I would rather—I have a lot of people who are young, they get pregnant, they have a baby, they think they’re in love and then they break up. Then they have—meet somebody else, have another baby, it’s—you might have like three kids and they’re not married. So that’s just not for me. So... I like the facility at Planned Parenthood because it’s mostly free.

Amanda’s life circumstances impacted her beliefs about the importance of birth control and family planning, but also contributed to her reasoning for using Planned Parenthood, understanding that they would be able to provide her with free birth control options.

Of course, a number of women do not qualify for completely free care through Planned Parenthood. Several participants discussed the sliding scale for income-based care, which allowed them to access necessary services within their financial constraints. For Ruth, the sliding scale was the biggest influence on her decision to use Planned Parenthood:

Well, the big one honestly is the sliding scale. For the amount of, you know, for your wage. That—that's what... in the past, you know, especially being a graduate student for so long. I haven't had hardly any money. Not having any insurance. Um, so for someone who has no insurance and very little income, um, with their—because before the Obamacare in ah, they had just like a sliding scale. And also this Plan First package? That specifically was geared towards um, reproductive care for women. So I would apply for that. I'd be covered by that, which I think is a... um. And then there also was the sliding scale. So for years I used them and didn't have to pay anything.

In fact, Ruth was able to use the sliding scale to achieve free reproductive healthcare. Gloria discussed a similar experience accessing funds for women's healthcare through Planned Parenthood. She said,

I successfully ah, applied for the—it's like the Michigan health card? And I, after I had my exam and my, um, STD test at Planned Parenthood I got the card back in the mail and it was just for um... it was just for like, reproductive health. That's what the, like, the supplemental state insurance was. It wasn't actually insurance. But it's a health card. And I got a check for like \$275 to cover the cost of my appointment. It was really, really amazing. I could pay for it up front but then the lady was like, hey, if you qualify for assistance... you can get reimbursed for the cost of the appointment and the test. And I did. And it was great.

Planned Parenthood employees were able to assist both Ruth and Gloria access affordable care by being networked into the available state resources.

Though the state resources were helpful to some women, Denise exemplified some of the barriers that accompanied her switch to coverage through the Affordable Care Act. She discussed the way this changed her care, saying “they switched me for awhile to a pill that once they kinda got rid of the sliding scale a little bit more, they changed their income requirements, or whatever, I couldn't afford so they were cool enough to switch me back to something else, but I just had to

come up with the money for like another month or whatever of it.” Once more comprehensive healthcare became available to Denise, she relied on Planned Parenthood to help keep her costs low, because the sliding scale had been her reason for selecting the organization in the first place.

Desire privacy from parents. In addition to those participants who discussed a lack of financial freedom to select a women’s healthcare organization, several discussed having health insurance through a family member, but wanting to keep their sexual healthcare needs private. For example, Skylar highlights her desire for confidential but affordable services in order to prevent her sexual healthcare from appearing on her father’s insurance:

First of all, I didn’t know if it was gonna be covered just, I just didn’t know. And then that wasn’t something that I wanted my dad to see that I was doing, I guess. So they’re extremely conservative, and I was 22 at the time, like, an adult and can make my own decisions, but it was just a conversation that I just didn’t want to have with them, I guess, so that was the main reason honestly, aside from it being free.

Skylar’s need for privacy about her sexual health was coupled by her financial restrictions outside of her family insurance plan.

Several participants discussed becoming sexually active when they left home for college, and that sex wasn’t something that they discussed at home. Similar to Skylar, several women discussed sentiments that their parents would not necessarily be angry about their sexual health choices, but rather that it was a conversation that they did not want to undertake. Gloria actually discussed her parents’ desire for her to get the HPV vaccine, but her reluctance to have that conversation:

Oh, my gosh my mom was also hardcore on my case for getting the HPV vaccine? And uh, I was like crap well I need to start going to the gynecologist because I need to get this done before I turn 26 or insurance won’t cover it. Or like, well, yeah. ‘Cause I hadn’t gotten the HPV vaccine because I didn’t have insurance. After it started existing. So I wasn’t about to like shell out money for that. Even though my dad said that he would pay for it. I didn’t want him to I guess. But yeah, that’s when I started.

She discussed growing up in a conservative household where sexual health was not discussed. However, she said “ they don’t want their daughter to get cervical cancer,” so when the vaccine became available it was important to both her parents that she get it. Still, it was her discomfort around discussions of sexual health at home that prompted her to seek alternative options for accessing the vaccine.

Heather also discussed family life factors that contributed to her desire for privacy from her parents. She discussed losing her father to AIDS when as a child, and becoming sexually active in high school. However, she did not want to broach the subject of sex with her mother, believing that she would be unhappy with Heather’s decision and fearful that she could lose another loved one to sexual health risks. She says,

I came from a family that had healthcare and so on and so forth, you know, we always had the best Blue Cross. But at the time, kind of not wanting to be open with my mom about, you know, what was happening, so it was a way to sort of sneak in there without her, like, you know, uh, being aware of, you know, everything that was happening in my life at that time.

Planned Parenthood was able to provide discreet services to women who required privacy but still wanted to protect themselves.

Being Sexually Active

In addition to financial constraints, women discussed the needs that come with becoming sexually active, such as seeking health services. Others discussed the limited options for young women before turning 18, and knowing that Planned Parenthood was a resource for young people to be protected when sexually active. Other women discussed having accessed birth control and met their sexual health needs when they became sexually active though other organizations, but a continued need for birth control prompting them to visit Planned

Parenthood. Finally, several women equated Planned Parenthood with pregnancy prevention or termination, and sought out the organization amid a pregnancy scare.

Became sexually active. A number of participants discussed becoming sexually active for the first time as their reason for visiting Planned Parenthood. Planned Parenthood was identified as a center for sexually active people for a number of these women. Dana described having had no interest in reproductive healthcare until she decided to become sexually active:

Well, it was never really an issue for me 'cause I never really dated or had much of any need of a sort for that sort of thing. I actually didn't really have a need to bother with that sort of thing until 2014, which is when I started dating. I actually used to be celibate until recently, just a personal choice I made when I was younger... When I was older I decided to you know start looking for that or whatever so I decided to start... I decided to start... As we know, you know, to make contact with someone is a requirement to have a relationship so I decided to go to Planned Parenthood to get some birth control, so that's what I did.

Dana discussed Planned Parenthood as a matter-of-fact option for accessing birth control.

Other participants discussed the onset of sexual activity as the reason they sought out Planned Parenthood, as well. Erin discussed losing her virginity as her reason for thinking and talking about pregnancy prevention. She said,

I've actually been going to the same Planned Parenthood since I was 14... The reason I started going was actually... I lost my virginity when I was 14, and my mom knew that I was going to. That was when I had my first boyfriend. She was like, okay, we're going to get you on the pill [laughs].

Lynn, too, discussed losing her virginity and her mother's role in prompting her to find birth control:

I had my first sexual encounter with a boy and I told my mother, and she FREAKED on me and she pulled me into a doctor, I immediately get my blood tested to make sure I wasn't pregnant, and she was sort of like, now you're going to have to figure out what you're going to do about birth control. You NEED to be on it. Like, okay... So, I grew up in Indiana, so I traveled about 45 minutes south from my little Podunk hometown... maybe it wasn't that far, maybe it was like 20 minutes... to [a nearby city], which was the closest Planned Parenthood, and I walked in.

Lynn's mother prompted her to find birth control, but unlike Erin, Lynn had to identify a place to access it on her own. These women's experiences seeking out Planned Parenthood also emphasized their need to access birth control as adolescents.

Were young. Several women discussed the need for birth control or other women's healthcare services prior to reaching adulthood. Heather elaborated on the need for accessible care for teenagers. She says of her experience,

Being 17 years old, you may not have money or resources to go to you know a family physician or, um, something that would require you to have, you know, a substantial amount of resources. You might not have had insurance or whatever the case may be because Planned Parenthood is affordable, I think that's why a lot of young women choose to go there and support it.

Janet also used Planned Parenthood as an adolescent, wanting to keep her reproductive healthcare separate from her general healthcare. She described her experience initiating contact with Planned Parenthood as a youth:

I started to go there in high school because I, I've been taking birth control for a long time. Since I was like 13 or 14 because I had really severe PMS, like I couldn't go to school. And I got it through my doctor and I still see the same family care doctor, but I just wasn't comfortable going to him for that kind of stuff. Um, so I kind of sought out alternative methods.

These women describe the need for adolescent women to have access to reproductive healthcare and birth control.

Other women discussed the organization's ability to meet the needs of young women, even those who had reached adulthood. Gloria discussed Planned Parenthood's accessibility to young women, and how that impacted her decision to use their services. She says, "I think like being a young person, like living on my own the first couple years of college I think that was kind of me just introducing myself to the possibility of using [Planned Parenthood]. And it being okay." Gloria discussed growing up in a religious household that associated Planned Parenthood

with abortions. Prior to college, she had seen a gynecologist using her family's insurance. However, navigating the healthcare system as a young adult with limited resources led her to reconsider Planned Parenthood as an option. She reiterated this when she said that the clientele at Planned Parenthood "definitely skews younger." Amanda also highlighted the demographic of Planned Parenthood users in contrast to the OB/GYN she saw when she was a teenager, saying at the OB/GYN "I felt like a little kid with their parents" and "I was like the only young one there" whereas at Planned Parenthood, the demographic is younger and more diverse.

Needed (new) birth control. A number of participants discussed initiating contact to meet their birth control needs, as evidenced above. Several women discussed situations in which they had lost their access to contraceptives. Gloria discussed being dropped from coverage when her father became eligible for Medicare. She said, "I have an older father. He's... gonna turn 70 this year? And when he... became eligible for Medicare is when I stopped... having insurance." When her father was no longer providing her health insurance, she had to seek out other options for all of her healthcare needs, including reproductive healthcare. Skylar shared a similar story of being removed from her father's health insurance. She would have found a primary care physician when she moved, but said, "it was just lack of planning on my part as far as, um, finding a doctor down here. I actually just... cause my dad took me off his insurance. Like just in the last couple months." Her need was based on continuing birth control without a gap.

Some of the participants discussed switching to Planned Parenthood based on more specific birth control needs. Lindsay described starting on the birth control pill, but wanting to try another option. She described her process of navigating reproductive healthcare and switching to Planned Parenthood:

I kind of went to like the doctor on my campus and, um, I was like 'Hey, I want some form of birth control,' so I started the pill. And then a year kind of went by, and then by

the next summer I had a new boyfriend, and I decided I didn't want to take the pill anymore. I just wanted something a little bit more effective, and that's when I first visited Planned Parenthood.

She described wanting an IUD, but that “the college clinic, um, couldn't do the IUD for me, cause they like didn't have them there. So pretty much they would send anybody who wanted one, they would like refer to someplace else.”

Similarly, Shonda discussed having been on the birth control shot, Depo-Provera. Like several women I spoke to who had experienced the shot, she was not satisfied, and found herself gaining substantial weight while using it. She brought this concern to Planned Parenthood, and asked them to help her switch to an alternative option. She discussed medical concerns that limited her options, and “[Planned Parenthood provider] was talkin' to me 'cause I have high blood pressure, so we were talkin' about pills, and she was tellin' me like the only thing she could really, she was only givin' me like two options, and I guess the one without the estrogen.” Her options were limited, but Shonda approached Planned Parenthood as an organization that would be able to provide her with an alternative option.

Experienced a pregnancy scare. Many participants discussed pregnancy prevention and accessing birth control as their rationale for approaching Planned Parenthood. However, several also made contact when they thought they could be pregnant. Planned Parenthood was identified as an organization that could confirm a pregnancy and provide options. Megan described, “Well the first time I went in to get a pregnancy test. It was because, um, I was having spotting issues, and um, I was worried about it so I went to get that checked out.” She described her rationale for going to Planned Parenthood for a pregnancy test rather than taking one at home, saying “I guess I wanted the support and I heard, like, they were nice there.”

Yvette also initiated contact with Planned Parenthood hoping for a pregnancy test. As far as her women's healthcare, she said, "I don't have like a lot of, like, things that maintenance that I do. Um, but when I started to go to Planned Parenthood it was for—to check, to see if I was pregnant or not." She identified Planned Parenthood with the help of her mom, saying "she said that, um, it's a good place to go to get that done and everything, so I mean, I don't really know much about any other, um places." Yvette described her mom having used Planned Parenthood for pregnancy testing "back in the day."

Liz described approaching Planned Parenthood because she had taken a home pregnancy test that came back positive. She described a friend telling her that Planned Parenthood would terminate a pregnancy, which led her to approach the organization:

I went in and they were really wonderful, you know? Um, looking back on it, they were um, they said um—so they had to do an ultrasound just like to confirm the pregnancy, but they were great because they said, um, we can either sort of show it to you or we can turn it away, that's you know, that was—I really appreciated that because like I—I know now what some of the other centers do, not Planned Parenthood, but like some of the TRAP centers, and um, that was, you know, just that was great."

Upon confirming the pregnancy, Planned Parenthood was able to help Liz move forward with terminating it. She described the importance of this option, because she had become pregnant with someone she described as "a bad guy" but that "I didn't feel like I could get away from him at that point because I was sort of emotionally manipulated by him, but I knew that like, I knew I didn't want to be like biologically connected to him for the rest of my life." Yvette also described the conversation she had at Planned Parenthood while waiting for her results, in which she was presented with a number of options in case the test came back positive, including resources for pregnancy, adoption, and abortion.

Being Directed to Planned Parenthood

When women made the decision to approach Planned Parenthood, they discussed a number of referral sources. As some of the previous examples indicate, several women talked about their mother's role in electing the organization for care; others discussed the role of friends and siblings. Some women were directed to Planned Parenthood through various forms of advertising or a general sense of the organization's reputation for providing care that met their needs. Finally, women discussed the impact of their family upbringing on their decision to seek out reproductive healthcare and pregnancy prevention.

Mom's role. As some of the previous examples demonstrate, several women discussed the role their mother played in directing them to Planned Parenthood for reproductive healthcare. Margo explains her open relationship with her mother, which helped her get on birth control in high school:

I had, uh, gone to my mom and I said 'I want to get on birth control.' And so um, she was fairly supportive of that. So she thought it was a good idea. Um, but... she didn't really know where to go? Um, and so Planned Parenthood kind of came up because it's pretty close and uh, um... we knew that we could see them without using insurance so um, I ended up going there and having my first like, um, pap smear there and everything like that there.

Several women reiterated the closeness and trust in their mother's advice regarding birth control. Yvette also took her mother's recommendation, who said that "[Planned Parenthood] is a good place to go to get [pregnancy testing] done." She also described her mother's role in helping her navigate the healthcare system more generally:

I'm 18 and like halfway through—little more than half, so I don't really have a job yet so my mom does like make calls for me sometimes but the... right now they tell me that I have to call in, but she pretty much finds the place for me and stuff.

Beth described the importance of her mother when selecting Planned Parenthood after learning that her friends were getting pelvic exams and other types of preventative care. She

described conversations with her friends, and feeling like she was behind having not taken any precautionary measures to screen for cancer or have other assessments of her reproductive health:

I remember calling my mom and being like, ‘Do I need to go and, like do that?’ and she’s like, ‘Well you can if you want, you know, if you want to,’ and stuff—it was kind of funny now that I look back on it and she was just like, “Yeah, I mean, make an appointment. If there’s not somebody there, you know...” and then my mom said, “You know, you could go to Planned Parenthood, you know, they have one in like every city, you know, and you can [laughs] do that.”

Some women also described the roles their mothers played in keeping their reproductive health on track. For example, once she accessed birth control, Erin says that her mother

showed me the pack and then she told me like, when I was supposed to start. Um, and I remember I—I was asking her like, ‘What if I forget to take a pill? Um, and then my mom was like “You are NOT going to forget to take a pill.”’

Though her parents were conservative and believed in abstinence until marriage, Skylar said that her mother did provide her with information about preventing unwanted pregnancies. She described, “She was, ‘well, don’t *have* sex, but this is how this stuff works,’ so I feel like I had a pretty good knowledge base going in, anyway.”

Friends’ or siblings’ recommendation. For some participants, having conversations about sexual health with a parent was not an option. In several instances, women referred to friends or siblings who helped them navigate their women’s healthcare. Megan discussed the role her older sister played in helping her take care of herself. She said,

My older sister had gone in [to Planned Parenthood] when she was like a teenager, um, for birth control, and then when we got closer, when we got older she like told me about them, and... and said like she was just, like, scared to go to a regular doctor, and um, that it was just a much better atmosphere, so that’s like kind of what I was just looking for.

She described the importance of the relationship with her older sister, who “would remind me to take care of myself” because “my parents like were not...we’re not really close on that subject so we’ve never really talked about it, so um, she was the one who helped me a lot.”

Denise encountered Planned Parenthood when she moved to a city far from where she grew up. She discussed her need for birth control to help manage her menstrual cycle, but also her financial constraints. For her, women she worked with recommended Planned Parenthood as a good option for affordable birth control, saying “I had a lot of the people, like the girls that I was working with recommend them, you know?” Beth also described her friends’ influence on her reproductive healthcare decisions:

It was mainly just from my friends. Um, you know ‘cause they were very open, you know, like just about their sexual health, you know, and what they do and then like I kind of realized I was—not behind, but like I should be on it, like taking care of myself, too. Like, taking these annual exams and stuff like that. And when I told them that I hadn’t, they were like, ‘Oh, my gosh, you need to go, you know, like, you know, if you’ve been having sex since you were 18, you know, then you’re supposed to go like every, like by the time you’re 21, you know?’

Like Beth, Lindsay’s friends impacted her knowledge and decisions about seeking reproductive healthcare through Planned Parenthood:

And since Planned Parenthood is such a widespread organization its like, um, every—pretty much everyone I’ve gone to has said like the same thing, and just like ‘Oh, they’re really good, like, I needed this done or like I needed to like get this form of birth control, or needed this tested,’ you know, whatever. Like everyone who I talked to would, you know, kind of said the same, like ‘They’re really great and you know you should definitely go to them.’

Planned Parenthood’s advertising and/or reputation. Friends often shared a positive reputation of Planned Parenthood with women, which impacted their decision to approach the organization. Other women discussed advertising as a reason for identifying and pursuing the organization. Shonda described folks on campus advertising Planned Parenthood as a resource for sexual health. She said,

They had like little stickers up on the poster boards in the dorms. And like I said the university health center, they had stickers, you know, stickers up and like when you go there, they have stuff hung up. Like I said, people were standing outside handing out the little packets [laughs] at the time they made up [laughs] yeah that's how I heard about it.

Part of Shonda's reasoning for using Planned Parenthood was also through word-of-mouth communication. She said, "that's what everybody was just goin' to Planned Parenthood. You can go there with no insurance. That's the only thing I heard." Amanda also said that she heard about Planned Parenthood through word-of-mouth communication. She described her needs, and that "I was looking for something close, something cheap, something I could afford and this Planned Parenthood just kept on coming up. And they were like, yeah its right [nearby]."

Skylar described the broader reputation of Planned Parenthood in her interview. She described her decision, saying,

It's the biggest name, I guess, and when I think of going somewhere to get something like that it's the first thing that you think of. I don't think I did too much research on other options. I just knew that, um, that's where you can go to do that and it has a pretty good reputation, so I just went with it.

Yvette discussed looking into alternative options for pregnancy testing, but settling on Planned Parenthood as the most trusted option. She said, "I know there's like little, little, um, stores like in East Lansing and stuff for that but, well not store, but you know what I mean. And um, yeah, [Planned Parenthood]'s just the one that's most, um, trusted I feel like."

Impact of upbringing and family life. Lastly, women brought their own family dynamics into the conversation about initiating a relationship with Planned Parenthood. Women described the impact family dynamics played in their own healthcare beliefs and intentions about reproductive healthcare. For example, Amanda discussed her upbringing in the foster care system, continuing to have a relationship with her mother but not her father. She discussed how

this impacted her decision to use a long-term method of birth control. She discussed parenthood, saying,

It's just not for me right now. I want to hopefully get married and have a kid, or my kid can always have their connection with their dad. Uh, I guess 'cause I don't have a father figure. So I guess it's a lot that went into trying to pick this birth control.

Having grown up without her father's presence in her life impacted her decision to take family planning seriously so that her child would have a different experience.

Margo also discussed the impact her family upbringing had on her beliefs and intentions with planning. She talked about the experiences of the women in her family influencing her decision to prevent early motherhood:

I think the biggest thing that prompted that is that my mom and all the women in her family all had children really young. My mom had her first child when she was 16. Her siblings all had children younger than that. My aunt had her first child at 14. Um, my mom didn't have any type of um... sex ed growing up when she got pregnant, she didn't even know that sex led to pregnancy. And so, um, she was trying to make sure that we were better informed than that, um, if I learned so... something at school and I came home and told her about it she would um... make sure that I felt comfortable in my body, because a lot of sex ed classes don't really leave you feeling comfortable? Or with—usually the best information even especially with umm... abstinence only education. So, uh, just making sure that was an option and that if I was considering becoming sexually active that I should get on [birth control]. Um...and then because I've always had such bad cramps and things like that, my mom also thought that was a really good thing for me to get on. So I think that was a big part of prompting it was just, um, I knew I was getting to be about that age and I didn't want to end up in the same situation that um, all my relatives have. So I was one of the first women in my family to even graduate high school so... I knew what decision I wanted to make and I made that decision pretty early.

In this instance, the desire to avoid early motherhood was both a reflection on the lives of family members and the impact of conversations with women in the family who wanted a different lifestyle for her.

Recognizing the Uniqueness of Women's Bodies

As participants discussed their reproductive healthcare options, the uniqueness of the female body came up repeatedly. Women discussed ways in which the female body is different

from the male body, and requires more specialized care. Several other women discussed the need to have a space that was dedicated specifically to women and their unique healthcare needs. Planned Parenthood's emphasis on women's healthcare contributed to the decision to initiate contact with the organization.

Specialists are better for the female body. Specialization came up in several interviews as a reason participants chose to initiate contact with Planned Parenthood for their women's healthcare. Erin discussed her preference for experts over generalists, which she perceived at Planned Parenthood:

I like going for like what people are experts in. Personally. Um, I don't know if there's other examples of that in my life where I do that. I'm not sure...I was just gonna say the one I can think of is like this isn't really that good of an example but um... like, when I [sigh] like when I go and buy a phone, I like buying it from actual stores. Like I have a Verizon phone, I went and got it from the Verizon store. I know they sell the Verizon phone at other stores, but I just feel better if I get it from the Verizon store because that's all they have is Verizon phones so that's what their main focus is gonna be on.

Because Planned Parenthood focuses on women's reproductive healthcare, Erin said she is more comfortable using them to meet her own women's healthcare needs.

Lynn emphasized the trust she has in practitioners who focus on women's health by highlighting the distrust she has in other medical specialists:

I don't know, maybe there's just this inherent distrust I have with people who don't work with female bodies, that they don't know what happens, and most regular practitioners are...they see...like all medicine is designed around male bodies. The female body is an anomaly. Right? And so I'm like, I would much rather go to people with problems that aren't even reproductive related but know what female bodies are supposed to do more than a general practitioner.

Lynn described as sense that the medical community has a better understanding of men's health, and that in order to get adequate women's healthcare, it is important to use an organization like Planned Parenthood that focuses specifically on women's healthcare needs. Dana continues this sentiment, highlighting the politicized nature of Planned Parenthood and women's healthcare:

But, it's not wrong to have a political agenda because women's health is a political issue as well as a medical one. You cannot escape the two. There's no real separation there. So, because they take that into consideration they treat people better so if any place forced someone to do that, like have those exams across the board, and I had to choose between Planned Parenthood and some jackass who's trying to hit me up for insurance money I would pick Planned Parenthood.

The desire for specialized care permeated several discussions of Planned Parenthood as an optimal choice for initiating women's reproductive care.

Women need their own space. Extending upon the need for women's specialized care, participants expressed a desire for a space devoted to women. Megan's interview highlighted this when she said, "its important for women to have like a place of their own. Um, because these, like, specific needs are not to be taken lightly, um, and it's good to have like that atmosphere, um, and just like an organization of women I guess." Megan emphasized the importance of a safe space for women to feel comfortable addressing sensitive healthcare needs, and the need for those concerns to be addressed by other women. Lynn discussed how Planned Parenthood functioned as a women's space. She explained, "it becomes women's space with women's talk. And so this is a place that women feel welcome."

Some participants discussed discomfort with a male doctor addressing their reproductive healthcare needs. Denise described her preference for a female doctor, saying, "I wouldn't, you know, wouldn't be comfortable with a guy." She revealed, "I was raised very conservative. I was never really comfortable with a man in that way." Erin extended this sentiment when she discussed visiting an urgent care facility when she was unable to get into Planned Parenthood early enough. She discussed an immediate need, but her discomfort when she had to see a male physician:

My physician at Planned Parenthood is a lady. Um, and this doctor was a guy. So I think the guy was feeling like kind of awkward. I think what also made it awkward is I actually brought my boyfriend with me, too. So he was like, I feel like there was probably that

guy thing where he was like, you know, are you okay with me looking up your girlfriend's vagina? ...kind of thing. [laughs]

Lynn discussed the ways in which OB/GYN and women's health practitioners are prepared to better care for women. She discussed the need for a medical professional that only focuses on the female body to determine the best route for care:

OB/GYNs are as good as any primary care physician I've ever been to. Um, and I think that's just because they see women, and they're like, oh, women are more likely—women of your shape, your stature, your age, your blood condition, this blood type, are more likely to have this thing, and I know it because I've seen it in all these other issues.

Beliefs about the centrality of the female body to adequate care resonated across participants.

Reconciling Conflicting Beliefs

While participants consistently shared positive sentiments about Planned Parenthood and women's healthcare that impacted their decisions to seek services there, several women discussed formative beliefs that complicated the decision. Women who were raised in a religious household discussed mitigating the conflict between Planned Parenthood and the religious community. Additionally, women who held conservative beliefs or came from a conservative household had to overcome psychological barriers before making initial contact with the organization.

Religious upbringing. Some participants discussed the impact of religion on their views of Planned Parenthood. This often arose in discussions of Catholicism and the role Planned Parenthood plays in providing access to abortion services, even if they were not approaching the organization to terminate a pregnancy themselves. Gloria discusses how this impacted her earliest views of Planned Parenthood:

I grew up Catholic so basically it was the abortions. That's like all it was. And it uh... it was just the, it was just the, the uh... like the pro-life thing. Um... But on the other hand I—I grew up with a mother that strongly, strongly supports birth control. Which is good! I guess if you're gonna—if you're gonna think abortions are wrong you might as well,

um, think people should uh... avoid having to terminate their pregnancies in the first place. So at least she's not a hypocrite, I guess. Uh... So, I think she, she encouraged me to go on birth control, you know, she was... her being a Catholic mom she was like as open as she could be about uh, the fact that I might eventually like... have sex. And I should try to not get pregnant, I guess. But um, still being like, very anti-abortion. Very like, you know, Planned Parenthood is the enemy because they kill babies... I guess.

Planned Parenthood posed problems because they provided access to abortions. However, Gloria shared her mother's support of birth control to prevent unwanted pregnancies. Though Planned Parenthood offers both birth control and abortion services, her formative understanding of the organization was rooted in the sinfulness of abortion. When Gloria did make contact with Planned Parenthood, she first had to reconcile this for herself.

Liz also discussed her mother's Catholicism, but in her case, it was positioned alongside support for Planned Parenthood. She discussed her mother's impoverished upbringing, and Planned Parenthood as the only organization that was able to provide affordable women's healthcare to her and her sisters. Liz explained,

Like when I say that my mom is Catholic, like Debbie, she goes to church like twice a week. Like holy shit! She's like in it, you know? She like, she's in it. And, um... And, uh, she goes by herself, you know? My dad's Jewish, and so, you know, she does that, but she's able to bracket that from her, um, from her like staunch and like unwavering support of Planned Parenthood. I can't explain it. I guess class trumps religion in this sense. It's bizarre.

Liz explained the contrast between her mother's Catholicism and support for Planned Parenthood alongside her own Catholic education and beliefs about sexual health and pregnancy prevention, which emphasized abstinence:

Once I went to Catholic school it was basically like, you're gonna go to Hell, just don't forget Jesus is attractive, I mean I'm not making this shit up. Jesus is attractive, abstinence is your only option, otherwise you're gonna die, you know that sort of thing.

Religion complicated the decision to initiate contact with Planned Parenthood in these instances. Women had to develop means of mitigating religious opposition to the organization before they were able to approach the organization for services.

Political stance. Participants also discussed mitigating political beliefs before approaching Planned Parenthood for women's healthcare. Often, these political beliefs were interconnected with religious beliefs. Denise discussed her need for affordable reproductive healthcare, and her internal struggle to use Planned Parenthood. She described her conservative upbringing and loyalty to conservative radio, where Planned Parenthood is often demonized. However, her disagreement with the organization lied in abortion services. Denise was able to reconcile that conflict because she was not using Planned Parenthood to terminate a pregnancy herself:

I feel like even though I'm against it, it's not something that most of us can control and it's going to happen so I'm not, I mean, I'm not going to support it but at the same time I'm not going to boycott them because I can't, like I said, I can't complain, they've been really good to me. And I appreciate what they do and I think it's sad that so many people look at the negatives, you know, the negative side of everything when instead of, you know, weighing in how much they've helped women, you know?

Gloria also experienced conservative influences growing up, and conversations about Planned Parenthood's faulty ethics. However, unlike Denise, she demonstrated resistance to that rhetoric. She explained,

I grew up in a pretty socially conservative family so everyone kind of always hated Planned Parenthood. And... Ever since I was a little kid, uh, even though like all these people were telling me that it was bad? I—I knew that, like inside myself, that it wasn't. Not even really knowing anything about it. But it just really pissed me off when anyone would talk about how it was bad.

Her resistance to the stigma around Planned Parenthood when she was young helped her to initiate contact when she required affordable care for herself. Denise and Gloria both discussed the organization's ability to meet their pertinent needs, which trumped areas of opposition.

Deciding to Develop the Relationship

Once participants had initiated contact with the organization, they made the decision to continue to develop a relationship with Planned Parenthood. Women discussed the ongoing accessibility they experienced with Planned Parenthood, and the consistency of care they received when they used centers in different locations because of travel or moves. Women also discussed their comfort level with the organization that was run predominantly by women, and that focused on needs specific to women's health. Finally, women discussed their decisions to develop and sustain the relationship based on Planned Parenthood's ability to meet their most pertinent healthcare needs.

Deciding to Develop the Relationship			
Accessibility	Consistency of Care	Community of Women	Ability to Meet Most Important Needs
<i>They're everywhere</i>	<i>Positive relationship with provider(s)</i>	<i>My concerns pertain to the female body</i>	<i>Contrast with bad experience(s)</i>
<i>They're easier to use</i>	<i>Consistent experiences across centers</i>	<i>They're everywhere</i>	<i>Recurring concerns</i>
<i>They're affordable</i>	<i>Accumulation of positive experiences</i>	<i>It's about championing women's health</i>	<i>Credibility of practitioners</i>
			<i>Lifestyle-related needs</i>

Table 2: Deciding factors for developing a relationship with Planned Parenthood.

Accessibility

Participants discussed the accessibility they encountered with Planned Parenthood, and the impact it had on their decision to continue to use the organization for their women's healthcare needs. Women discussed the prevalence of Planned Parenthood clinics across their region, but also the nation. Often women described Planned Parenthood in contrast with traditional women's healthcare sites, saying that it was easier to use Planned Parenthood. Finally,

affordability resonated as a primary reason women continued their relationship with the organization.

They're everywhere. Several women discussed the convenience of Planned Parenthood having multiple locations across the region as well as the country. Ruth discussed how that made her healthcare decisions easier:

So, I guess Planned Parenthood, there's one that they're pretty, like, everywhere. So I knew that if something happened, I had to move or if I was in a different area I could still pick up my pill packs at a different location. Or maybe on a Saturday office. And that wasn't the case for my other place.

Beth's interview highlighted this, as well, when her mother recommended Planned Parenthood because "you know you could go to Planned Parenthood, you know, they have one in like every city."

Lynn elaborated on the convenience of Planned Parenthood's national presence:

I've always felt like Planned Parenthood is easily accessible. Um...I've never had—other than sometimes they're hidden, like their locations are like...hidden. Um, other than that, I feel like, um, they've always been accessible. I've always been able to find out where they are. Um, they've been in almost every city that I have lived in or nearby. Um, the same procedure, right, you go in, someone does your intake, um, if you haven't been—'cause they're divided into regions, so if they don't share information from region to region you have to redo your intake information—do you feel safe where you are, um, when was the last time you had a pap smear, um, those sorts of things.

The availability of Planned Parenthood centers also contributed to Lindsay's involvement with the organization, because her friends used the organization in other parts of the country. She shared that she became involved with the organization after gathering information about Planned Parenthood from a variety of friends:

First, 'cause like I know a few people who um... and like actually kind of all over the country... I've got you know friends who are away for school and stuff. And since Planned Parenthood is such a widespread organization its like, um, every—pretty much everyone I've gone to has said like the same thing and just like oh they're really good.

Shonda described being out of town on a vacation and needing access to women's healthcare. She discussed the continuity of care she was able to receive when she accessed the center in a different part of the country:

It was one in San Diego and it was one right by the house, and I went to that one. And it was a lot, it was a lot of people in there and actually, that one wasn't as bad a wait time. And it was an office full of people but it wasn't as bad a wait time. Same experience. Same thing as far as medication right away. Same, same experience. No difference as if I was home. And it was the same things. It was no different. At all. And I couldn't, you know, I really couldn't believe that I found one right there where I was. And...yeah, I loved it.

Having continuous access to care in a variety of locations impacted the extent to which women were able to develop a stable relationship with the organization in a variety of ways.

They're easier to use. A number of participants compared their experience with Planned Parenthood to other healthcare organizations. For example, Janet compared the variety of services available at Planned Parenthood with seeing specialists or getting referrals from her family care physician:

Honestly it's more convenient because it's like going to—it's, it feels like, and this is a really weird analogy, it feels like if I went to just a gynecologist it would be like going to a little mom and pop shop that doesn't have everything, and I could only get certain things and then I'd have to bounce around to get them from other places, and then Planned Parenthood is like the superstore of women's health. It's like I can ask any questions and even if that person I'm talking to doesn't know, they can say you know what I do know somebody here who can answer this for you, let me put you in contact with them. Um, so it's more comprehensive. It covers everything. That's why I like it.

Yvette reiterated this notion in deciding where to continue her women's healthcare, saying, going to different places is kind of like tedious, um, for specific things and since they like do offer all that.”

More generally, women discussed the ease they encountered with Planned Parenthood, which contributed to their decision to continue the relationship with the organization. Amanda discussed being able to be seen on a walk-in basis, saying, “I go there and make an appointment,

or you can go there the day of...” whereas an OB/GYN requires an appointment scheduled in advance. Beth also talks about how other organizations cannot be as responsive to clients, “Because I think a lot of times healthcare organizations, they don’t have that accessibility, you know? And so it was just convenient, you know, and they had what I needed, you know, for my particular needs.”

They’re affordable. Just as affordability impacted women’s decisions to initiate contact with Planned Parenthood, it played an important role in women’s decision to sustain the relationship. Denise discussed her ability to take care of all of her women’s health needs in a way that was affordable to her, because “I mean they do all my basic you know...like I said the exams and stuff, they provide it all at a decent price for me based on income, I mean they’ve been really good.” This was the same reason Beth continued to use Planned Parenthood when other options became available. She said it was about “affordability. You know, it’s just less expensive.”

In other instances, the type of care women required led them to make more frequent visits than the average person. Lynn discussed her lifestyle, which required her to have access to affordable healthcare in order to stay safe:

I have consensual sex with more than one partner and have more than one relationship. Making sure that people are tested consistently is a high need for me. And Planned Parenthood does it at a lower cost, um, they do it professionally, they do it for men, women, everybody.

Ultimately, affordability continued to resonate in women’s decisions to sustain their healthcare relationship with Planned Parenthood.

Consistency of Care

When participants decided to sustain a relationship with Planned Parenthood as their primary women’s healthcare site, a number of women discussed the consistent they received

through the organization. Several participants discussed having a relationship with a provider at the clinic. Others discussed an appreciation for the consistent care they received across Planned Parenthood clinics. The notion that “they’ve always been good to me” arose in many interviews, in which women discussed having a positive experience each time they visited the organization and the impact that had on their decision to continue the organizational relationship.

Positive relationship with provider(s). While a number of women discussed the consistency they experienced with different Planned Parenthood centers, several still preferred to see the same caregiver each time. Erin most strongly advocated for this in her interview, saying, “I also see the same physician. I think she's the only one that's there. At the one I go to. I've been seeing her for so long. And I mean yeah, she's known me forever. So... you know. It's just—it's comforting.” Lindsay also discussed the positive experience she had seeing the same care provider for consecutive visits. Though she did not request to have the same provider, she said it made her feel better about her follow-up visit. She discussed having her IUD inserted, and worrying that it had migrated because she was unable to find it herself. When she made a follow-up appointment, she trusted the provider easily because it was the same provider who had done the initial insertion:

Like when she um—it was the same woman who had done the insertion for me actually so I'm not sure if she's the only one there or if that was just like they scheduled with me. I'm not sure. But it was really nice to have that continuity.

Janet said that she does always request the same provider. She prefers to see the doctor with whom she has developed a rapport. However, she also described being comfortable when she was not able to schedule with her preferred provider, because she has consistently received quality care from everyone at Planned Parenthood:

I obviously like, you make a rapport with people, so now I try if—if available I try and see the same person, but I'm never, like if I have to make an appointment for something

I've never been like, oh no so-and-so's not available. You know I can't go now because I know they'll have somebody there who I can trust and is confidential and informed and educated, um, and they won't be judgmental. You know if I went to like my doctor or my gynecologist and they weren't available I wouldn't say like, 'Oh, just put me in to see anybody!' Um, but there I would because I wasn't—Now I'm not so concerned with, you know, who I see because I know anybody there is gonna be a fairly decent person. And good at their job.

In contrast, Amanda described her preference for seeing a different practitioner each time she visits. She prefers the anonymity and privacy she experiences, and feels more comfortable being honest about her lifestyle knowing that she will not likely have the same provider the next time she visits:

You know that you're not going to see them for such a long time that you're probably going to have another doctor. Like I've had it where I have a (inaudible) lady one time, the next day it's like an older white lady then a black lady and then—like it's just always somebody new. So I don't always have to worry about them noticing me, like the next time I come in there. So I'll be like, yeah, you know I might have sex two to three times a week, smoke maybe once a day. I do—yesterday I just bought me a bottle of Andre champagne so I drunk half the bottle. So you know, I will be perfectly honest. Like, they're never gonna see me again! I love it.

Consistent experiences across centers. A number of participants described their preferred Planned Parenthood center; still, several provided instances in which they used another center. In these cases, several women discussed the continuity they experienced across clinics. Lynn described how this continuity exists across the several clinics she's visited as she has moved from one state to the next:

There's a certain amount of continuity that every Planned Parenthood, while they're in different regions, every Planned Parenthood is the same. Um, they have... Or they at least have a lot of the same forms, sometimes they can access your records from previous places like when I was back in [a Midwest metropolis], in [city] proper, they had my records from when I was going and visiting them in [a nearby city]. Which is about an hour, hour and a half away. But it's the same sort of community, so I was in the same system.

Similarly, Ruby explained that she was confident in her relationship with Planned Parenthood should she have to relocate in the future:

I know that if I move? I can still get the same kind of care. It'll be a different doctor, but if I move to... presumably most large metropolitan places I can still get the same kind of like, outlook on what my care should be. And I know that I'm listened to there. Um, in a way that I don't think is consistent across healthcare.

The confidence that Planned Parenthood will be a familiar place even after relocating resonated with several participants.

Alternatively, a few participants discussed visiting different clinics and noting marked differences. For example, Janet described having to visit a different Planned Parenthood clinic in her area, but noting differences in available resources. She said, "The one I think in [my preferred location] especially like, I've gone to one in [a nearby city], too, which is still really friendly, but they just don't have like the resources that the one in [my preferred location] does I guess?" Dana visited another clinic, as well, but found that the interpersonal experience was less satisfying:

Last year's renewal, I had to go to a facility in [a nearby city] and there I got into an argument with a doctor who was doing that stuff, and that was something I found very unhelpful and sort of put me off to ever going to at least that particular facility again.

Accumulation of positive experiences. Several participants discussed Planned Parenthood as an organization that consistently treated women well. This positive history with the organization contributed to participant's decisions to continue to use their services. Janet described her commitment to the organization, saying, "When I go to Planned Parenthood it's a good experience, you know?" Megan reiterated this sentiment as she described her continued commitment to Planned Parenthood:

I think I've always had a...a good experience there. Um, and I've never had any issues with them. It's always, it's easy to make an appointment there also, or to go in. Um, it's close and, um, they're just like nice, so I like it.

Ruth elaborated on her positive history with Planned Parenthood, describing how they respond to her specific needs in a way that she appreciates:

I mean I think at Planned Parenthood, like, I've never had an experience there where I wanted or didn't want something and that didn't happen. Obviously they know how to perform a pap. You know. So it's not like that. But they might suggest you know well, okay, we're gonna do the pelvic exam. You know and they'll ask like do you want us to do a pap smear, do you want an STI test, why or why not. They'll say like, you know, this time, you know, I don't think that's necessary, I haven't been in a situation where I've contracted anything. You know, whatever. And they'll say 'okay cool.'

Ruth described how she had positive interactions at Planned Parenthood because they did not try to push anything she did not want.

Shonda also described having a history of positive experiences with Planned Parenthood. She described how the organization was able to help her when she had limited resources, and the impact that had on her continued relationship with the organization:

I have a positive feelin' [toward Planned Parenthood]. Like I said, they've helped me because, like I said, when I didn't have any insurance I went straight to them, and they have helped me like when I... like when I didn't have no money and when I couldn't see a doctor. Like now, I have insurance now, and like I said its hard to see my doctor now, and I went straight to them without a problem.

Denise also described how Planned Parenthood was able to help meet her needs under strained financial circumstances:

I can't complain, they've been really good to me. And I appreciate what they do and I think it's sad that so many people look at the negatives you know the negative side of everything when instead of, you know, weighing in how much they've helped women, you know?

Planned Parenthood's ability to help women in difficult situations surfaced in nearly every interview.

Community of Women

Because Planned Parenthood focuses on women's healthcare, a number of participants discussed the organization's women-centeredness as central to their decisions to sustain the relationship. Several women discussed their healthcare concerns, explaining that they only worry about those that pertain to the female body. Others appreciated that only women tend to provide

services at Planned Parenthood. Finally, several participants discussed Planned Parenthood as a champion for women's healthcare, and felt involved in that movement through their continued support.

My concerns pertain to the female body. Women visit Planned Parenthood to meet healthcare needs that are unique to women. In fact, several participants said that these women's healthcare needs were the only concerns they felt were pertinent on a regular basis. Lynn described her rationale for continuing to use Planned Parenthood based on the femaleness of her health concerns:

All my problems tend to be about my body is a female body. So, that's probably why I keep going back to them. Is that every issue I've ever had, they've been able to solve, they've been able to give me a solution that I could use.

Ruby continued this sentiment, saying that,

Planned Parenthood has been the only [healthcare center] that I've needed to see. I don't want to go to a general practitioner for, for birth control. Um... and nothing else has popped up that would be more beneficial for a general practitioner... to... to do for me.

Similarly, Amanda shared her reasoning for using Planned Parenthood when she encounters abnormalities in her women's health. She discussed the intimate nature of women's health, and the preference that other women, and women's health specialists, address those concerns for her:

I would rather go to Planned Parenthood than be like okay... this is what's happening to me. Then go to the ER and probably have a male doctor who doesn't know my body, so... it's, it works for me just because you know, it's so intimate and so tiny and so confidential.

The uniqueness and intimate nature of the female body contributed to several women's decisions to continue to seek services through Planned Parenthood.

They're women like me. Several participants also discussed a preference for Planned Parenthood because they are women-run. Megan sees women at Planned Parenthood who she

can identify with. She discussed her local Planned Parenthood, saying that it “has all um younger girls, more closer to my age, um, more like understanding I'd say, and um, it's just always been like a good setting when I go in there, it's a good environment, so that's why I like it.” This notion resonated in Shonda's interview as well, when she discussed the women who work at Planned Parenthood feeling like “girlfriends”:

I can ask her a question that may feel weird but I just ask, you know, she answers it right away like, like we're girlfriends. But I can ask her a question and I don't feel just, like, icky about it, but I have to ask because she's the only one that can tell me.

Several participants also discussed their preference for a woman doctor to tend to their reproductive healthcare. Beth described feeling more comfortable at Planned Parenthood than she would at a more traditional clinic because of how the organization is gendered:

I do feel comfortable like every, you know, I know sometimes people have the opposite feeling when they're in you know a clinic or something like that but I never really had that experience just because they're all women, you know? And so, I think that that plays a role too, just because I feel like I can be a little bit more open, you know? And so I think that that also is—plays a part in why I keep returning there.

Denise shared this sentiment to a greater extent, saying that she would not be able to receive reproductive healthcare from a male practitioner:

I'm pretty shy, and conservative. I mean, I've had male doctors do certain things but it was more just like basic physicals and you know listening to your lungs and your heart and that kind of stuff. Not any of the...I certainly don't think I'd ever be comfortable going to a male OB/GYN or anything like that, so.

In fact, Lynn observed that women practitioners seemed to be a constant at Planned Parenthood, noting, “I've never actually seen a man working at Planned Parenthood.”

It's about championing women's health. Among the reasons for developing a relationship with Planned Parenthood, several participants discussed the organization as a champion for women's health and healthcare. Women discussed their role in supporting this effort by continuing to use Planned Parenthood's services. Ruth discussed the need for an

organization devoted to women's healthcare, and how she positioned herself as a supporter of the organization's mission:

I think it's a really great place and that the public is largely misinformed. And when I say the public, I mean a lot of people that are causing a ruckus. And I don't really know how to talk to those people about a lot of things? Because people don't want facts. They want to be biased and that's unfortunate. I think that, you know, using the services or being a champion of those services and just understanding people need them. Or people want them. Um... it's really important. And that—that's, you know, something you can do if you care about women's health. Or if you are a woman. Or if you like women. Or... agree that women are humans? Then [laughs] you know perhaps [laughs] um you know, supporting your local Planned Parenthood or at least, you know, not holding a giant picture of a fetus in front of it would be a nice thing to do. And that's, you know... it's really hard to convince people to talk about their experience. And some are really hard to talk about. But I think if your friend asks you like, 'hey where, what's your doctor.' Don't be ashamed to say Planned Parenthood. It's not... it's not something to be ashamed of. It's a place you go to make sure you don't have cancer. And to make sure that... you know you're having regular periods. And if you are pregnant you are getting the right resources.

Similarly, Gloria discussed continuing her relationship because, "I agree with their goals, I guess, of being able to uh, provide necessary services to women regardless of economic position." Lynn, too, shared this sentiment and reflected on her experience terminating a pregnancy through Planned Parenthood:

I like their politics. I like the fact that I don't think—I don't know, like, I don't know if I could have gone to a gynecologist and gotten an abortion. I don't know if actual, "actual" gynecologists do that, or if... The only place I've ever heard of being able to have that procedure completed at, is at a Planned Parenthood, and I went there, and there was no fucking judgment about it.

Gloria discussed how lack of judgment for women's reproductive health decisions is reflected in Planned Parenthood's hiring process, because, "no one who would like, shame someone for wanting an STD test would ever apply at an organization that they just see as baby killers."

For Dana, Planned Parenthood served as an obstacle she could overcome in order to access birth control. She expressed frustrations with clinics that require a pelvic exam in order to

access contraception, and uses Planned Parenthood because they don't require women to have the exam. She contrasted the organization with other healthcare centers, saying,

Most doctors force you to submit to a pelvic exam in order to get birth control. And there's lots of, like women—most women won't say anything about it because it's one of those things you're just expected to accept despite the hypocrisies and the inherent invasiveness of the procedure, but most women do not want to have to submit to that and rightly so. 'Cause it's just a cancer screening, it's not supposed to be mandatory, not like a cancer screening is supposed to be. But doctors do it because they know that they can get away with it because of how politically charged the situation is and because they know women need this medication, so they'll do anything to get it 'cause you can only get it from a doctor. So it's good to have organizations like Planned Parenthood that don't require you to do that in order to get birth control so you can get access to it.

While Planned Parenthood is a politically charged organization, so is women's reproductive health more broadly. Planned Parenthood allowed Dana the opportunity to make a decision that other providers may not have.

Ability to Meet Most Important Needs

Planned Parenthood meets a very specific set of needs—women's reproductive healthcare. Participants discussed ways in which Planned Parenthood meets their most important needs, the needs that are most relevant to them on a regular basis. Several women contrasted their relationship with Planned Parenthood with a negative experience at a traditional provider in the past. Others discussed recurring issues that Planned Parenthood was able to address efficiently. Finally, some participants highlighted lifestyle choices that made Planned Parenthood a good option for affordable, reliable care.

Contrast with bad experience(s). Several women compared their decision to continue to use Planned Parenthood's women's healthcare services with negative experiences they had in the past. Janet's rationale for sustaining her relationship with Planned Parenthood was grounded in the stigma she encountered with a traditional gynecologist:

I went to see a gynecologist. I had a really bad experience, and I just didn't—like it made me really uncomfortable and I was just like, I find that with Planned Parenthood it's a lot more judgment-free, I don't know why, but when I went to like a private professional gynecologist, not that they aren't like professionals [at Planned Parenthood], but when I went to like a specific place that was recommended to me it was just very, I don't know, I felt very judged. 'Cause, 'cause I'm queer and I am like I don't really engage with men, so when I kind of—they questioned me a lot about like some of my birth control choices, and my sexual health, and it was very like harsh and judgmental. But, like when I go to Planned Parenthood, they're all like, yeah its all fine and great! So its a lot like... it's, it's more comfortable, it's more like not heart-beating-out-of-my-chest nervous to disclose information about myself to them.

Dana also compared her experience at Planned Parenthood with a previous gynecologist visit. She discussed her first and only pelvic exam at a traditional clinic, and said “it was very traumatic for me so I just stayed away from that sort of thing I guess.” She elected to use Planned Parenthood for birth control because they allow her to access contraceptives without requiring a pelvic exam.

Ruth contrasted her experience at Planned Parenthood with a clinic she used prior to initiating contact with them. After beginning her relationship with Planned Parenthood, she experienced an unwanted pregnancy, and returned to her previous provider to terminate it:

I just found that I really enjoyed [Planned Parenthood's] care better. Um... and I still did go to [my previous clinic] for that, um... like 2008. Because um, for abortion services. So... um, as a result... um, of sexual assault. And so... I mean I felt like that experience was, it was okay? And it was like, pretty supportive? But also kind of like not... not um, you know, considering how long I'd been seeing that... doctor, nurse or whatever. It was not as like, genuine and you know, like what I was going through at the time she knew the circumstances of the pregnancy. And it was still kind of like... you know, cause she's not the one who performs it. They have a doctor who comes and performs it because they have to have a different form of licensing or whatnot. And that was like the last kind of, not that it was a bad experience and like I have no regrets. But it was just ah... like a turning point in like, recognizing that like, my decision-making wasn't their first and foremost concern? And that's a problem for me. So then I've been going to Planned Parenthood since then like, only.

Though Ruth did not categorize her relationship with her alternative provider as strictly negative, she did describe it as a motivator to return to Planned Parenthood for more personalized care.

Erin shared a similar sentiment with her use of an urgent care clinic when the wait for an appointment at Planned Parenthood was too long:

Urgent care is on the same road as me. And it was like Saturday and it was burning and itching really bad. I was like I can't, I can't take this anymore. So I did go to the urgent care. Um, you know I had a good experience with it. It cleared up, they gave me the right medication. Um... it was just, I think, you know, cause I—I called them before I went in and I was like 'do you guys treat yeast infections? You know I think I have one.' And I went in and I won't say that they weren't knowledgeable about doing it? But it was... they were kind of like this isn't something that we normally do. And I was like well you said on the phone that you did. And they had the equipment and everything, but...

In fact, Erin characterized her experience with urgent care in a positive light because they were able to meet her needs immediately. Still, she perceived hesitation to address her women's healthcare concerns.

Recurring concerns. Participants further discussed Planned Parenthood's ability to treat recurring healthcare needs. Shonda discussed her history of yeast infections, and having to visit Planned Parenthood monthly for treatment:

I used to get yeast infections, um, a lot before I started my menstrual. I used to always get them before then. A lot. And, um, and sometimes after, which was kind of weird cause you just, you know, you wouldn't get—that was like on, uh, you know you would get yeast infections occasionally, but I would always get 'em right before I would get them, so I would always have to go in before then or I would just wait out 'til after I start my menstrual and go after to you know relieve it, and um, so, that's why I would go in regularly like that, but once I started taking those vitamins that they recommended then they would subside.

Shonda refers to vitamins that her provider recommended to help control her yeast infections. She explained that, through regular visits to Planned Parenthood, she was able to dramatically decrease the frequency of infections. Erin discussed a similar concern, and said her practitioner at Planned Parenthood was quick to address the issue. She shared that, "I tend to get a lot of yeast infections and she's given me a lot of information on that and like referrals to get prescriptions."

Yeast infections were a frequent issue for women. Lynn described having a chronic yeast infection after experiencing a pregnancy:

I had a chronic yeast infection for about a year and a half that kept coming back and I went back to them to retreat it. So I think the first reason why I go back to them is just 'cause I've always gone to them. I don't have a paradigm where I would go to like—I would walk into like an urgent care, or I would schedule an appointment with a gynecologist in an office where we can sit down and chat, um, I would set an appointment online, walk in for my appointment, be there for like an hour and then leave.

Janet described her need to practice safe sex in a same-sex relationship. She approached Planned Parenthood to gather information, because she was newly sexually active, and unsure about how two women could have safe, protected sex. Janet learned about dental dams through Planned Parenthood, but was frustrated with the limited outlets available to her for purchasing them, and regularly returned to Planned Parenthood for more:

I started going there more frequently because I needed things like dental dams but if you just go to like CVS or a lot of places where you could buy condoms, they're not really prominent. And they're not really there, and you have to go to like a specific like sex type store, like Noir Leather, you know you have to go to somewhere more specific. And I didn't wanna do that, 'cause it kind of, it frankly it freaked me out. So I would go there because they supplied everything and it was free and you could just get what you needed and it wasn't like weird or like the shameful pull your hood over kind of purchasing of under the table goods.

Credibility of practitioners. The credibility of care providers was identified as another reason participants decided to continue their relationship with Planned Parenthood. Women discussed the specialization involved in women's health, and the ability of Planned Parenthood practitioners to most effectively address their needs. Erin suggested that, "specialization is to me, I think you have more credibility that way." Lynn elaborated on this, discussing her preference for practitioners who specialize in the female body:

All medicine is designed around male bodies. The female body is an anomaly. Right? And so I'm like, I would much rather go to people with problems that aren't even reproductive related but know what female bodies are supposed to do more than a general practitioner.

Ruby continued her relationship with Planned Parenthood based on the type of care she received specifically from nurse practitioners and physician assistants. She discussed her history working in the medical field and how she sees care delivered differently based on profession:

I appreciate either a PA or a... um... an NP, a nurse practitioner, as opposed to a physician. I feel like they give... better patient care? They tend to listen to the patient. They never seem as rushed? When you're discussing things with them.

Ruby found that she was more likely to see the type of care providers she prefers at a Planned Parenthood than if she were to visit a more traditional clinic setting.

Lifestyle-related needs. In some instances, participants discussed lifestyle choices that required them to have access to regular reproductive healthcare. For example, Lynn described her polyamorous lifestyle and the need for regular STI testing within that community:

I was part of the poly education advocacy Sundays, um, which was a closed group of individuals, probably about 40 or 50 people, who met to talk about education within the poly community and issues that the poly communities specifically faced. And when you would talk about STIs and STDs, it was sort of a given. Right? It was sort of given that when you talk about STD and STI testing, they meant Planned Parenthood.

Planned Parenthood served the needs of the poly community without judging the lifestyle; rather, members of this group were able to access what they needed and feel respected.

In other cases, Planned Parenthood functioned as a resource for participants to learn how to engage in sexual activity safely. Janet described not knowing how to have safe sex with a woman when she came out as queer, and recalled approaching a traditional gynecologist for information. Because she felt shamed during that interaction, she turned to Planned Parenthood for help, and found the information she was looking for. The positive interaction led her to return to Planned Parenthood as other questions arise. She described Planned Parenthood's role, saying, "I think for me, it allows me to have safe sex, like that's, it, they kind of taught me how to do that. They provided the tools for that."

Yvette acknowledged occasionally having what she called unsafe sex. While she said she did not intend to do so often, she said it does happen on occasion. In these instances, Planned Parenthood provides necessary resources for follow-up care. Amanda, too, revealed, “I have engaged in unsafe sex, so I mean, it happens once in awhile, so—but, like, mostly it's like stressful if I don't, like, I feel like that's a necessity and, um, and yeah, STD prevention and all that.” Yvette described conversations she had with Planned Parenthood practitioners about protecting herself in various ways, and feeling comfortable discussing gaps in her own preventative care.

Negotiating the Relationship

As women became more committed to Planned Parenthood, they described the ways in which they navigate their healthcare needs through the organizational relationship. Most participants discussed feeling listened to when they expressed concerns at Planned Parenthood. They considered this unique among their medical care experiences. They also discussed Planned Parenthood's ability to make them comfortable disclosing health concerns. As they negotiated the relationship, women also discussed a number of barriers that impacted their experience.

Negotiating the Relationship		
They Listen to My Needs	They Make Me Comfortable	There are Barriers to My Care
<i>Everything's my choice/They aren't pushy</i>	<i>They're judgment-free</i>	<i>I encounter protestors</i>
<i>I can ask questions/They provide information</i>	<i>They foster honesty</i>	<i>They can't do everything I need</i>
<i>I can bring my needs/They work to accommodate me</i>	<i>We make decisions collaboratively</i>	<i>Our ideologies conflict</i>
	<i>They care about <u>you</u></i>	<i>I experience problems with their hours and wait times</i>
	<i>They offer a sense of community</i>	<i>They're paternalistic</i>

Table 3: How women negotiate the relationship with Planned Parenthood.

They Listen to My Needs

Participants frequently discussed feeling listened to at Planned Parenthood. This was often in contrast with a traditional doctor-patient setting. Participants discussed feeling like they were in control of their decisions, and that Planned Parenthood was a tool to help them access appropriate care. Often, women discussed feeling comfortable asking questions about their care. Some did not need to ask as many questions, but receiving a thorough explanation of their healthcare. When Planned Parenthood could not meet their needs, some women felt that the organization still tried to accommodate them in other ways.

Everything's my choice/They aren't pushy. When making women's healthcare decisions, several participants discussed feeling in control. Participants described positive conversations with practitioners at Planned Parenthood, but felt comfortable making the final decision. Shonda felt particularly in control of her healthcare decisions:

Oh, I make the, the sole [laughs] decision. Like, I tell my doctor, like, what I want. Like, what I want to take, if I want to take it. You know. If I don't want to take it. 'Cause you know if I don't wanna take it I'm not taking it, so, I make the sole decision on how I— what goes in my body.

Margo also said that she does not feel that she has to do anything she does not want to do at Planned Parenthood:

I never felt like they tried to, um, push it on me. Um. a—tried to push any other form of birth control on me. I already knew that I wanted to get the IUD when I went in. So it wasn't like oh well you should really do this.

She contrasted her experience with her sister's, who was pushed to get the birth control shot. Her sister's experience took place at a general practitioner's office, and was unsettling because, "we're Native American, we can't have Depo. It's really bad for minorities. So even that, you're her doctor you should know that's not something that... this particular minority can take."

Megan felt that Planned Parenthood provided her with options and tools to make the best decision herself. She said she feels comfortable sharing information because she feels listened to, and that her practitioners take that information into consideration before providing advice:

They're very willing to listen to what you have to say. Um, before they give you an answer, um, rather than just like providing whatever they think it could be, um, and I think they're willing to like look at other options too, um based on what you think is best for you.

Alternatively, Amanda felt comfortable knowing that she would not have to discuss anything she was uncomfortable sharing:

I feel like I don't have to talk about anything I don't want to talk about. Like they'll be like how many times do you have sex or so, I'll be like you know a couple of times. Then I'll just be like okay what's a couple? What is that? 3? Is that 5? They're just like 'okay.' Write down a couple of times.

The Planned Parenthood website helped her inform herself in advance of the appointment. She said, I looked at a lot of options on their website. Um. Then a lot of uh, they got a quiz you can take! That's like what's the best birth control for you." This tool helped Amanda approach Planned Parenthood with the specific form of birth control she wanted, and was able discuss it with her provider without being provided a list of alternatives.

I can ask questions/They provide information. Participants also discussed feeling free to ask questions, and confident that they would get a thorough explanation of procedures. Erin shared, "I feel comfortable to ask a lot of questions there. Just because everyone just makes me feel comfortable." This was very important to Megan, who described needing extra explanations for new healthcare experiences:

They do everything to make sure that you're comfortable, like they'll ask you for like your opinion first before they do anything, um, explain the...every process that they're doing and, um, like if you're scared or nervous they'll be like extra gentle with you and just kind and understanding.

Yvette differentiated between a traditional clinic, where the physician asks the patient a series of questions to gather information, and Planned Parenthood, where the practitioner explains processes with the patient. She explained,

With a doctor it's more of just like answering a lot of questions. They, um, explain a moderate amount. Um, at Planned Parenthood they like, explain thoroughly and it's more conversational with the doctor. It's more like, okay, so what are you here for, and um, ask my information, and just like, um, ask me different symptoms I may have and stuff like that.

Planned Parenthood's willingness to explain procedures marked the organizational experience as unique and preferable.

Lynn highlighted the necessity of healthcare explanations. She reflected on her mother's insistence that she access birth control when she became sexually active, but her lack of knowledge about the pelvic exam she received when she scheduled her first appointment:

[My mom] was like 'you should go and do this.' And then, what's really funny about the whole process was when you get birth control for the first time I think they're supposed to do a cervical exam, and my mom didn't prepare me for that. Right? She was just like 'go and do it.' Okaaay. And so I didn't really know exactly what to expect. The nurses walked me... the nurse, the nurse practitioners, the people there were all, very, like open and very kind and they were like this is sort of how the procedure works, this is how your visit will look like, I just remember being very comfortable with them all, and then being just very like easy-going and easy to talk to.

The extra explanation of reproductive health procedures was important for Lynn and others to understand the processes their bodies would undergo.

I can bring my needs/They work to accommodate me. Some participants discussed instances in which Planned Parenthood was unable to meet their needs. In these cases, participants described how the organization worked to accommodate them in other ways. For example, Amanda described making an appointment for the birth control implant. When she arrived, she was told that she would have to wait, because it needed to be inserted while she was

menstruating. Though she understood the reasoning, she said practitioners worked to accommodate her birth control needs in other ways:

We can give you this birth control like, birth control sack! (laughs) For you know, for next time you know. You just come in here and we'll give you the Implanon, and I was like no thank you, but thank you. I'll just—I'll just wait. So... they try to make sure that you're set, like even though you couldn't—you're not there for what you need. But they'll still try to accommodate you.

Ruby described her desire for permanent birth control. She visited Planned Parenthood, and asked about her options with the organization. Unfortunately, Planned Parenthood was unable to conduct the procedure that Ruby wanted. They were able to help her with a referral, but “They felt supportive. It almost kind of seemed like I—I, you know apologetic in a sense. Like we, you know, we're sorry we can't offer this service to you but...you know, here's someone that, someone that can.”

They Make Me Comfortable

As participants navigated their relationship with Planned Parenthood, they consistently discussed feeling comfortable in that space. Many participants described Planned Parenthood as an organization that does not pass judgment on women for their reproductive decisions. Several women described ways in which the organization allowed them to be more honest about their lifestyles. A number of participants described the organization's ability to work with them collaboratively to make the best healthcare decisions. Other's emphasized how Planned Parenthood cares about their patients in ways that other healthcare providers do not. Finally, several women discussed a sense of community when they visit Planned Parenthood clinics.

They're judgment-free. Judgment surfaced several times as a barrier to quality care at traditional clinics. Women discussed feeling comfortable at Planned Parenthood because they did not have to worry about being judged for their healthcare decisions. Heather described Planned

Parenthood as “a judgment-free zone.” Gloria expressed having an overall sense that she would not be judged at Planned Parenthood:

I definitely automatically feel less judged. At Planned Parenthood. Um. For anything that I might... do I guess. Not that I'm doing anything that would warrant judgment in the first place. But if I were I guess I automatically feel less judged.

Heather put the judgment-free nature of Planned Parenthood in contrast with other providers she's visited:

You go to a lot of clinics and you go in and they're like, ‘Oh my god, you're coming in for this!’ Or, you know it's, ‘Well you know why did you get there?’ And I've had nurses that I've like literally wanted to like pimp slap because I felt like they were being disrespectful and they were like looking down. And um I think that that's the wrong type of um attitude to have. Like if someone's coming in for something, it's because they're—they're out of resources. They don't know how to fix it themselves. They might be scared, they might be whatever. But they're coming to you seeking help. And I think it's important to just be open and to have, just have a good bedside manner.

Janet described Planned Parenthood's ability to reserve judgment because “they seem unfazed.” She described going to Planned Parenthood when she experienced heavy bleeding. She explained that she had “ended up getting myself in a sticky situation and I had a miscarriage, um, and I didn't know I was pregnant, so I didn't know what was happening.” She worried that visiting an emergency room would invite judgment, but did not face this at Planned Parenthood:

They were so nice and like you know they do follow-up calls and she called me a few days later and said you know how are you, what's going on, do you need anything, and they recommend you know different therapists if you need that, so it just felt a lot more personal. And it was a really positive interaction. I think that kind of set in stone for me like that's where I should go because it's just so much more open and judgment-free and more like, you know we don't care how you got into this situation. But you're here now and we're gonna help you. Which is really important.

Janet's experience reiterated Heather's point about women who need to be able to access help without fearing persecution.

Planned Parenthood offers a wide variety of reproductive and women's healthcare services. Ruth described how the organization was willing to help her pursue her decision not to have children without facing the response that she was used to hearing:

I, you know, got birth control, they always ask you a million questions about like do you have any children, have you ever been pregnant, that kind of stuff. And I'm always like, 'no, I don't have children. I've never ever wanted children.' And immediately it was like 'okay cool.' It was not a conversation. It was like 'okay, cool. So check that off and it's a perfectly valid choice. I'm not even going to recognize that that's weird because it's not. And cool.' And that was just like the fi—it was immediate. It was salient to me because I have to fight this every time. I have to fight this with regular physicians; I have to fight this with like, people in my life about—not so much anymore, because I've been yelling about it my entire life. But in general you go to—you have a big family and you go to like someone's family Christmas. And it's like 'Oh when are you and so-and-so having babies?' I'm not having babies. So... the fact that it was just not even... I almost was like taken aback. Like oh! When I have to fight about this, this is a good place for me. It's not, it's so like, anti-everything feminism to attack anyone's choice about anything. And so I just felt like it was a really like...it wasn't that it was actively open. It was doing what it was supposed to do. It was not recognizing anything was weird. And that was great.

Ruth reiterated that it should be the norm for a feminist-oriented organization to reserve judgment about women's reproductive choices. Still, she appreciated the experience she had.

They foster honesty. Several participants discussed feeling unable to be completely honest when they visit a traditional medical clinic. However, Planned Parenthood allows them to feel more comfortable being honest about their lives. Amanda illustrated the difference she experienced between a traditional gynecologist's office and Planned Parenthood:

To be completely honest with your doctor, so I guess on the record or whatnot, uh, you know to be perfectly honest, I do smoke weed. So I have no problem telling a Planned Parenthood doctor like, you're on this, this and that. Like yeah, I smoke weed. I smoke about a blunt a day, you know. I stress... Meanwhile at the OB/GYN they're like, you know, 'Do you take any drugs, have you taken any?' and, uh, you're just like 'no. [laughs] Nope, I've never tried that before. You know, peer pressure never hit me in the face.'

Ruth expanded on this when she described the importance of comfortably speaking her truth:

I know I'm not going to get crap. And like... no one's gonna... you know. I—I think that's important. And it makes me want to go there because I know I'll get the best care because I can tell them really how I feel.

She explained, “it's not just that it was a place to feel like you can be honest in a way you won't be judged, but that now you have a relationship with your caregiver in a way that continues to foster that.”

Erin discussed the importance not only of being honest herself, but that her doctor be honest with her. She described needing a physician who could openly address her concerns:

It's important to me to have a physician who's honest. And will, will tell me stuff and also will answer questions when I ask. You know, because some doctors if you ask them questions they get annoyed or they think it's a stupid question. I—I don't like dealing with that because I have really bad anxiety. So I need someone who's going to work with that. And you know, is actually willing to answer questions.

Skylar provided an alternative perspective on her healthcare. She described lying when she approached Planned Parenthood in order to have her needs met:

I actually lied about it when I went to Planned Parenthood 'cause they asked me if I'd had [a pelvic exam] like in the last year and I was like yes....because I wasn't gonna get birth control otherwise. So I actually lied, but I ended up, you know, getting the birth control and everything.

Skylar's understanding was that accessing birth control would require a pelvic exam. She knew that she did not have time to schedule an appointment with a primary care provider before she ran out of the birth control she had left, and decided that lying would be the best way to ensure that she was still protected from pregnancy.

We make decisions collaboratively. Several participants explained that Planned Parenthood allowed them to make decisions about their reproductive healthcare collaboratively. Participants frequently described navigating their healthcare decisions through conversations with their provider. For example, Shonda described how she made the decision to change birth control methods, and the role her provider played in helping her choose the best option:

I was gainin' a lot of weight with the shot, I mean A LOT tremendously lot of weight. And it would make me bleed a lot so I was tellin' her that my periods were like too heavy and the weight was just outrageous. So, an....So that was like the main concern and she was like, well we can just come off for a while you know let it wear off so I wasn't on anything for a while. So then I let the shot wear off and then once the shot wore off we were gonna switch straight to the pill, and that's what we did.

Shonda discussed the process of changing birth control using inclusive language, exemplifying the collaborative nature of her care.

Lindsay shared a similar experience. She discussed Planned Parenthood's role sharing information about different options, but allowing her to make the final decision based on her provider's recommendations:

They're very understanding, and very friendly and um you know like they'll, they'll talk to you for like as long as you need to feel comfortable or to get information you need. They're super knowledgeable and like they'll help you out. They'll be like okay like what's your specific situation? Like, you know, what exactly are your needs? And they'll get like really into it instead of just the sort of flat overall like oh you want birth control what do you want to try? They'll like help you figure stuff out. And they're very up to date on everything. And, they're just like very kind of like there with you, I guess is the best way to put it kind of.

Beth's had a similar experience switching birth control options to meet additional needs. She knew what needs she wanted met, but not how to achieve them without her conversation at Planned Parenthood:

Going this time around when I went to Planned Parenthood I was just like, you know, I want that as my primary reason, BUT, I also you know want to address like A, B, and C. And then from there we were able to determine, she was like I'll try something new and then when you come back we can talk about how it is, you know, how it's working and addressing that other stuff.

Like Shonda, Beth used inclusive language to describe her decision-making processes.

Erin explicitly used the word collaborative to describe how she navigates her healthcare decisions at Planned Parenthood:

Well, I would say its on the one hand it's a collaborative effort. And when I say that I mean like, I will talk to my physician and my physician's very blunt, which I enjoy. I'm a

very blunt person. So you know, it's—I can literally just be like, you know, am I gonna like this? Is it gonna make me bitchy? Or whatever. And she'll be like, yeah. She'll tell me the risks and benefits of each birth control and like, and she's even given me education. Because I tend to get a lot of yeast infections and she's given me a lot of information on that and like referrals to get prescriptions. And like I, when she did it for me I didn't have to have—I didn't have to go get the prescription but she still wrote the script in case I wanted to. I, so I would say that we're collaborative and like, I can tell her about it. But then the final decision always rests with me. Um... so, so it's collaborative but then I get to make the final decision. So I do feel really in control of it just because I am able to do that. But I do get to ask the questions I want. Because if I'm going to use something that's going to go in my body then I want to know what it is, what the risks are.

Planned Parenthood provided the necessary tools for Erin to make the final decision about her healthcare.

They care about you. Several participants discussed feeling like providers at Planned Parenthood cared about their individual needs. They often contrasted this with traditional healthcare sites, where they felt they were just a part of the job. Megan explained how Planned Parenthood approaches women's healthcare differently from a traditional office:

I think that, uh, Planned Parenthood is much more personal... Um... to the actual patient. And, um they like take their time, um, and then the traditional office is like not as private. There's doctors walkin' around talking to each other and, um, it just seems more like just work for them.

Women also described feeling like the space at Planned Parenthood provided more emotional support. Erin's experience exemplified this:

They let me like, cry and like, you know. If I—if something hurts or if I'm uncomfortable they let me feel comfortable enough to do that? 'Cause like when I got my IUD in that shit hurt like Hell. Like, I'm not even kidding. That was horrible. And they just let me cry and they actually like brought in a lady to like, hold my hand and like comfort me. Because I was in that much pain. Um, which I found out later is it's—you're in more pain if you haven't had kids. And I haven't had kids. So I think that's why it was hurting so bad. Um. But they just—they just make me feel comfortable and like normally if this is the place I wasn't comfortable with like, I would probably still sit there and cry or whatever, but I mean, I would try to like hide it more. But since I've been going there for so long and like, the physician knows that I'm kind of tender in certain spots, like, she doesn't mind. I feel comfortable enough to do that which I think is good.

This emotional support carried through in Lindsay's interview. She discussed how practitioners at Planned Parenthood are attentive to her emotional needs:

One of my previous, um, relationships was pretty like emotionally abusive and a little bit sexually abusive toward the very end of it before I got out of it. And, um, just like when I go in there, um, they'll sit down like whoever's like the intake person will like sit down with me and they'll be like do you feel like you're in a safe place? Like, is there anything that we can do for you if you don't feel like you're in a safe place?

The idea that Planned Parenthood provides support to women's specific, gendered needs resonated in discussions of compassionate care.

They offer a sense of community. Participants often discussed Planned Parenthood as a safe space to address their women's healthcare needs. This notion continued to resonate as they experienced the organizational relationship and encountered a sense of community. For example, Lynn described the community nature of a women's healthcare setting:

I also think about the community aspect of it. Right? I think about women being there for women. About issues regarding women. Um, I think about people who are like, 'Oh, I know the signs of domestic abuse, um, I know that you have all these bruises on your body, I know what that means.' I think it's something about women's sexuality, and to say you are more than just reproduction, here's how you have a healthy, happy sexual life. Here are issues regarding weight loss, but you should feel positive in whatever body you have. Here, because genderized body image is a fucking thing. And, like if—like I think that women's healthcare wouldn't—because of the, sort of the community aspect that women are socialized to do and the, just, community building that we do.

Women also discussed how this sense of community extended beyond Planned Parenthood. Several women described referrals that Planned Parenthood provided to help them meet other healthcare needs. Denise described this broader network as a community:

It's nice because it's kind of a community, especially when you have the different income-based services. I feel like they're kind of interconnected, especially in such a big city. They know, you know, hey this is where you need to go for this and this is where you need to go for this, kind of thing.

Janet also found an extended community through Planned Parenthood. She described getting involved with a queer community through Planned Parenthood's network:

I mean, they deal a lot with people who are queer. Um, so they do something, ah, usually through this group called Affirmations, um, which is just a queer friendly space there, and there's a lot of different, um, like, I don't want to say therapy places, but there's a lot of different counseling for queer people there. And so they'll advertise and like sponsor or say like hey, there's information you know about this group discussion coming up, there'll be a medical professional there, if you have any questions, um, which is really beneficial. I've sent other people there. Um, and that's how I learned a lot.

The community aspect of Planned Parenthood helped Janet discover a new network of peers.

There are Barriers to My Care

While many participants discussed positive aspects to negotiating their healthcare experience with Planned Parenthood, they also frequently discussed barriers. Often, participants discussed protestors at times influencing their decision to visit the center. Several participants appreciated the experience they had with Planned Parenthood, but wished the organization were able to provide more services. Some participants discussed the impact their ideology had on their organizational relationship. Frequently, participants discussed the hours of the organization or the time they spent waiting for care as a frustration. Finally, there was some discussion of the paternalism inherent in conversations with providers.

I encounter protestors. Protestors are a frequent presence at Planned Parenthood centers across the nation. Protestors often served as a psychological barrier for participants. Denise discussed avoiding Planned Parenthood when protestors were present. She shared that, “ I have gone by just for general questions or to pick something up and there have been people outside and I’m just like okay, I’ll go at another time.”

Other women did not want to see protestors as a deterrent to their care. While protestors did impact their experience, Janet explained that employees at Planned Parenthood took her emotional experience seriously after she crossed protestors:

They apologized profusely. Like you know I watch the news, I know what happened. And they literally said, ‘you know it will probably die down in like a week,’ and I was

like, 'yep! Probably, people will get tired 'cause they'll realize people will still come.' Um, but they were really, I felt bad because I walked in and every—like the lady at the front desk turned and looked at me with these wide eyes like, 'oh no, did they say anything to you,' and I was like, 'no I'm okay, you know, that was like the first question.

In fact, Liz discussed how Planned Parenthood approached her prior to terminating a pregnancy. She said she was warned that protestors might be present, but assured her that they had no way of knowing why she was visiting:

When I called to make the appointment with them they said we want to prepare you that we don't generally get a lot of protestors but when—if there are protestors and they try to mess with you, um they have no idea whether you're coming for an abortion or for any other medical care. They have no idea. And so you know they may try to tell you, give you information but they have no idea. They you know, 'cause we do so many other things and so you know they did prepare me for that possibility.

In some instances, women described wanting to visit Planned Parenthood despite the presence of protestors. Gloria described wanting to show protestors that they could not impact her decision:

I want to walk past them and I want them to see like a confident, self-aware woman going into Planned Parenthood and not giving... a care about their presence. Because I'm going there for women's health needs. I'm not going there because I have an unwanted pregnancy. I mean honestly I'm at the point where if I did get pregnant I would probably, would keep it, you know? But uh... I would rather do everything in my power to not get pregnant. Uh. And Planned Parenthood, uh, helps me do that.

They can't do everything I need. Though Planned Parenthood helped women with their reproductive healthcare needs, several participants discussed ways in which the organization still fell short. While Planned Parenthood is often associated with abortions, Ruby actually described needing to terminate a pregnancy, but getting a referral because her Planned Parenthood was unable to provide the service:

I didn't like it (laughs). I didn't, wherever I came wherever I went. It was janky. It was specifically an abortion clinic. I didn't like it. I—I really wish that I could have gotten my care at my local Planned Parenthood. I wasn't really happy with getting... referred.

Ruth expressed similar frustrations with her referral. She needed an ultrasound to identify cysts, but her Planned Parenthood wasn't equipped to provide the service:

So she says we don't have ultrasound, we don't have the equipment to do whatever, however good the picture needs to be, or whatever? We don't have that kind of equipment. So she's like, you know, here's a—and it was a list of all places that they're like affiliated with or... in the same system with or like, cool with? I don't know. That also had this kind of equipment or had someone who has access to it.

When Planned Parenthood centers were unable to provide necessary services, participants did receive referrals. However, the preference would have been to stay with Planned Parenthood.

Others expressed a desire for Planned Parenthood to offer more general health services.

Lynn described Planned Parenthood's ability to identify health risks, but not provide care:

When I went to Planned Parenthood last time, they told me that I was at risk for diabetes. They were like we can't test that here, but according to your BMI you are running a risk for diabetes, so maybe take it easy on—or take it harder, I guess, on your exercise, and take it easy on your food intake. Which, right? But, I mean, they can't do it, but I really wish they could. Because I trust them anyway. Like, I would go to them for anything. I would—I mean they have just, in my opinion, I feel like they're much more practiced, they've seen much more people, and they deal exclusively with women's bodies.

Margo described similar frustration that she could not get here standard care through Planned Parenthood:

I just wanted to do... just a regular um... like health screen. To see how I was doing overall. Um. Not necessarily going for a pap smear or anything. And I know that's not something that they can do? Which is something I wish that they could. Um. I—I, and they're just reproductive health, I understand that. But it would be nice if they did, um, if they could do even that.

Our ideologies conflict. Because of the politically charged nature of Planned Parenthood and the services they provide, several participants discussed instances in which they felt conflicted. Denise demonstrated the most internal conflict with Planned Parenthood based on her conservative Christian beliefs:

I listen to the family life radio, and they were just talking about how the couple of comments that got leaked from one of their conventions a couple... like the CEOs

whatever talking about like... how they dispose of the fetuses and that kind of stuff after abortions, um, I think that in itself was really heartbreaking, like how they were talking about, you know, what they do. And the one was talking about how she wished she could just drive up north and build a big bonfire and burn them all, and like, that was leaked from one of their conventions that they had. And that itself I think is one thing that has really screwed them over, you know, they need to work on a public image, I mean I don't understand.

The same incident resonated for Amanda, who remarked that hearing the news changed her perspective on Planned Parenthood momentarily:

I guess just the, the scandal that came out? Maybe like changed my perception for like a minute? It was like a lot of like abortion type scandals or something. Or they were... I don't know, stealing baby parts or something? I didn't really understand what was going on. But it didn't—I wasn't like I'm never going to go there again. I was like okay, this is gonna die—being a PR major probably helped. I was like this is gonna die down. It's, you know, if it was really that important they would really be shut down already. They can't be doing that much illegal stuff. I mean, like, it's not that big of a place!

Liz experienced conflict only after she terminated her pregnancy. She described feeling confident in her decision, and having a positive experience with the providers at Planned Parenthood. However, once it was over, the public rhetoric made her feel like she had done something wrong:

I didn't feel bad right until outside sources told me I should feel bad. And that to me, I was like something stinks, something is wrong and I have been trying to figure that out. It was a very professional appointment and it was really just the dumpster fire of public discourse afterwards that, um, placed that guilt upon me.

I experience problems with their hours and wait times. Though participants described positive interpersonal experiences, the wait time for appointments was discussed frequently as a barrier to receiving care. Margo described the time it took her to get an appointment to terminate her pregnancy:

Usually if I call, um... it's a good month or so before my first appointment. Um, the time that I... um, went... basically when I was, um, called about having an abortion that I went in for that it took me... um... I realized I was pregnant right away. So I was about a week pregnant when I realized I was pregnant. So it was very early. Um. I... called and made the appointment it took... took three weeks for them to see me and It was going to be

another month before I could have an abortion at that point. So I knew in a week and I still had a good almost two months wait time, um... to take care of everything. So I think that... that is their biggest downfall.

She explained that this is consistent with the length of time it generally takes to make an appointment.

Shonda discussed very lengthy wait times every time she makes an appointment. She described her most recent visit, saying:

Appointment was at 130-2 o'clock. 5 o'clock. That's the lengthy part. Two o'clock to five is a long time to be sittin' in the waitin' room. Finally the doctor come in. Finally you get seen. Five minutes process. Ok, you waitin', I guess they, after you get seen, five minutes, okay finally she come back in with the results, maybe about 15 minutes later. Okay, you get the results. Medication. You out the door.

The long wait time caused additional problems for Shonda, who described a two-hour parking limit outside, but appointments and waiting always lasting longer than that. Ruth discussed inconvenient hours at Planned Parenthood, making it difficult to schedule appointments around her work schedule:

Their hours kind of suck. It's like, an inconvenience. And you know you can't (inaudible) money. I understand reasons but um, I think that that's... being accessible to people maybe one location has an after hours clinic.

Though the hours and wait time posed problems for participants, there was a shared sense of sympathy toward Planned Parenthood. Participants recognized funding and staffing struggles that contributed to those issues. Lindsay explained why the long hours did not negatively impact her view of the organization:

I suppose it does impact it, but not in a negative sense really. Um, it just kind of makes me I guess kind of sympathetic towards them because I just wish that, um, the organization in general like had more funding and you know support and stuff like that. 'Cause um the way it seems to me is just that really like they are understaffed. Like, they don't—at least the clinics I, you know, the clinic I go to, it's not big. But the waiting room is always full because people do want and need to go there, so I guess the way it impacts my view is just like I, you know, like they're good people and I just wish that, um, they

had a bigger staff and just more money to have bigger facilities so they can have, you know, more people in there at once and so that people don't have to wait so long.

They're paternalistic. Though most participants described positive experiences with Planned Parenthood, there were instances of paternalism. Dana was highly unsatisfied with multiple conversations she had about refusing a pelvic exam. While she acknowledged the desire employees likely had to help keep her healthy, she explained that,

When you use that sort of patronizing language to try to get someone to do something that's completely invasive, it can often be painful and traumatic for people. So like a pelvic exam, that is like a whole different ballgame. You're asking someone...you're opening up a big can of worms there that no one really thinks about or considers. And the worms are currently crawling across the room.

She felt that Planned Parenthood employees did not consider her possible reasoning for denying a pelvic exam. She emphasized the invasive nature of the procedure, and the importance of remaining empathetic and understanding of women's desires. Dana she feels that birth control should be offered to women over the counter, and that Planned Parenthood is a barrier that she has to cross in order to get what she needs. But, she said, "Planned Parenthood is at least a barrier with roses growing on it."

Liz discussed her experience terminating her pregnancy, and the counseling she received about alternative birth control options. She said that, "I was like OCD perfect birth control use and it failed." Still, when she scheduled her abortion, a social worker provided information about options that would be more effective, and eliminate potential for human error:

I remember being a little bit annoyed that I had to do that because, it wasn't patronizing but I was kind of um, uh, I don't know if it was arrogance or it was just like... Like I didn't want to know like how I could like not think about this.

For Liz, she knew she was using her oral contraceptive correctly, and was focused on taking care of the situation at hand, rather than considering alternative options.

Understanding Women's Health/care

Throughout the process of establishing a relationship with Planned Parenthood and navigating the organization for necessary care, participants remarked on how the relationship impacted their understandings about women's healthcare. Women explained how their relationship with Planned Parenthood contributed to their advocacy for the organization and/or women's healthcare. Participants also discussed the organization's contribution to their understanding of their own healthcare. Finally, women identified ways in which the organization contributed to their ability to become healthier.

Understanding Women's Health/care		
Led to Advocacy	Learned about Personal Care	Helped Get Healthier
<i>Advocating to others</i>	<i>I'm the expert in my body</i>	<i>Identifying other issues</i>
<i>Engaging in a fight against protestors</i>	<i>They filled holes from sexual health education</i>	<i>Taking up free STI testing</i>
<i>Exercising feminism</i>		<i>Managing ongoing concerns</i>

Table 4: Planned Parenthood's contributions to women's understandings of health/care.

Led to Advocacy

As participants discussed their relationship with Planned Parenthood, they described shifts in their understanding of women's health and healthcare as a political issue. This led women to advocate in a variety of ways. First, women described advocating to others to access care, and to use Planned Parenthood specifically. Second, women remarked that they felt involved in a fight for women's healthcare and did not want to allow those protesting the organization to win in the end. Finally, women remarked on their experiences negotiating their reproductive healthcare, and the impact it had on their feminism.

Advocating to others. As a result of positive experiences with Planned Parenthood, participants described an increased tendency to refer others to the organization, or to women's healthcare generally. Amanda became enthused about recommending Planned Parenthood as an

affordable option for family pregnancy. She said, “I tell everybody that! I tell them that it's right down the street, it's free, I'll take ya. But birth control is a choice, so...” The recognition that birth control is something women need to choose for themselves remained salient for Amanda. Shonda discussed her advocacy of Planned Parenthood for women who cannot afford traditional care saying, “I will always recommend someone that does not have insurance, to who does not have insurance I would say go there! I will always recommend them, so... it would be my first place.”

Janet reflected on her entry into Planned Parenthood in high school and the positive experience she had. Janet described always being aware of the risks that accompany sexual activity. Once she realized how accessible and private Planned Parenthood was for young people, she described being an advocate among her friends:

I had friends in high school who would rather like potentially accidentally become pregnant than go there for birth control. So I almost became like a shuttle there. Like, I'm drivin' your ass there and you're getting what you need because this is ridiculous and I will not see you go down this road. And in the end, you know, it helped them, but I think it's really sad that there are, you know, young women in my position who just can't—feel like they can't go there or get the help they need and they'd rather be stuck in a bad situation than advocate for their own health just because of the angry political ties to it.

Participants recognized the tumultuous political climate that surrounds Planned Parenthood, but once successfully navigating it for themselves, they became more enthusiastic about bringing others into the organization.

Engaging in a fight against protestors. Because of the heated political climate that surrounds Planned Parenthood, positive experiences with the organization often increased participant's desires to refute the negative discourse. Gloria talked about protestors and how she could, “feel, like, the rays of judgment coming from them, you know? But I mean I guess that's

part—that's another reason why I wanna keep using them. 'Cause I don't want to let them win, you know?" This resonated with Ruth, as well, who shared:

I think I'm almost like continuing to go there out of spite for how hateful people are. Like, hey, look, I'm an adult person who is highly educated that has a good job, that's had a great career, that owns a house, and I'm going to continue to go to Planned Parenthood because this is a place that meets my expectations and matches my philosophy about what healthcare for women should be like—and men, whatever—what this should be like. And what kind of services we can provide and we care and engage with our patients. And so now it's like, like honestly I probably just go there forever, I don't care.

Margo's experience accessing an abortion through Planned Parenthood moved her to be more politically active. She described having been an active supporter of the organization, but terminating her pregnancy led her to seek even more involvement:

Before, I had gone to counter protests at Planned Parenthood in the past. Um. Basically trying to support them and keep people away from the doors. But I never um, been an escort before. Um... I guess I could see more of the reason for it after that. Wha—how people, how and why people would feel unsafe or uncomfortable and things like that.

In other cases, women described feeling angry that people choose to spend their time protesting a resource that has been helpful to them. Amanda expressed her strong dissent toward protestors:

I hate them people 'cause they're basically all dudes. And I'm just like you have no right. If it was all women, it would probably make more sense to me. But it's like an old guy with a sign. It's like we believe in Jesus. You should have your babies. And I'm just like, you don't pay my bill.

Ruby said that this sentiment toward protestors contributed to a stubbornness that provoked her to stay with the organization:

There is some kind of weird... stubbornness that also kind of... makes me—if there's something along the lines of... I almost feel that... they have a bad rep? Like most people, or at least most uneducated people on what they do, immediately see it as an abortion clinic. Um, so there's part of me that almost wants to be a spokesperson and say no, that's not all they do. So maybe there's some kind of stubborn streak in myself that I want to continue to use the—them specifically for that purpose. In order to be able to speak to all the other good care that they do provide. That has nothing to do with... abortions.

Gloria explained the counterintuitive nature of protestors at her center. She noted the visibility of the clinic, and hypothesized that many of the protestors were simply there to be seen:

I mean you're in the—in the waiting room and it'll be like a nun looking through the windows. Like seriously. Like in full habit. Like it's like for real. Its—its nuts. Uh. And I mean I think a lot of it has to do with, well number one, uh... the Planned Parenthood I go to shares a wall with a Catholic organization. Which is crazy. Um. The other part is that the Planned Parenthood I go to is on [a busy street]. So it's in a very, very visible spot. So I think these people um... know that people will see them. But the clinic I go to doesn't even provide abortions so you know as usual it's just a waste of their time and effort since they're not actually stopping uh, anything negative in their eyes from happening. You know. Unless they just want to stop the access to birth control so everyone has to have a bunch of unwanted children, you know.

Exercising feminism. Women also discussed their experiences with Planned Parenthood contributing to their own feminist identities. Liz described not identifying as a feminist before she terminated her pregnancy, and how negotiating politicized women's healthcare influenced her to change in that regard:

I didn't even consider myself a feminist which is really funny, I was like, well no men and women should be equal so the—like I was such a fool, you know? So it wasn't really a major concern for me. That's why it was so transformative and it's really cool actually now to be able to reflect on that, but um you know it's one of those things that you don't become invested in it until you need it and then once you need it you're like 'Oh, my god! How could other people not have this option?' you know? It was like it was baffling to me, like as somebody that was, like you know it's like you don't know until...

Alternatively, Megan found that she did hold feminist beliefs, but that her relationship with Planned Parenthood reinforced them:

I think that like the girls who work there are um, like the strong feminists who share a lot of like the same views as I do, um, and I know they're like choosing to work there 'cause they're passionate about like women's issues and I think that I liked that a lot.

Lynn also discussed holding strong feminist beliefs throughout her relationship with Planned Parenthood. However, she described the political climate elevating her beliefs and politics:

I'm more political because people wanna make Planned Parenthood political. And without any knowledge about how it works. Like, I'm not even a part of Planned Parenthood, and I have a really solid understanding of the way that its internal organization is structured. I know how the intakes go. I know why they go a certain way. I know why they ask the questions that they ask.

Having experienced the kind of healthcare Planned Parenthood provides to women in need, women found themselves more likely to identify openly as feminists.

Learned about Personal Care

Through their relationship with Planned Parenthood, participants how the organization helped them learn about their own care. Participants discussed being the experts in their own bodies, with Planned Parenthood providing the tools to get them there. Others reflected on the holes in their sexual health education, and discussed ways in which the organization helped them fill those.

I'm the expert in my body. Several participants discussed being the experts in their own bodies. Heather asserted this concisely, saying, “at the end of the day, no one knows your body like you do. And I think it’s important, if you’re not feeling well or something’s going on.” Participants identified being best equipped to identify their own wellness, and described ways in which Planned Parenthood provided knowledge that allowed them to better address their own healthcare needs. Ruth discussed being the expert in her own wellness, but recognized the important role physicians play in helping people to be healthy:

I know my situation and you don't know my situation. So they have to kind of, yeah doctors aren't going to see things clear all the time, but you also have to understand your patient knows their life. So regardless of... you know, it's a hard balance. Because the doctor does know things that are best, but at the same time, you know, they don't know the ins and outs. So for some patients you have to really take into consideration their points of view on their care. I think that Planned Parenthood does that.

Several participants also described feeling empowered to better address issues on their own. For example, Erin discussed having to use an urgent care clinic when she could not get into

Planned Parenthood quickly enough. When she asked her urgent care practitioner for advice on preventing yeast infections, she found that she was actually more knowledgeable:

When I was like starting to, um, talk about it I was like you know why do you think I keep getting these, you know, or like what do you think I can do to prevent them. They didn't really know how to like answer stuff like that. Like they were just kind of like, 'oh well keep it clean and use unscented soap' and I'm like well that's not helpful 'cause I already know that, versus, um when I've—I have gone to Planned Parenthood for yeast infections in the past, um, when they were able to get me in sooner, and when I talked to my gynecologist about it, you know, I was kind of like you know what—what can I like, you know—what, what do you think is the cause of this, and I mean she named a whole slew of stuff and she was like, well, she was like if you're not keeping it clean that can do it, she was like you know if you eat too much sugar I've heard that can do it, she was like eat a balanced diet, um, she was like eat, you know, she was like you need to make sure you eat some yogurt in your diet, some cultures, um, I have Mirena, she's like you know Mirena... sometimes people who have—get Mirena get more yeast infections so its like she had this whole slew of things.

Having the knowledge from Planned Parenthood made Erin realize that she was better informed about the causes of yeast infections than her urgent care physician. Shonda also discussed her body's tendency to get yeast infections regularly. Her experiences with Planned Parenthood helped her to learn how to take on new behaviors that would decrease the frequency:

I would always get [yeast infections] right before I would get my menstrual, so I would always have to go in before then or I would just wait out 'til after I start my menstrual and go after to you know relieve it. And um, so, that's why I would go in regularly like that, but once I started taking those vitamins that they recommended then they would subside—with those type of vitamins that I was takin', so that helped a lot.

Working with her Planned Parenthood provider allowed Shonda to take self-care steps at home to minimize the recurring issue.

They filled in holes from sexual health education. Participants often discussed holes in the healthcare learning they experienced growing up. Several women discussed receiving inadequate education in adolescence, including Lindsay, who said that, “overall like I suppose, like, I didn't really know that much about it 'cause I went to a public school and we didn't have like a great health class or anything like that.” In instances like this, Planned Parenthood was

able to educate women where it was lacking. Liz described the necessity of this education for her learning how to most effectively prevent unwanted pregnancies:

My sex ed. knowledge, it wasn't strong. Like I didn't know at what point in the ovulation cycle you were actually most at risk to get pregnant. I had no idea, you know, it was just one of those things like, don't fuck up, make sure you're protected, and I knew that was really important. But otherwise it was, um, yeah, you know just sort of, um Internet knowledge and that's about it.

Janet struggled with sexual health education perhaps more, because she did not use feel comfortable with Internet searches, but also did not learn about safe sex practices for same-sex couples in school:

I was a little bit too shy to like Google on the Internet like hey, how do 2 women have sex? But it was like I didn't, I didn't know so I went [to Planned Parenthood] for like all kinds of education, like, and I—it's nice because you can ask a lot of questions there. It was like, I don't understand how do you use condoms for this? Are there women for women condoms? And dental dams, which I hadn't even heard of until I got into college.

In other cases, participants discussed misinformation they learned growing up. When Shonda described her chronic yeast infections, she explained that the information she learned as a child contradicted medical advice:

As a kid I was taught to, to use [scented soaps] you know to freshen up, but as I got older, you know, I would get infections and stuff, and um, you know when I started to go see about my own help, then the doctor be like no you're not supposed to use that. So as I got older I, you know, they told me you know you're not supposed to use that, you're supposed to, basically your body's supposed to refresh yourself but you can, you know, eat certain foods and stuff like that to redo your own... I guess your own, uh, uh, fluids, I guess. And that's how I learned to do that instead of using the scented stuff because that pushes it back...the bacteria back in there and makes it worse.

Planned Parenthood provided education about how to most effectively take care of common women's health concerns.

Helped Get Healthier

Finally, participants discussed the impact their relationship with Planned Parenthood had on their ability to become healthier several ways. First, several participants discussed Planned

Parenthood's role in identifying an underlying issue that was contributing to poor health. Second, nearly everyone discussed Planned Parenthood's free STI testing, and the role that played in helping them ensure they maintained a clean status. Third, participants discussed the role their relationship with Planned Parenthood played in helping them manage ongoing concerns.

Identifying other issues. In several instances, participants described Planned Parenthood's role in identifying unrecognized health issues. Through the relationship with the organization, providers were able to better understand symptoms and identify potential causes. Lynn discovered that she had been treating a condition with birth control, but was unaware she had it until her provider identified it for her:

Like when they were like, 'oh we think you have polycystic ovarian syndrome, and we think you've been treating it with hormonal birth control for five years, and now that you're off hormonal birth control we can realize that that is a thing.' And PCOS deals with my weight, which deals with my diabetes.

Lynn also discovered her pregnancy through Planned Parenthood when sought treatment for a yeast infection. She said that her provider, "uncovered my yeast infection, the underlying cause was the fact that I had become pregnant. Right? She was like, 'you, you are pregnant.' And I was terrified. Absolutely hysterical." The emphasis on women's bodies and reproductive health helped Lynn uncover two conditions through her ongoing relationship with the organization.

Margo also realized she had a chronic condition through her standard women's healthcare. She said that early in her relationship with Planned Parenthood she "discovered I had cysts, um, within one of my very first visits there. So, um, even just them having records of it so every time I go back in for pap smears and things they keep track of it." Once her condition was discovered through Planned Parenthood, she continued to trust them to follow it over time.

Similar to Lynn's experience, Janet visited Planned Parenthood when she was concerned about the severity of her menstrual cycle. She felt the concern was urgent, but was hesitant to visit an emergency room. She explained:

I had a miscarriage, um, and I didn't know I was pregnant, so I didn't know what was happening. And, I really, I called my best friend and I was like I don't know what to do or where to go and he told me okay meet me at the one in [an area suburb], we'll go there and we'll try and figure it out. Um, and they, you know, kind of talked me through what was going on and prescribed me what I needed. So I go there for like follow-ups and stuff, and now my body is like back to normal.

Planned Parenthood was able to help Janet uncover her condition, but also provide necessary follow-up care.

Taking up free STI testing. Nearly every participant discussed free STI testing at Planned Parenthood positively. Participants discussed being given the option to test for chlamydia, gonorrhea, and HIV when visiting Planned Parenthood for any appointment. Because it is quick and convenient, and offered at no additional charge, women found it helpful in ensuring that they were clean. For example, Dana discussed only using Planned Parenthood for birth control, but because it is convenient and noninvasive, she said “the option of getting a urine test for like a gonorrhea and chlamydia I believe it is? I do that every year.” Heather discussed the importance of this opportunity, because “I think that it's important to know your status and it's something that doctors should encourage versus to not.”

Several participants discussed the test in matter-of-fact terms. Beth explained, “they also offer, because you're there, STD testing. And usually I say, yeah sure, you know while I'm there and stuff and so I also get those tests while I'm taking my annual exam.” Shonda described the convenience of STI testing during the time spent waiting to see a practitioner:

They would ask, um, would you like to do a, um, STD testing, would you like an AIDS test, would you like a chlamydia, gonorrhea, they would ask that. They would ask do you want a pregnancy test. They would ask, um, like you know when you go back there, I

guess while you're waiting for a room, or while you're waiting to see the doctor would you like any of those testing. It will take 20 minutes or anything like that. They would ask that, and um, while you're waitin' on a room, and I would just take it wherever they ask, they would come back there and ask you while you're waitin' on a room or waitin' on to see a doctor, the would ask would you like that, and I would just say yeah, you know?

Margo emphasized the importance of follow-up care when and where STD/STI testing is offered. She described people who are deterred from testing for fear that they will be referred to a traditional doctor's office should it be positive. She described why she finds this misinformation dangerous, and how she tries to correct it:

If you find yourself with some type of STD there... they have... so much information and just... um... I'm trying to figure out how to word it 'cause it's so unusual. They have the information, they don't have that stigma, um, and basically they do have the ability to prescribe you medicines and things like that. Because I've met people who thought, well you go there and you get tested, but if you find out you have something you have to go to your regular doctor. So that's another bit of misinformation that I wish wasn't still out there. That yes you will get treated fair and you can get prescribed things and they can help you with cost on that. Sometimes they can have medications in office and they can, um, try to help you get access to those and things of that nature. Or even just really low cost, um, or contraceptives. Um, they've always done those at a discounted price there. Um. And usually based on your income it could even be free.

While the organization offers screenings for sexually transmitted infections, Margo argued that it is equally important to provide accessible treatment options.

Managing ongoing concerns. Lastly, participants discussed ongoing conditions that required follow-up care. They described Planned Parenthood as a useful resource managing their care. Lynn described her commitment to Planned Parenthood for follow-up care based on a specific experience:

I had a chronic yeast infection for about a year and a half that kept coming back and I went back to them to retreat it. So I think the first reason why I go back to them is just 'cause I've always gone to them.

Janet described her appreciation and commitment to Planned Parenthood for continued care after her miscarriage. Planned Parenthood was able to provide her with additional resources to manage her psychological and physical health:

They do follow-up calls and she called me a few days later and said you know how are you, what's going on, do you need anything, and they recommend you know different therapists if you need that, so it just felt a lot more personal.

Others needed Planned Parenthood to help manage their standard reproductive healthcare. Amanda highlighted this when she discussed her birth control implant. Planned Parenthood made it accessible to her by providing the service for free. While she said that she would try to manage her pregnancy prevention on her own, Planned Parenthood helped her to be more confident that it was under control:

If it wasn't probably for Planned Parenthood, I—I probably would still you know, try to manage [pregnancy prevention] myself with uh, probably condoms or whatnot. And condoms aren't always a safe bet. So I probably would have spermicide too. And that's just like a lot of... pressure! While you're in the moment. Just like, okay, alright, let me put this together type of thing. Where now you know you can just—you don't have to worry about it. I don't—I... half the time forget that I have it in my arm, so... I like it. Uh. The first month or so it was weird? 'Cause you keep touching it. But after three years, you had two—two to three years. You just get used to it.

Access to more reliable birth control allowed Amanda to eliminate concerns that she would become pregnant, and increased her confidence in her ability to manage her reproductive status.

Summary

Participants reported a variety of reasons for choosing Planned Parenthood as a reproductive healthcare site. Most discussed financial constraints, and explained that Planned Parenthood was among the only organizations available to meet their needs. Additionally, participants reported becoming sexually active as a reason for seeking reproductive care. Word-of-mouth communication from a variety of sources, including parents, siblings, and friends, led participants to the organization as a site that would be able to effectively meet their needs. In

particular, the uniqueness of the female body was a salient for concern, which contributed to women's preference for a women-centric organization. While women discussed reasons for electing Planned Parenthood as a reproductive healthcare organization, some still had to reconcile conflicting religious and political beliefs.

Participants provided several reasons for deciding to develop and sustain a relationship with Planned Parenthood. First, several discussed accessibility, convenience, and affordability, even when moving from one city to another. Along the same lines, participants reported consistent, positive care across different interactions with the organization. Several participants highlighted the organization's commitment to women's needs as fundamental to their positive assessment. Lastly, some participants described Planned Parenthood's inability to meet the needs they found most important and timely.

Once participants decided to develop an ongoing relationship with Planned Parenthood, they described how they experienced and negotiated their healthcare and healthcare relationship. Participants frequently discussed feeling listened to at Planned Parenthood, and contrasted this with more traditional healthcare settings where they were simply treated for their symptoms. This contributed to participants' comfort level with the organization, and a sense that they could share health concerns among a supportive community without feeling judged. Meanwhile, women did express barriers when using Planned Parenthood's services. They often discussed protestors, conflicting ideologies with the organization, long wait times, and an inability for the organization to meet all of their needs.

Lastly, participants discussed Planned Parenthood's contribution to their understanding of women's reproductive health and healthcare. In many cases, participants found themselves becoming greater advocates for women's reproductive health as a result of their ongoing

relationship with the organization. They also developed expertise about their own care, and became more educated about reproductive health in general through the organizational relationship. Several participants discussed Planned Parenthood's contribution to their improved overall health. The next chapter presents the conclusions of this study with a discussion of how understanding women's perspectives as they develop and negotiate the organizational relationship contribute to a larger understanding of nonprofit organizations and their role in meeting client needs.

CHAPTER 4 DISCUSSION AND CONCLUSION

This chapter provides a discussion of the findings provided in the previous chapter, and offers implications from these findings and avenues for future scholarship. First, the main findings are summarized. Next, a discussion of findings for each of the four research questions guiding this study is provided. Third, theoretical implications for stakeholder theory and the culture-centered approach are offered. Fourth, practical implications for nonprofit organizations and women's healthcare access are provided. Finally, limitations of this study and areas for research are discussed. This chapter concludes with an overall conclusion drawn from the study.

Summary of Main Findings

Women require reproductive healthcare. However, access to healthcare is constrained by poverty. Moreover, "The relationships between women's poverty, health insurance coverage, and health status imply that those with the greatest health care needs are least likely to have financial access to care" (Braveman, Oliva, Miller, Schaaf & Reiter, 1988). Women constrained by poverty are further restricted by their limited reproductive healthcare choices. The nonprofit sector has experienced steady growth over recent decades, making up 5.4 percent of the country's gross domestic product in 2013 (McKeever, 2015). This sector fulfills gaps left by the public and private sectors, and functions to meet needs of marginalized groups unable to access resources through traditional outlets. Planned Parenthood is one such nonprofit organization that exists to meet the reproductive healthcare needs of women despite income, race, marital status, nationality, or other marginalizing signifiers.

Nonprofit organizations that work with marginalized clients have the opportunity to empower clients and preserve/highlight their agency. However, the nonprofit sector is often viewed in comparison with the for-profit sector. It can be problematic for nonprofit organizations

to adopt for-profit strategies, particularly because adopting business strategies is often incompatible with the values orientations of nonprofits (Sanders, 2015). A for-profit orientation threatens the extent to which nonprofit organizations effectively empower clients by focusing on earnings and economic viability over social change. In order to assess the extent to which nonprofit organizations recognize and accentuate the agency of clients, it is important to understand the organizational relationship from the client perspective. Clients make the decision to visit the organization, experience and navigate their care, and come to new understandings through the organizational relationship. Nonprofit organizations serve a number of stakeholder groups, including donors, government agencies, staff, volunteers, and clients. Clients are a central stakeholder group to the mission of service-orientated nonprofit organizations. Therefore, the relationship that socioeconomically disadvantaged women have with their reproductive healthcare organization deserves examination and critique.

As such, the aim of this research project was to use qualitative methodology to understand the relationship women have with their reproductive healthcare organization, as well as their decision to visit that specific healthcare site. This chapter answers the research questions posed in chapter one, discusses the implications for nonprofit organizations and women's healthcare, and provides directions for future studies.

Research Question One: What beliefs, understandings, or motivators of health influence women's decision(s) to make initial contact with the organization?

This study was guided by four research questions presented and discussed in chapter one. The first research question sought to identify the unique set of beliefs, understandings, and/or motivators of health that impact women's decisions to approach the nonprofit health organization for care. These influences were revealed through interview conversations and ongoing analysis with women who use Planned Parenthood as their primary women's healthcare organization.

Individuals make health decisions based upon the contexts in which they are embedded and their own internal set of beliefs. However, structural (sociopolitical, socioeconomic, or sociocultural) barriers constrain the resources available to marginalized individuals (Dutta, 2008). Individuals enact their agency when they move toward action, in this case initiating contact with the women's healthcare nonprofit organization. Healthcare consumption is constrained by access, particularly when private health insurance is out of financial reach or dictated by employer options (Mittelstaedt, Duke & Mittelstaedt, 2009). Understanding women's beliefs and influences for making contact with an accessible healthcare organization helps to "illuminate the complexities of communication, revealing manifestations of power and offering alternatives to top-down power structures" Ellingson, 2010, p. 96).

Financial constraints and limited healthcare access directly impacted participants' decisions to visit Planned Parenthood as one of the few options available to meet their healthcare needs. In many cases, women reported that their access to healthcare was constrained by lack of insurance coverage. Because of this, they were unable to access healthcare services through a primary care physician. In other instances, women discussed difficulties being seen by general practitioners while using government-provided insurance due to long waiting lists and a limited number of providers willing to see patients without private insurance. When healthcare options were constrained by financial issues, particularly health insurance, women turned to Planned Parenthood as an organization that would provide services regardless of their financial constraints. Planned Parenthood offered an alternative to traditional healthcare organizations that were inaccessible to low-income and/or uninsured women.

Some participants did possess health insurance through a parent. A desire for privacy regarding their sexual health choices prevented them from using insurance to access reproductive

healthcare at traditional sites. The onset of sexual activity was often a marker for women's decision to visit Planned Parenthood; the organization was identified based on a reputation for helping women stay sexually healthy. Accessibility to adolescents often prompted participants to reach out to the organization to meet immediate reproductive healthcare needs where there were few or no alternatives. Planned Parenthood's stance as a progressive reproductive healthcare organization that would work with low-income and young women prompted participants to choose the organization to help meet their needs. This is reflective of constrained consumption in the healthcare system, identified in previous literature, which may be "imposed by illness, healthcare choices, or health care financing" (e.g., Mittelstaedt, Duke & Mittelstaedt, 2009, p. 97). In addition to the reputation of the organization, word-of-mouth communication about the accessibility of healthcare through Planned Parenthood often contributed to women's entry into the organization.

In addition to constraints on traditional access to women's healthcare, participants held specific beliefs that impacted their decision to visit the organization. Lorber and Moore (2011) discuss the significance of gender identity on women's decisions to seek specific healthcare and procedures. The findings from this study confirm the impact of gender on women's healthcare experiences, and emphasize the importance of gendered space in healthcare interactions. Participants reflected the importance of gendered space when identifying a healthcare organization for women's healthcare. A space devoted to women's needs, with practitioners that specialize in the female body, was frequently identified as a motivator for participants choosing Planned Parenthood. Often, witnessing the role of motherhood in loved ones lives and the impact it had on subsequent lifestyle choices contributed to women's understandings of reproductive control and prevention of pregnancies or infections.

Beliefs about reproductive healthcare frequently complicated women's decisions to use Planned Parenthood's services. Some women discussed grappling with the decision to use the organization, which they saw in direct contrast with their religious or political belief systems. In these instances, women's options for healthcare were constrained by financial means, but the array of services offered through the organization, namely abortions, contributed to tensions about approaching Planned Parenthood for care. Participants reflected on the constrained choices they faced. Once they began using the organization for care, they discussed the positive aspects of their healthcare relationship with the organization and their ability to avoid contentious services freely appears to minimize conflicting beliefs.

In summary, women described a number of beliefs and motivators that impacted their decisions to approach Planned Parenthood for women's healthcare. Constrained choice due to their financial situation and/or privacy concerns and becoming sexual active were frequently identified as primary reasons women approached Planned Parenthood as an organization that could meet their needs. Often, women were directed to Planned Parenthood by friends and family members; this was frequently coupled with the organization's reputation for providing the care they required. Women cited beliefs about the importance of addressing women's healthcare in a space devoted to the female body as a critical motivator for choosing Planned Parenthood. However, certain political and religious beliefs strained women's decisions to confidently choose the organization for care.

Research Question Two: How do women initiate, develop, and sustain relationships with the health organization?

The second research question guiding this inquiry explored how clients of this nonprofit approached the organization, and made decisions to develop and sustain a relationship with that organization. Once women made the decision to initiate contact with the organization, this

question inquired about how they communicatively developed the relationship. Participants described their rationale for deciding on Planned Parenthood as their women's healthcare organization, and influences that contributed to their sustained relationship. They further explained ways of collaboratively developing a relationship with the organization that effectively met their most important needs.

Participants' decisions to develop and sustain a relationship with Planned Parenthood continued to reflect their constrained choice. Women discussed the accessibility of the organization, particularly because it was an affordable place to receive necessary care. Access to a primary care physician was described as a privilege several women did not have, either due to lack of healthcare coverage or because navigating the publicly-funded healthcare system is arduous and inefficient. Several participants also brought up the strain of geographical moves on finding a new primary care provider for continued care. These women discussed the national scope of Planned Parenthood as a reason for continuing to develop a relationship with the organization, providing continuity of care amid significant life changes.

Regarding consistency of care, women discussed positive relationships with a particular provider, but also trust in the array of providers working for the organization. Participants identified consistent care when visiting new clinics, and felt that they were treated fairly and openly for the needs they themselves identified. They also discussed their involvement in making healthcare decisions, citing a sense of empowerment in these conversations. This was often positioned in contrast with negative experiences women had with providers in traditional healthcare settings. Frequently, women discussed feeling like "just another patient" in more traditional healthcare settings, and did not feel that their needs were being addressed directly.

Previous experiences contributed to women's approach to their care at Planned Parenthood. Participants continued to contrast their experience with Planned Parenthood against relationships with traditional healthcare settings. Participants discussed feeling that they could be more open and honest as they developed their relationship with Planned Parenthood, and that the sense of security in their care contributed to their desire to continue to use the organization's services. Rudd (2015) discussed ways in which health literacy inquiries should look at both the literacy skills of patients and the communication skills of providers, taking into consideration policy-related constraints that impact healthcare access. Participants discussed a sense that providers at Planned Parenthood communicated clearly and openly with patients. Participants appreciated Planned Parenthood practitioners who would describe procedures and processes while they were taking place, again in contrast with traditional healthcare settings. Moreover, Planned Parenthood helped some of these women navigate financial barriers by providing information about existing government initiatives that help cover costs of reproductive healthcare services for low-income patients. Participants indicated that Planned Parenthood was, indeed, considerate of the policy constraints that prevented women from using traditional healthcare outlets for care, and in fact assisted women with access to additional resources. This is also consistent with the role nonprofit organization's play in fulfilling needs not easily met through the government and for-profit sectors.

As the women-centeredness of Planned Parenthood provoked some women to initiate contact with the organization, others discussed the impact of gendered space on their organizational relationship development. Participants noted a sense of security knowing that providers at Planned Parenthood focused specifically on the female body. They identified comfort being treated for women's healthcare issues by women providers who experienced

similar healthcare concerns. They also recognized the biological differences between the female and male body, and the impact of reproductive healthcare differences on women's health—for example, the role of pregnancy exacerbating autoimmune disease in some instances and improving it in others (Bird & Rieker, 2008). Some participants noted medical research that standardized the male body, assuming generalizability to the female body. The centrality of the female body to the organization, and conversations with practitioners about what makes it unique, contributed to participants' continued relationship-building with Planned Parenthood.

Nonprofit organizations that work toward social missions and address structural inequalities also take on a very public, political role. Planned Parenthood's mission asserts, "to provide comprehensive reproductive and complementary health care services" despite income, race, marital status, sexual orientation, or age, and prompts advocacy within the public sphere (Planned Parenthood, 2016). Participants frequently noted threats to the organization's funding and/or ability to provide services, specifically abortions. This often provoked a sense of political activism. The government sector directly impacts nonprofit behavior through funding and regulations (Smith, 2003). As participants developed a relationship with the organization, they perceived greater stake in the organization, and a desire to continue to use the organization's services in solidarity with its mission.

In summary, participants described a series of evaluative steps they undertook as they exercised their agency and developed relationships with Planned Parenthood. While the accessibility of the organization was an important factor in the decision to initiate and sustain a relationship, discussions of the quality of care, woman-centeredness, and ability to freely discuss private healthcare matters were highlighted across interviews. These latter factors were positioned as more important in sustaining the relationship.

Research Question Three: How do women experience and negotiate the organizational relationships?

The third research question guiding this investigation explored ways in which clients of the nonprofit communicatively navigated their relationship with the organization. Specifically, how women experienced their interactions with healthcare providers contributed to their ability to express agency in healthcare interactions. While much of the interpersonal communication women experienced was positive, the political nature of the organization and political discourse surrounding women's reproductive healthcare options (e.g., access to contraceptives and abortion services) posed barriers. Women mitigated these through their own belief systems or through counter-balance with positive aspects they identified in the organization.

Nonprofit organizations work with a number of stakeholder groups to accomplish their goals. Among these are clients, staff, and volunteers. These stakeholder groups often work collaboratively toward the mission of the nonprofit; however, they experience the organization and their relationship with it very differently, with a unique set of specific social goals (Knox & Gruar, 2007). In particular, human service organizations that cater to marginalized clients may (or may not) work to empower clients, while clients may exercise resistance within these organizations to define their own needs and exercise agency (Trethewey, 1997). Participants described experiencing the organizational relationship differently in comparison to previous healthcare interactions in more traditional medical settings, demonstrating a sense of empowerment through their use of the alternative healthcare organization. They expressed feeling like they were in control of decisions about their healthcare, and a freedom to openly ask questions about their care. Additionally, participants referred to their provider interactions positively, saying that they would receive more thorough explanations of procedures and answers to questions they posed without feeling ashamed for asking. Participants expressed their

stake in Planned Parenthood differently than other healthcare organizations. Increased openness in communication interactions with Planned Parenthood benefited their understandings of their own women's health and healthcare, and is consistent with the organization's mission to provide education alongside access to care. Participants identified stronger communication skills from their Planned Parenthood providers than they had received in more traditional medical settings, where they felt their role was to answer intake questions and receive a single solution from their "expert" provider. Participants described being the expert in their own body, and the need for open communication about healthcare concerns.

Participants expressed an overall sense of comfort in their experience navigating and negotiating women's healthcare with Planned Parenthood. They discussed making healthcare decisions collaboratively, and an ability to be more honest with providers at the nonprofit organization than in traditional medical centers. A feminist interpretation of stakeholder theory argues that "persons are inextricably embedded in context" and that "persons are fundamentally connected with each other in a web of relationships" (Wicks, Gilbert & Freeman, 1994, p. 483). This context impacts how clients of the nonprofit organization experience and negotiate their healthcare experience. Women participants in this study indicated that they may reach out to a nonprofit healthcare organization to receive services they cannot access elsewhere. They are embedded in their socioeconomic limitations and individual healthcare beliefs. As they navigate the organization, women experienced empowering communication with staff members and other clients. They described collaboration and a feeling that their humanness was central to the care they received. Several women compared their Planned Parenthood experience to previous medical encounters where they felt judged; at Planned Parenthood, they described being able to bring their concerns and questions openly without fearing judgment.

Participants also defined Planned Parenthood as a community. They described the space devoted to women and their healthcare as a positively gendered environment that fostered community across patients and providers, but also among the clientele. Women described ways in which genders are socialized differently, emphasizing the impact of community on their healthcare experience. Lorber and Moore (2011) argue, “Women’s bodies are controlled by institutions dominated by men, namely, medicine and religion, but body knowledge gives women increased autonomy” (p. 218). By developing relationships within the healthcare organization, “it is possible for the marginalized...to forge communities that give their bodies value” (p. 218). Women described conversations with employees and other clients of the nonprofit that fostered community within the space.

While participants described a number of positive aspects of Planned Parenthood, which allowed them to experience the organizational relationship positively, they simultaneously encountered threats to the quality of their care, and constructed their own means of working around barriers. The presence of protestors at clinic sites negatively impacted participants’ experiences accessing care. While some avoided appointments when protestors were present, others described discomfort that triggered stubbornness, leading them to cross protestors and enter the clinic. A sense of connection to the organization led women to show continued support even amid a contentious political climate.

Organizations like Planned Parenthood rely on government funding to operate. Participants were aware of threats to Planned Parenthood’s federal funding, and took this into consideration when navigating barriers. Participants discussed long wait times to receive care, either when setting an appointment or waiting to be seen upon arriving at the office. Similarly, some women voiced frustration in not being able to have other health issues addressed by the

organization. They described a preference for the relationship they had developed with Planned Parenthood over finding an alternative primary care physician. Participants referred to Planned Parenthood as underfunded and understaffed when they discussed these barriers. Sympathizing with these organizational strains led these women to continue, and often increase, their support of Planned Parenthood.

Just as participants described conflicting ideologies that complicated their decision to initiate care with Planned Parenthood, this affected how they experienced the organizational relationship. In particular, women discussed the 2015 controversy ignited by the anti-abortion organization, the Center for Medical Progress. The story claimed that Planned Parenthood was selling fetal body parts, and quickly went viral. Several participants discussed the impact this coverage had on their feelings about using Planned Parenthood's services. Though the individuals responsible for the controversy have since been indicted, with no wrongdoing on the part of Planned Parenthood, the coverage surrounding the case was substantial enough to impact users' perceptions of the organization. However, several participants explained ways of negotiating the conflicting ideologies, differentiating between the practitioners at their own clinic and Planned Parenthood executives, or writing it off as a public relations crisis that would soon be forgotten. The positive experiences participants had with Planned Parenthood outweighed the negative publicity the organization received; this positive relationship history led women to move beyond the negative coverage swiftly.

Some participants discussed a paternalistic air in their visits to Planned Parenthood, in some ways harkening back to the ideological shift of the early 1940s. As the organization shifted its focus from women's liberation to family planning, female employees with long tenure at the American Birth Control League were displeased with the shift toward masculine leadership.

Though most participants discussed Planned Parenthood positively, particularly in contrast with traditional healthcare settings, the paternalism identified by some suggests the organization struggles to effectively work with women toward empowerment. As employees advocated for reproductive healthcare and preventative procedures, one woman in particular felt that her desires were not being adequately considered. However, she described Planned Parenthood as a barrier she was able to cross efficiently enough in order to get the birth control contraceptives she required without undergoing a pelvic exam, which would have been required elsewhere. She discussed her constrained options, and though she felt patronized when practitioners and employees encouraged her to have the exam, Planned Parenthood was able to give her what she needed in a way that other healthcare sites would not. She recognized that in order to access contraceptives, she would need to find a practitioner willing to prescribe her preferred method. She argued that the politicized nature of women's health made it unnecessarily difficult to access contraception, and that the organization ultimately served as a barrier she had to cross in order to have her needs met. She argued that birth control should be accessible without a prescription, but because that is not the reality in the United States, she preferred Planned Parenthood in spite of the recurring pelvic exam conversation because other healthcare sites would require what she feels is an invasive procedure.

Nonprofit organizations run the risk of reinforcing dominate ways of understanding health, and preventing marginalized groups from voicing their own concerns and understandings (Dempsey, 2009). The insistence that women receive regular pelvic exams is indicative of a tendency to minimize localized knowledge or deeply held health beliefs. When nonprofit organizations silence those they serve by emphasizing expert knowledge over lived experience and internal beliefs, they limit the extent to which marginalized groups are able to contribute to

shared knowledge-building and understandings of health and healthcare. Another participant identified feeling frustrated when presented with alternative, more reliable forms of birth control when her current method had failed. Though she did not experience the paternalism the first woman described, she felt that the information was unnecessary at the time given the immediate circumstances she faced. She discussed understanding the importance of the conversation, though, because not everyone has had comprehensive sexual health education. She recognized differences in health literacy across users of the organization, and the need for someone to provide that information to women who lacked sufficient education. Still, she felt that the conversation was inappropriately timed given her more pressing reproductive healthcare concerns.

In summary, participants described the importance of comfort and agency in positively experiencing the organization. They found the interactions to be safe spaces to ask questions and gain knowledge on their own health and healthcare, and felt it was less judgmental than traditional healthcare settings. Women also identified a sense of community among users and employees of the organization. However, women did experience barriers to their care as they navigated the organizational relationship, including protestors, long wait times, restricted services, and a sense of paternalism.

Research Question Four: How do the needs of individual women and the nature of their relationship with the organization contribute to understandings of women's health and healthcare?

The final research question guiding this exploration inquired about the nature of the client-organization relationship, and the extent to which the organization contributed to women's understandings of their health and healthcare. Participants discussed ways in which their interactions with the organization and their providers contributed to expanded knowledge about

personal healthcare. They further described a tendency to exercise increased advocacy toward the organization and women's healthcare overall.

Participants expressed a number of ways their ongoing relationship with the organization positively impacted understandings of women's health and healthcare. The findings from this study confirm and illustrate the argument that health literacy is dependent upon both the literacy skills of patients and the communication skills of providers (Rudd, 2015). Participants expressed an increased sense of agency through the care they received from practitioners at Planned Parenthood. Through communication with providers, women identified health literacy conversations that helped them to better care for persistent reproductive health concerns. Participants also described educational opportunities in their interactions with the organization, which filled holes in their sexual health knowledge and background. Through flyers, experiences, and conversations, participants described interactions that redirected their held beliefs about caring for the female body safely (e.g., avoiding scented soaps and changing diet to alleviate chronic yeast infections). Participants often identified barriers to their reproductive health education (e.g., limited funding for public school health education; abstinence-only sexual health education) that left them with an inadequate understanding of women's healthcare. They identified ways the organization helped them become better educated about their own healthcare and take ownership of their health decisions.

Through their relationship with the organization, participants also identified instances in which Planned Parenthood was able to identify and address health concerns that had not yet become apparent. Developing an ongoing relationship with women's health specialists resulted in some participants identifying health concerns that impacted their overall health, but that they had not yet perceived as issues in their own health status. For example, one woman discussed

using hormonal birth control since she was an adolescent. She learned that she had polycystic ovarian syndrome (PCOS) after stopping her contraceptive use for a period of time. Through healthcare interactions, providers were able to identify signs of PCOS, understand her reproductive healthcare history, diagnose the disorder, and help her make choices to treat symptoms.

Planned Parenthood also offers STI testing at appointments, which most participants found convenient. Participants described these tests as a way to ensure that their sexual health status was what they believed it to be. One woman described the importance of accessible follow-up care when an organization does offer this resource. She discussed the availability of follow-up care through Planned Parenthood, which was important for individuals being tested for STIs. She suggested that a lack of affordable and accessible follow-up care can deter some individuals from screening for infections, believing that if they test positive for something, they will have to find their own follow-up care through another doctor's office. When healthcare options are constrained, it becomes increasingly important for the organization to be able to continue to see the individual under such circumstances.

Through their experience navigating women's healthcare with Planned Parenthood, participants also discussed becoming more politically active. Planned Parenthood's role as a political entity became increasingly salient as participants became more aware of the limited resources available to the organization alongside the heated political climate surrounding reproductive healthcare. As participants encountered protesters, they became more invested stakeholders in the organization, and increased their advocacy either to friends and family or in more public support of the organization. Participants pitted themselves against protestors, and worked with the organization toward its continued success. In ways not sanctioned by the

organization, participants worked to politicize their needs and the needs of other women by speaking or acting publicly.

As participants expressed increased activism, they also expressed increased feminism. As participants faced more difficult reproductive healthcare decisions, they described pivotal moments that increased their realization that women's healthcare is highly politicized. These realizations contributed to women's increased involvement in feminist activism, as they came to understand it as a more salient need. Knox & Gruar (2007) argue that stakeholders of nonprofit organizations hold greater organizational importance than stakeholders of private enterprises specifically because they are mobilized around social goals. These findings suggest that stakeholders of nonprofit organizations do have significant stake not only in the success of the organization but in the greater social discourse and activism in which the organization participates. This is experienced by the organization as well as clients. Participants described not necessarily being a part of the Planned Parenthood organization; however, through their use and support, they identified their role as an important extension of the nonprofit and their power to advocate on the organization's behalf.

In summary, participants described several ways in which their relationship with the organization impacted their understandings of women's health and healthcare. Through continued care, participants developed greater expertise in their own bodies. They also identified ways in which Planned Parenthood was able to identify and/or address healthcare needs that had not been recognized previously. Finally, participants discussed ways in which the politicized nature of the organization and their care contributed to their own activism in support of women's reproductive choice and Planned Parenthood's work toward preserving that right.

This study has explored and described the experience women have approaching their nonprofit reproductive healthcare organization, developing and sustaining that relationship, negotiating their care, and the role of the organizational relationship in contributing to their reproductive health/care understandings. The next section discusses the implications of these findings for stakeholder theory and the culture-centered approach.

Theoretical Implications for Stakeholder Theory and the Culture-Centered Approach

Two theoretical frameworks guided the conceptualization of this research project: stakeholder theory and the culture-centered approach. Stakeholder theory, although developed to understand for-profit organizations, provides a starting point for understanding the nonprofit organization. This theory emphasizes the multiple stakeholder groups involved in and affected by the organization. By centering on clients as the primary and defining stakeholder group, the following implications demonstrate how this study extends stakeholder theory's application to this segment of the nonprofit organization. These implications demonstrate the uniqueness of stakeholder relationships in mission-driven nonprofit organizations in contrast with for-profit organizations, specifically those organizations that serve clients who cannot access services elsewhere and which are persecuted for their mission itself. Next, the culture-centered approach, a social change approach to health campaigns, was applied to nonprofit organizations, which are uniquely driven by social missions. This approach was developed in critique of the top-down logics of health campaigns. The implications offered below illustrate how it was extended to understand the expert-driven nature of service-orientated nonprofit organizations and investigate ways in which these organizations can better empower their clients.

Stakeholder Theory

A stakeholder theory application to service-oriented nonprofit organizations should consider the complex role of clients in affecting the organization's success. Findings illustrate that mission-driven nonprofit organizations have different relationships with stakeholders than do for-profit organizations. Research on nonprofit organizations often emphasizes the internal aspects of the organization (leadership, staff, volunteers). However, service-oriented nonprofit organizations are dependent on their clients in order to affect positive social change. The client perspective is integral to understanding the effectiveness of the organization, as well as the complicated nature of stakeholder relations. Findings also show that service organizations that serve clients who cannot access services elsewhere have unique stakeholder relationships. Moreover, these findings demonstrate that organizations that face persecution for their mission have a unique relationship with the clients they serve.

Mission-driven nonprofits have a different relationship with stakeholders than do for-profit organizations. Nonprofit organizations differ from their for-profit counterparts in some fundamental ways: (1) their value rests in the achievement of social purposes rather than financial revenues, and (2) they receive financial revenue outside of customer purchases, from sources including government and private grants and private donors (Moore, 2000). In fact, for-profit practices can be problematic in nonprofit organizations specifically because of the incompatible values orientations. The mission statement of the nonprofit is vital to these organizations, providing a means of publicly defining their identity and purpose. Alternatively, in for-profit organizations, the mission statement allows the organization to develop an "ego ideal" by which the organization can measure itself and strive for perfection (Fairhurst, Jordan & Neuwirth, 1997, p. 243). It is the values orientation of the nonprofit organization that makes the

mission statement important as means of communicating its purpose for being to the public, helping the organization secure necessary funds and define itself as an organization that provides social value.

Stakeholder theory was conceptualized within organizational studies for the purposes of making capitalist enterprises more effective. The complex conceptualization of the organization and the many stakeholders involved is useful for nonprofit organizations. However, mission-driven nonprofit organizations have a different relationship with stakeholder groups than do for-profit organizations. Stakeholder theory positions owners, employees, suppliers, and clients as internal stakeholder groups (Freeman, 2010). This study offered insights from clients of the nonprofit organization regarding what the organization did well to meet client needs (and execute its social mission) and where the organization struggles. Engaging clients as primary stakeholders is central to uncovering these concerns.

This study demonstrates clients' ability to assess the nonprofit organization's effectiveness in meeting their social mission. Client assessment of Planned Parenthood, in fact, often positioned the nonprofit organization in contrast with traditional healthcare sites, emphasizing the difference between the two types of organizations and highlighting the mission of Planned Parenthood. To briefly summarize the Planned Parenthood mission statement, they exist to provide "comprehensive reproductive and complementary health care services" to all women and men, emphasizing self-determination and privacy, recognizing ownership of one's fertility as a fundamental right (Planned Parenthood, 2016). Also encompassed in this mission statement are commitments to advocacy for public policy that will continue and preserve these rights and access to services, education, and promotion of research in reproductive health. When comparing their experiences with Planned Parenthood in contrast to traditional healthcare

settings, participants highlighted ways in which Planned Parenthood gave them space to express their concerns free of judgment, as well as the sense of community they experienced in “women’s space.” These experiences were contrasted with reports of feeling like “just another patient in the day” in traditional settings where women “just answer questions” and do not have discussions with their providers about their healthcare decisions. These examples illustrate ways in which Planned Parenthood embodies their organizational mission statement.

However, women also expressed concerns with their Planned Parenthood experience. For example, participants discussed a perceived lack of privacy when seeking services due to the structural design of the space. One woman discussed hearing providers in a room next door with a patient, and said that she would be very uncomfortable receiving sensitive health information under those circumstances. Participants also discussed instances in which they were unable to receive the reproductive healthcare services they desired (e.g., permanent birth control; abortion services) and being referred to other organizations. These examples illustrate ways in which the organization was unable to execute their mission to provide privacy and comprehensive reproductive care. Of course, Planned Parenthood is a national organization, and the physical environment and services offered across clinics vary. As a primary stakeholder group, clients are able to assess the effectiveness of the organization in meeting its social mission. Whereas organizational leadership and staff understand the mission of the organization and strive to effectively embody it within the organization, clients of nonprofits experience the organization as it is intended for users, and provide an important perspective in assessing its value.

Whereas for-profit organizations often provide services to clients, they differ from mission-driven nonprofit organizations that reach out to marginalized populations to provide access to services that is otherwise constrained. Therefore, while for-profit organizations manage

multiple stakeholder relationships (e.g., with owners, employees, suppliers, and customers), their mission orientation is toward increased revenue. Alternatively, mission-driven nonprofits balance a unique set of stakeholder relationships (e.g., with clients, employees, private donors, government agencies, and a board of directors). The interests of these stakeholder groups are not necessarily compatible, thus complicating the nonprofit's ability to successfully execute its social mission. Nonprofit organizations are dependent upon government funds, private donations, and committed employees to develop the necessary infrastructure to operate. Yet, Young (2002) argues that it is clients who "come closest to personifying the mission" of nonprofit organizations (p. 4). Therefore, as nonprofit organizations balance the multiple stakeholder groups impacting their work, clients represent a fundamental stakeholder group that is most directly associated with and affected by the organization's mission.

A service organization that serves clients whose options are constrained has unique stakeholder relationships. Service-oriented nonprofit organizations often serve clients whose access to resources is heavily constrained. Consumption may be constrained through legal, cultural, personal, or systemic barriers, and may be real or perceived (Mittelstaedt, Duke, & Mittelstaedt, 2009). Within the healthcare system, consumption is often constrained by access to care, a direct effect of limited health insurance options. For service organizations that serve clients with constrained access, stakeholder relationships must be reflective of the many potential barriers to care.

Stakeholder theory suggests that organizations can be more successful when they create value for the multiple stakeholder groups that affect and/or are affected by the organization. A stakeholder understanding of the organization posits that employees, special interest groups, environmentalists, suppliers, governments, local community organizations, owners, consumer

advocates, customers, competitors, and media are all stakeholders of the organization (Freeman, 2010). Herman and Renz (2008) argue that organizational effectiveness in nonprofit organizations is multidimensional, and that measuring effectiveness based upon a single criterion is a poor approach to assessment. Moreover, “The viability of nonprofit organizations hinges on organizational credibility and on successfully engaging with a wide array of constituencies, including contributors, volunteers, staff members, the population being served, the media, and the public at large” (Sisco, Pressgrove, & Collins, 2013, p. 282). Nonprofit organizations “are dependent on markets to sell services; on donors to provide gifts and grants; and on government for contract revenues, tax benefits, and legal oversight” (Young, 2002, p. 4). These organizations are also responsible to those they serve, but those interests are not necessarily in line with the entities that fund or govern the nonprofit.

A number of stakeholder groups have the ability to shift allegiances and/or withhold resources from the nonprofit organization (e.g., donors or government agencies) if the organization is not meeting expectations. Clients, too, have the ability to change allegiances to another organization, cease to receive services at all, or consume from multiple organizations at the same time if available (e.g., using Planned Parenthood and a community health clinic based upon availability to meet immediate needs). It stands to reason that organizations, particularly service-oriented nonprofits, should remain particularly attentive to clients. Clients are imperative in order for the organization to successfully execute its mission; it is clients who “come closest to personifying the mission” (Young, 2002, p. 4). While clients of this type of organization face constrained choices, they still have the agency to decide whether or not to continue a relationship with the organization.

Because nonprofits must be attentive to the parties that fund or govern the organization, service-oriented nonprofit organizations must work to stay attuned to the extent to which they meet the needs of their clients. For example, Trethewey (1997) demonstrated ways in which marginalized clients challenge dominant organizational discourses in human service organizations. She described clients' abilities to resist dominant discourses by picking and choosing services to challenge bureaucratic definitions of their needs and speaking publicly to communicate resistance when the organization did not incorporate their perspectives in defining needs and solutions. Moreover, nongovernmental entities often speak and advocate on behalf of marginalized groups, without drawing upon the localized knowledge and experiences by incorporating them in the program development and assessment processes (Dempsey, 2009). This study highlighted nonprofit clients as a primary stakeholder group, and positioned client feedback as a preferred means of evaluating the success of the organization, rather than simply conducting evaluative measures internally.

The findings of this study illustrate women's ability to access reproductive healthcare services more easily through Planned Parenthood when other options were out of financial reach (or in the case of abortions, unavailable through most traditional settings). Women also reported learning more about their reproductive health through interactions with the organization, either through conversations with providers or literature provided in the office and on the organization's website. This contrast with traditional settings is important to understanding stakeholder relationships within service-oriented nonprofit organizations that specifically serve clients with constrained options. Whereas clients of public or private service orientations may "shop around" for a preferable experience, nonprofits work with clients who have few (if any) alternatives within reach. It is important that service-oriented nonprofit organizations recognize

the needs and agency of their clients, despite the limited options these individuals have. It is this stakeholder group that depends on the services the organization offers, and which has the power to turn away from the organization if their needs are not being met satisfactorily. Clients should be considered central to these organizations, not only in executing the mission, but also in evaluating the organization internally.

A feminist interpretation of stakeholder theory “suggests that persons are inextricably embedded in context” and that this impacts the relationships individuals develop across stakeholders (Wicks, Gilbert, & Freeman, 1994, p. 483). This lens is helpful in understanding the unique relationships service-oriented nonprofit organizations have with stakeholders. The findings of this study reveal the need for organizations to more fully incorporate the lived experience of clients to better understand how to effectively meet their needs. For example, participants discussed conversations with providers about healthcare options that neglected the understandings of women (e.g., abstaining from the pelvic exam). These examples were colored by previous negative healthcare interactions (often at other healthcare sites) or an immediate need to address a reproductive concern (e.g., terminate a pregnancy) and focusing on that concern and the relationship implications surrounding it rather than a new conversation about alternative birth control options. While women revealed a number of ways the organization was effective in contrast to traditional healthcare sites (e.g., collaboratively discussing options; abstaining from judgment; expertise in the female body), barriers to quality care remained. More thoroughly positioning program evaluation within the context of clients as primary stakeholders can allow nonprofit organizations to better execute their social missions.

A feminist approach to stakeholder theory argues for more meaningful involvement across stakeholder groups, wherein value is created for the entire network of stakeholders “by

working to develop effective forms of cooperation, decentralizing power and authority, and building consensus among stakeholders through communication to generate strategic direction” (p. 493). This study highlighted how open communication and information sharing can empower clients of the nonprofit healthcare organization. This was identified in contrast with examples from traditional top-down medical practices. Women also identified collaborative decision making with employees of the organization, and involvement in their own healthcare decisions.

Due to the social commitment of nonprofits, these organizations are positioned to serve the public in a way that private enterprises are not. Therefore, using a traditional stakeholder approach to service-oriented nonprofit organizations is helpful in understanding the multitude of stakeholders that impact the organization, but less so in understanding the social success of the organization. The feminist stakeholder lens provides a space for the voices of marginalized groups served by the organization to contribute their knowledge to the explication of the organization’s values and mission. Highlighting the context, experience, and relationships across stakeholders, with client voice central, more meaningfully uncovers the effectiveness of nonprofit organizations.

Organizations that are persecuted for their mission have a different relationship with clients. Nonprofit organizations work toward social missions while simultaneously advocating for causes within the political sphere. These organizations advocate for policy that positively impacts the access their clients have to necessary resources. Moreover, nonprofit organizations often depend on government funding to support their mission and to carry out their work, making their work highly public. The public nature of nonprofit organizations means that, oftentimes, they will be persecuted for their mission. This persecution has a unique effect on the relationship nonprofit organizations have with their stakeholders.

Whereas for-profit organizations are also embedded in a web of stakeholder relationships, nonprofit organizations are consistently subjected to critique from the broader public, particularly when the mission of the organization is contentious. Planned Parenthood exemplifies a nonprofit organization that is consistently persecuted for its mission to make family planning options accessible to women regardless of income, race, marital status, religion, or age. One family planning resource Planned Parenthood is committed to preserving is access to abortion services. A 2016 Gallup Poll reported that 47 percent of the US population identifies as pro-choice, while 46 percent identifies as pro-life. Moreover, 29 percent of individuals polled felt that abortion should be legal under any circumstances, 50 percent felt it should be legal only under certain circumstances, and 19 percent felt abortion should be illegal in all circumstances (Gallup, 2016). These numbers reflect the contentious political atmosphere that surrounds abortion services, and inherently affects Planned Parenthood as the most notable abortion provider nationwide.

Nonprofit organizations that face persecution for their mission have unique relationships with their stakeholders. First, these organizations depend on public funds to conduct their work. While Planned Parenthood is restricted from using public funds to provide abortion services, ideological protest of the organization's mission impacts the amount of time Planned Parenthood executives must spend rearticulating the organization's mission and continuing to advocate to sustain the right to terminate a pregnancy. Moreover, religious contentions often pit Planned Parenthood against the Catholic community on the basis of birth control in general. It is important to note, however, that several participants in this study described religious parents who supported access to birth control, despite conflict with religious doctrine, on the basis of preventing additional abortions. While these organizations worked to preserve rights for their clients, those who most directly embody the mission of the organization (Young, 2002), they

must balance their public image and numerous other stakeholder groups in order to increase public support, defend their image, and preserve/increase funding.

A feminist stakeholder perspective provides a structure for understanding client perspectives as central to the nonprofit organization's value-centered work. Wicks, Gilbert & Freeman (1994) argued that a feminist stakeholder inquiry would be grounded in "The rich tapestry of experience, language, and impression to construct a picture of both problems and solutions that is complex and reflects the variety of perceptions of the stakeholders involved" (p. 489). This study highlighted the role of clients of the nonprofit organization, and presented a rich understanding of their experiences navigating the organization. This process uncovered a complicated relationship—one in which women were largely pleased by the nonprofit organization's ability to meet needs they were unable to address through other outlets, while also facing a number of barriers to their desired care. Though the nonprofit organization offered a point of access to women with limited healthcare options, organizational structures (e.g., limited services offered; strained resources) and external forces (e.g., conflicting ideologies; negative news coverage) posed threats to the quality of care received. It was, ultimately, other stakeholders of the same organization posing these threats to clients.

This study demonstrated clients' abilities to identify the barriers they encounter in their efforts to use nonprofit services. In this study, clients identified external threats (e.g., protestors; political pundits) that impacted their decisions to use the organization's services. They also identified internal threats (e.g., long wait times to be seen; paternalism from providers). While employees and management of the organization may conceptualize some of these threats internally, the extent to which they impact client experience and continued commitment to the organization is best understood from clients themselves. Clients, in fact, identified other

stakeholder groups (e.g., special interest groups) as threats to their own continued use of the organization.

Knox and Gruar (2007) argue that stakeholders of nonprofit organizations may have greater importance than stakeholders of private enterprises because they work to achieve social goals, rather than simply increase capital gains. The multiple stakeholders of an organization are woven together in a web of relations that, taken together, affect the success of the organization. Nonprofit organizations, which are dependent on donor support and government funding, often experience strained relationships across stakeholder groups. Internally, nonprofit organizations manage the interests of a number of stakeholder groups, and are likely to miss important details of the client experience without directly involving this group in assessing organizational achievements, as women in this study indicated was the case for Planned Parenthood. This is particularly salient for organizations that are persecuted for their mission and the very services they provide.

Culture-Centered Approach

The second theoretical framework used to conceptualize this study was the culture-centered approach. The culture-centered approach offers, “an alternative entry point for theorizing and practicing health communication by highlighting the absences and/or silences in current health communication theory and practice, and by presenting voices of the marginalized sectors through engagement in dialogue,” (Dutta, 2007, p. 310). This approach was developed in contrast with traditional, top-down health campaigns, which are ignorant to sociocultural and socioeconomic contexts that situate health experiences. This study employed the culture-centered approach as a means of interrogating the health-based nonprofit organization. Specifically, this study extended applications of the culture-centered approach to service-oriented nonprofit

organizations as drivers of social change, and as a means of highlighting the centrality of clients in defining nonprofit organization's social change trajectories.

Recognizing culture, structure, and agency among clients of service-oriented nonprofit organizations. This study applied the culture-centered approach not as a direct intervention, but as a critique of a nonprofit organization providing reproductive healthcare services to marginalized women. The three main concepts that ground the culture-centered approach—culture, structure, and agency—are useful in examining the extent to which these service-oriented nonprofit organizations engage and respond directly to the needs of clients. For example, culture, is “the living framework of individuals and their collectives” through which knowledge is produced and within which individuals and social groups operate, and “emerges as the strongest determinant of life that shapes knowledge creation, sharing of meanings, and behavior changes” (Dutta & Basu, 2008, p. 561). The cultural understandings that foreground women's beliefs about their reproductive healthcare are fundamental to the type of care they seek.

The findings from this study illustrate the ways in which cultural affiliations drive reproductive healthcare. For example, one woman discussed being a part of the polyamory community, and the need to ensure that she and all of her partners regularly receive STI testing. She discussed Planned Parenthood as the preferred site for testing because of its convenience as well as the lack of judgment shed on her sexual lifestyle, which is seen as deviant among normative sexual practices. Similarly, another participant discussed her unsatisfactory experience with traditional healthcare when she sought information about safe same-sex practices. Recognizing the romantic and/or sexual cultures of these women was necessary to provide adequate care. In both of these instances, the organization was able to respond to their lifestyle

needs and provide the resources and healthcare each woman desired. However, as the second example illustrated, when providers are unable or unwilling to recognize the cultural practices that differ from their own individual understandings of sexual health, they are unable to provide adequate care and often push patients away from the organization and the healthcare they require.

The second tenet of the culture-centered approach is structure, which refers to the institutional restraints that limit or constrain the resources available in marginalized spaces. These can be thought of as sociopolitical, socioeconomic, or sociocultural barriers to desired health and healthcare. Moreover, social change and behavior change are intertwined. This is important to nonprofit organizations that work to execute their mission both by providing services not available through traditional outlets and by engaging in the larger political dialogue to challenge a status quo that prevents access to services for some portion of the population. Dutta (2014) argues that “culturally centering social change also suggests that the impetus of the change is on engaging with the broader structures of silencing and oppression” (p. 70). This study demonstrates socioeconomic barriers that affected a majority of participants’ access to reproductive healthcare. Lack of insurance or underinsurance constrained women’s access to care, proving a need for an organization like Planned Parenthood to provide reproductive healthcare for a reduced cost.

Moreover, participants regularly discussed the political rhetoric that surrounds Planned Parenthood, specifically with regard to access to abortion services. These sociopolitical barriers to health make it necessary for an organization like Planned Parenthood to exist. The organization must be able to engage in dialogue and listen to the needs of marginalized groups in order to adequately gauge need. In two separate instances, women discussed conversations

with Planned Parenthood employees that helped them access financial support for their care that they otherwise were not aware of. Listening to client needs and understanding these financial restraints, while also engaging beyond the organization in the political discourse around access to healthcare allowed employees to have the knowledge of alternative programs to share with women.

These structures also impact the extent to which marginalized individuals are able to exert their agency. Agency “works through the mobilizing of cultural resources working in relation with structures to voice meanings from the margins” (Dutta, 2014, p. 72). By listening to marginalized individuals about the experiences that contribute to their health, the enactment of their agency is able to arise and provide directions for social change by interrogating those dominant structures. The findings from this study demonstrate how some participants enacted their agency by using Planned Parenthood as an alternative to traditional healthcare organizations that served more as obstacles than resources to their care. For example, one participant discussed preferring Planned Parenthood even though she had insurance and a family practice physician because health interactions in a traditional setting had made her feel further marginalized for her needs. Though she initially felt confident approaching her care provider with specific questions, she was met with little understanding about her unique healthcare needs, and felt that she was doing something wrong. Switching to Planned Parenthood allowed her to express her needs and discuss her sexual practices more openly, so that she could effectively navigate her reproductive healthcare options.

Another participant painted a different picture of her interactions with Planned Parenthood, explaining that she knew exactly what she needed and that Planned Parenthood was the only organization that would provide birth control without a pelvic exam. Still, she felt that

she was being marginalized in her conversations with Planned Parenthood providers who she felt were to adamant about her need to have the screening. In this way, Planned Parenthood could have served as a barrier to her access to birth control if she were not confident enough to push back and firmly request only what she desired. Service oriented nonprofit organizations must remain attuned to their own actions that stifle the agency of marginalized clients.

In much the same way that health interventions can be more effective by adopting a culture-centered approach, service-oriented healthcare nonprofits can be more responsive to the needs of those individuals who exemplify their mission by recognizing that health is grounded in culture, structure, and agency. As organizations that work toward positive social change for underrepresented groups, it is imperative that these nonprofits not further contribute to this marginalization. This study highlights some ways these organizations can more effectively engage in their work and meet client needs.

Moreover, this study demonstrates the value of the culture-centered approach in providing a framework for qualitative iterative research. Through in-depth interviews, this study highlighted ways in which participants negotiated reproductive healthcare decisions based upon cultural and familiar beliefs. They also discussed their healthcare constraints and the socioeconomic and sociopolitical barriers they faced when having reproductive healthcare needs addressed. Women frequently discussed ways in which the organization contributed to their sense of agency in navigating their personal healthcare in a way they felt was more restrained at other healthcare sites. These findings help to illuminate the role of the nonprofit organization in women's healthcare experiences, demonstrating the value of the culture-centered approach as an appropriate tool for crafting this type of research.

Nonprofit organizations as drivers of social change among marginalized populations. Nonprofit organizations often exist to meet needs otherwise left unmet within the government and for-profit sectors. When nonprofit organizations develop their mission, agenda, and evaluation measures internally without recognizing the importance of listening to their clients' assessments or inviting their clients' participation, they resemble the expert-driven health campaign approach. Here, messages are developed outside the target group by experts and inserted into the community considered in need of an intervention. In nonprofit organizations like Planned Parenthood, women make the decision to visit the organization for services, and are not involuntarily subjected to campaign messages. However, when women develop a relationship with the organization, they seek services from medical professionals and an organization with a reputation of expertise in the area of women's reproductive health.

The culture-centered approach offers an alternative to traditional, top-down approaches to health campaigns. In critiquing the logic of these campaigns, it also critiques the civil society sector as an extension of neoliberal governance. Dutta-Bergman argues, "It is only by participating in the generation of greater capital for the United States that NGOs generate the capital for their survival" (p. 279). It is worthwhile to note that this critique is often applied to international organizations that conduct social change work overseas, targeting marginalized groups, and generating capital for their own survival, which is returned to the Western economy. Arguably, domestic nonprofit organizations run the risk of perpetuating the same marginalizing approach to social change. When nonprofit organizations develop their mission and agenda internally, they risk missing important insights into the beliefs, understandings, experience, and knowledge of the population they target.

Planned Parenthood was developed to resist laws that made access to contraception illegal for women. Over its hundred-year tenure, the organization has continued to champion social issues to provide increased opportunities for women to control their own reproduction. As the Birth Control League, the organization accounted for the impact that socioeconomic status had on women's reproductive choices, and worked to make services available to these groups (Primrose, 2012). The culture-centered approach argues that nongovernmental organizations and civil society agents tend to promote personal and neoliberal agendas, though de Souza (2009) argues that "civil society organizations such as NGOs are not inherently antithetical to community programs, but only insofar as they silence community voices" (p. 694). Therefore, this study positioned clients of the nonprofit organization as central to assessing the organization's ability to meet the needs that they themselves expressed. This study inquired about women's reproductive healthcare needs, and the extent to which Planned Parenthood was able to effectively and satisfactorily meet them.

The shift from the Birth Control League to Planned Parenthood was marked by replacing women with men in leadership roles (McCann, 1998). The demographic shift in Planned Parenthood's leadership led to resignations and a decreased commitment to women's reproductive self-determination. This mirrors a common critique of nongovernmental organizations: "NGO representations are a product of communicative labor, a term describing forms of work primarily oriented around representing and speaking on behalf of marginalized groups" effectively silencing those individuals most in need of a space to speak on their own behalf (Dempsey, 2009, p. 328). Planned Parenthood's history demonstrates the need for nonprofit organizations to be scrutinized for the extent to which knowledge is generated directly with clients.

By positioning clients as the experts in their own lived experiences and knowledge of their own health and healthcare, nonprofit organizations can better develop programs that effectively meet most pertinent needs. While nonprofit organizations are affected by a number of stakeholder groups, service-oriented nonprofits should consider the knowledge of their clientele as fundamental to crafting a mission that has true social value. In so doing, clients are able to discuss their health beliefs, structural barriers to face, and the means they have to address their needs independently and with the assistance of the organization. This also provides nonprofits with a means of preventing further marginalization of already underrepresented populations. It is important to keep in mind, though, the localized knowledge necessary to inform health beliefs and understandings. Planned Parenthood, for example, is a nationwide organization with regional jurisdictions. It should not be assumed that client perspectives in one jurisdiction will necessarily transfer to another.

Nonprofit organizations do have the opportunity to empower marginalized clients. Looking to clients to understand how these organizations meet needs and highlight agency can provide insight into the extent that nonprofits effectively empower clients in health decisions or further marginalize them. This study demonstrates the value of critiquing nonprofit organizations to understand the extent to which they empower or further marginalize clients. Moreover, extending critiques grounded in the culture-centered approach to nonprofit organizations by directly involving clients in assessment allows space to generate knowledge and programmatic changes from within the targeted group.

The centrality of clients to defining nonprofit organizations' social change trajectories. Though nonprofit organizations face scrutiny from multiple stakeholder groups, they are arguably most responsible to the clients they serve because they most closely embody

the organization's mission (Young, 2002). The social mission of nonprofit organization is what most strongly distinguishes them from their for-profit counterparts, and where the value of these organizations lies. The nonprofit mission effectively communicates the organization's social purpose to the public (Fairhurst, Jordan & Neuwirth, 1997). Because clients directly embody the mission of service-oriented nonprofit organizations, it makes sense that they should be central to defining the organization's social change trajectory.

In order for nonprofit organizations to avoid operating on top-down logics developed internally, clients must be directly involved in defining how the mission is most effectively carried out. Listening is central to the culture-centered approach as a means of working "in solidarity with the margins to co-construct theory rooted in the ontologies, epistemologies, and values of the margins" (Dutta, 2014, p. 68). This study demonstrated the applicability of this approach to interrogate the effectiveness of service-oriented nonprofit organizations. Women's experience is central to understanding the role the nonprofit organization plays in their reproductive choice. Moreover, individuals that use nonprofit organizations exercise their agency when they make the decision to approach the organization and as they develop the organizational relationship.

This study demonstrated the value that women's perspectives have on the assessment of the organization's work. It also uncovered ways in which women navigated the organization without necessarily agreeing with everything the organization does. In several instances, women revealed how they mitigate differences in beliefs about reproductive healthcare in order to continue to receive services, though they were not necessarily pleased with the service they received through the organization. An interrogation of nonprofit organizations should consider the extent to which clients are satisfied with the organization, but also how clients resist

organizational messages and effectively use the organization in order to meet their personal needs based on their own belief systems.

Listening also allows power structures that perpetuate marginalization to be interrogated, and provides a space for localized knowledge and meanings to be realized. In large nonprofit organizations, it is important to recognize localized knowledge that will differ across sites. This study identified a number of health beliefs that impacted women's healthcare decisions. Women grappled with contradictions between their own beliefs and values and aspects of the social mission of the organization. It may not be possible for a nonprofit organization to acknowledge and mitigate all of these belief contradictions in the way they execute services. However, this study demonstrated the importance for organizations to listen to the needs and beliefs of women to better orient themselves to effectively serve their social mission. Women in this study identified ways in which they mitigated their own conflicting beliefs through the positive care they received at Planned Parenthood. Organizations that are situated in a tense political climate should be interrogated for the extent to which they consider the belief systems of their clients so that they can better facilitate positive care. Ultimately, service-oriented nonprofit organizations should be interrogated for the extent that they engage clients in dialogue and reflexivity.

This section offered theoretical implications for both stakeholder theory and the culture-centered approach for nonprofit organizations. The next section suggests several practical implications for nonprofit organizations and women's access to healthcare.

Practical Implications for Nonprofit Organizations and Women's Healthcare Access

The findings of this study offer several implications for nonprofit organizations and women's access to healthcare. Nonprofit organizations make up the third largest employment sector in the United States, and this sector continues to see growth (Sisco, Pressgrove & Collins,

2013; McKeever, 2015). With the growth of the nonprofit sector, these organizations have come to adopt principles from their for-profit counterparts. Yet, nonprofit organizations differ from for-profit organizations in values orientation. Whereas for-profit organizations are driven by competition for earnings, nonprofit organizations are more altruistic and driven by a social mission (Sanders, 2015). Nonprofit organizations often adopt for-profit strategies in order to remain viable in the capitalist economy (Sanders & McClellan, 2013). “It is only by participating in the generation of greater capital for the United States that NGOs generate the capital for their survival” (Dutta-Bergman, 2005, p. 279). The findings from this study offer implications for nonprofit organizations that deliver services to socioeconomically marginalized women while working to remain viable within the constraints of the market economy.

These findings suggest several practical implications for service-oriented nonprofit organizations with specific relevance to women’s healthcare needs. First, women who participated in this study illuminated complexities that affected their relationship with Planned Parenthood. Clients should serve an important role in evaluating the work of nonprofit organizations and be incorporated in assessment. Second, this study provides insight into client expectations of national organizations, specifically in terms of consistent care across centers. Third, in the context of women’s health among socioeconomically marginalized clients specifically, these findings suggest that nonprofits be attuned to the belief systems that impact client decision-making (e.g., the role of religious/political beliefs on reproductive decisions). Finally, this study recognizes the opportunity nonprofits have to empower their clients in healthcare decision (e.g., sharing knowledge that allows women to attend to persistent healthcare concerns on their own), and offers suggestions for these organizations to work collaboratively with clients toward that end.

The Role of Clients in Program Evaluation

Previous research suggests the impact and efficiency of the board of directors, responsiveness to resolving differing judgments of multiple stakeholder groups (Herman & Renz, 2008), management effectiveness, and program effectiveness (Sowa, Selden, & Sandfort, 2004) as measures of nonprofit effectiveness. Absent from this literature is the perception and experience of clients. This is troubling in the context of service-oriented nonprofits. These organizations work with marginalized clients to help meet needs otherwise unmet through the government or for-profit sectors.

Highlighting the experiences of women who use Planned Parenthood, this study emphasizes the importance of client voice in nonprofit program evaluation processes. Nonprofit organizations are likely to face negative repercussions if clients share negative experiences about them through word-of-mouth communication. While participants discussed a number of ways they are pleased with their experiences and relationship with the organization, they shared several frustrations with their healthcare interactions. While some of these frustrations may be reflective of the politicized nature of the organization (e.g., protestors) or funding constraints (e.g., long wait times to see a provider), a number of concerns could have been uncovered and addressed by the organization efficiently. Women discussed inconsistencies across clinics, leading some to strongly prefer one site to another. Other women discussed provider interactions that felt patronizing. Ultimately, participants emphasized a preference for the site that provided the most client-centered care. Clients directly experience the service provided by these organizations. By engaging clients in reflection of their interactions with the organization, nonprofits can uncover concerns, improve their approach, and execute their mission more effectively.

Service-oriented nonprofit organizations exist to meet the needs of marginalized groups. In so doing, it is important that program assessment measures extend beyond the for-profit in-house model. Clients of these organizations are vital in order to carry out the organization's mission. Moreover, the mission of these organizations is to create a better social world for clients. Clients should be considered the experts in their own needs. Nonprofit organizations should talk with and listen to client needs as they assess their impact and success in meeting their missions. Incorporating client voice into program evaluation is a vital component of nonprofit assessment.

Consistency of Care/Brand Continuity

This study also demonstrated the importance of understanding the relationship patients develop with their organization beyond the patient-provider interaction. Traditional medical centers allow patients to develop relationships with specific doctors or other healthcare providers by seeing the same provider on a regular basis. However, for healthcare users whose options are constrained, a consistent relationship with a provider may not be an option. Rather, these individuals develop a relationship with the nonprofit organization itself and the care they receive through visits to the same organization, but not necessarily the same provider. Because of this, it is important that nonprofit organizations offer consistencies across locations.

Participants discussed the relationship they have with the nonprofit based on agreement with the organization's social mission, but also because of the quality of interactions they had with providers. In some instances, participants discussed undesirable discrepancies across both clinics and providers. It is important for service-oriented nonprofit organizations that rely on employees to directly provide the service to develop some consistent standards of accountability. In some cases, these standards may exist but not be regularly enforced. Because the

organization's mission is carried out directly through employee-client interactions, consistency measures that are in line with the organization's values orientation need to be prioritized. This demonstrates the importance of nonprofit organizations to develop consistent standards of care within the organization, so that clients experience quality care across visits. While women noted the reality that some clinics are better equipped and better funded than others, the quality of practitioner care can and should be consistent.

Across multiple sites, nonprofit organizations should strive for some environmental consistency. Of course, the demographics of the clinic neighborhood will have a substantial impact on the environment of the site, and in fact should be considered when tailoring services to specific client groups. Still, when nonprofit organizations grow to the regional or national level, this continuity is important to clients. When nonprofit organizations grow, they develop a brand identity for clients, leading clients to expect a similar experience when referred to another site. Planned Parenthood demonstrates the unique needs that are intertwined with funding constraints that contribute to differences across sites. However, client expectations indicate that consistency across sites is important. Multisite nonprofit organizations should be cognizant of these expectations as they develop the physical environment of their locations.

Consistency in environment should not be conflated with standardized care. Planned Parenthood demonstrates the need to be attentive to unique healthcare needs of populations they serve in different geographical locations. Healthcare sites offer varied healthcare services based on financial resources and the needs of the demographic in which the center is located. Consistent with client-centered services, these organizations can and should be attentive to the individualized needs of their communities. Nevertheless, a desire for brand continuity was expressed across interviews in this study. One woman referred to Planned Parenthood as a

franchise, adopting for-profit language to describe the nonprofit organization. It is important for nonprofits to recognize that clients do compare their organizations to the for-profit world, and expect similar consistency across interactions. While nonprofits are constrained by funding and resource limitations, developing a set of criteria for client-centeredness for each site is important. Women reported discrepancies in wait times across centers (which sometimes led them to an alternative site), varied lobby seating, and concerns about the thickness of the walls in one clinic versus another. These are concerns that should be addressed when nonprofit organizations open a new site. When nonprofits grow, this brand continuity is important for clients who develop a relationship with the organization rather than a specific care provider.

Recognizing Belief Systems of Clients

This study provides suggestions for service-oriented nonprofits working within highly politicized contexts. It should be noted that most nonprofit organizations do work toward social and political change, due to their mission to meet needs that the government and for-profit sectors neglect. Because these organizations' work addresses politicized issues, their clientele come with set beliefs. In this study, women grappled with contradictions between their own beliefs and values and aspects of the social mission of the organization. It may not be possible for a nonprofit organization to incorporate and mitigate all of these belief contradictions in how they execute services. However, it is important for organizations to listen to the needs and beliefs of women to better orient themselves and effectively execute their social mission.

Women in this study identified ways that they mitigated their own conflicting beliefs through the positive care they received at Planned Parenthood. Nonprofit organizations exist to meet needs that marginalized individuals cannot address via traditional settings. In the case of women's healthcare access, Planned Parenthood allowed women a place to access services

despite financial constraints. Women's healthcare consumption is constrained by financial situations (e.g., lack of health insurance), personal belief systems (e.g., religious or conservative beliefs about women's reproduction), and structural barriers (e.g., limited facilities offering abortion services). Nonprofit organizations often exist to meet the needs of individuals who face disparities within social constraints. Women are among the populations more likely to experience greater health disparities (Cameron, 2013). However, these constraints are not only about access and financial limitations. In some instances, beliefs and knowledge impact the likelihood that individuals will seek services. Nonprofit organizations must be responsive to both internal and external barriers to care that impact client decisions to seek services.

This study specifically addresses constrained choice among women's healthcare options. Gender directly impacts healthcare decision-making. Women are "culturally defined by their bodies," and "make decisions that reflect prevailing social expectations but which they feel are important to their self-identity" (Lorber & Moore, 2011, p. 65). This impacts the extent to which women seek certain healthcare services. Moreover, women's societal roles impact the healthcare procedures they desire (e.g., a desire for long-term birth control options while in college in order to break the family cycle of women ceasing education at the onset of motherhood). This study demonstrates the impact of social influences on healthcare decisions. Participants used Planned Parenthood based on their understandings of birth control or pelvic exams as necessities. Often, social pressures impacted the decision women made to seek these services. In other instances, witnessing others' social situations (e.g., family members who became mothers before completing high school) impacted their decision to prevent early pregnancies. Social expectations regarding the division of labor relegate women to the domestic sphere; this impacts women more strongly than men when women do become pregnant unintentionally. These social

drivers impacted women's decisions to access care through Planned Parenthood as an organization willing to work with underrepresented populations.

Improving communication skills within patient-provider interactions is fundamental to uncovering these belief systems. In service-oriented nonprofit organizations, wherein services are carried out directly through employees, those employees must be equipped with the necessary tools to discuss the beliefs that contribute to clients' decisions to seek services. In Planned Parenthood's case, employees need to be prepared to have conversations with women about their reproductive health beliefs and listen to the experiences of their clients in order to deliver quality care. Healthcare organizations that are situated in tense political climates should be particularly attentive to client belief systems so that they can better facilitate positive care.

Empowering Practices for Nonprofit Organizations

This study argued that nonprofits have the opportunity to empower clients. The findings offer ways these organizations can more effectively do so. Participants expressed how the Planned Parenthood mission to provide comprehensive healthcare to all women was present in their interactions with the organization. This was in contrast to experiences in traditional healthcare settings. Participants described Planned Parenthood's ability to provide options and choice for women who required reproductive healthcare. They indicated that this choice was more constrained at traditional healthcare settings, where the expertise of the practitioner directed the options provided.

This study highlights the need for nonprofit clients to exercise agency. Because civil society organizations operate within capitalist frameworks, de Souza (2009) argues "civil society organizations such as NGOs are not inherently antithetical to community programs, but only insofar as they silence community voices" (p. 694). Clients should be responsible for voicing

their own needs and expectations within service-orientated organizations. The findings of this study highlighted this, as women compared their experiences with the nonprofit organization to previous experiences with traditional healthcare centers. Women found that Planned Parenthood employees were more likely to listen to their needs, reserve judgment, and make healthcare recommendations and decisions collaboratively with clients.

Still, some participants felt patronized by Planned Parenthood employees for their healthcare decisions. While employees of these organizations hold some level of expertise in their service areas, they should keep in mind that women are the experts in their lived experiences, and have the agency to make decisions for themselves. In several instances, women described conversations with healthcare professionals at Planned Parenthood that helped them to better understand their own bodies. These conversations can be empowering, allowing women to leave the visit with a better understanding of their reproductive health. However, instances of silencing and paternalism are important reminders of the tendency experts can have to exert authority without engaging collaboratively with clients. Because nonprofit organizations work specifically with underrepresented groups, it is important that they not further silence these individuals, but rather exercise collaborative communication and decision-making processes that allow clients to remain the experts in their own lived experiences.

This study uncovered certain measures that nonprofit organizations can take to enhance agency and empower clients. It illustrated the utility of stakeholder theory in conceptualizing clients as central to the organization, and the value of the culture-centered approach to interrogate the assessment measures of these organizations. It also unveiled ways in which clients face constrained choice, and should be considered more completely in evaluating the successes and failures of the organization. Specifically, it offered insights regarding how

nonprofit organizations can incorporate client voice into program assessment and work toward empowering marginalized consumers. It also stressed the importance of consistency across sites for larger nonprofits, and the importance of understanding clients' underlying beliefs in order to effect positive social change. The next section provides limitations of the study's findings and direction for future research.

Limitations and Future Research

Limitations

There are several limitations that should be considered alongside the findings of this study. First, this project focused on a regional sample of participants for a national organization. All women interviewed for this study used Planned Parenthood of Mid and South Michigan as their primary women's healthcare organization. While several participants did refer to their past experiences with Planned Parenthood clinics in other parts of the country, this study is limited in its understanding of women's experiences and understandings of the organization based upon their regional limitations. Planned Parenthood is a national organization, and has clinics serving all fifty states. Therefore, a more comprehensive assessment would take into account the perspectives of women from the different regions of the country, as this no doubt impacts their beliefs and understandings that contribute to their involvement with the organization. However, a regional sample was used to confine the pool of participants and prevent diversity of geographically distinct perspectives from providing too much variety in experiences both among participants' lived experiences and the regional jurisdictions of the organization. A regional sample also better-allowed localized knowledge to surface. Alternatively, focusing on diversity among services sought by clients as the selection criteria was important, but including additional demographics in the selection process may have provided a more nuanced understanding of the

organization's clientele and their respective beliefs and understanding of women's health and healthcare.

Second, part of the methodological approach for this study included follow-up interviews with participants. Follow-up interviews were intended to increase the depth of understanding from each participant that a single interview may not allow. Though many of the participants stated that they were interested and available for follow-up interviews at the time of the initial interview, only four participants responded to requests and followed through when approached for follow-up interviews. The limited number of follow-up interviews impacted the extent to which concepts could be clarified. Additionally, follow-up interviews were used as a means of member checking, and only a small number of participants were ultimately involved in confirming findings through this approach. It is worth noting that my positionality as a feminist often allowed me to establish rapport swiftly. Still, in certain instances, the power difference (as discussed in chapter two) between a white, educated researcher and often underprivileged participants likely impacted the study.

Third, this study recruited participants who were willing to share their experiences with Planned Parenthood. This method of recruitment tends to result in a collection of organization cheerleaders and detractors—those who want to speak about the organization because they strongly identify with the cause and have a positive disposition toward it and those who feel negatively toward the organization and wish to voice their grievances. The data collected in this study suggest that many of the participants were organization cheerleaders. Therefore, the study is not wholly representative of those more complacent users who simply patronize the organization based upon need and nothing more. It is important to acknowledge that this impacts the findings positively.

Fourth, while not necessarily a limitation, it is important to reiterate that while this study incorporated the culture-centered approach to health communication as a means of interrogating the extent to which the organization highlights client voice, it was not a direct application of the culture-centered approach. Rather, this study used the culture-centered approach as a means of highlighting client voice through interviews, and used these to examine the extent to which the organization was able to meet clients most direct needs. A direct application of the culture-centered approach may target a more focused population, and would go further in enact social change to improve reproductive health and healthcare from within the culture.

Fifth, due to the qualitative nature of this study, findings are not generalizable to all service-oriented nonprofit organizations. This study is specific to women's reproductive healthcare accessed through the nonprofit organization. Moreover, other nonprofit organizations offering women's healthcare services may provide a very different experience from Planned Parenthood as the most identifiable, national women's healthcare nonprofit organization. Smaller nonprofit organizations focusing on similar work will not experience the same notoriety or corporatization as Planned Parenthood. Future studies looking at smaller healthcare nonprofits should take this difference into consideration. However, given these limitations, this study's findings do add to the research literature and expand the understanding of the role of nonprofit organizations in effectively meeting women's healthcare needs, and offer some future research directions in this area.

Future Research Directions

Given the findings of this study there are several directions for future research that can both expand the research literature and improve nonprofit relationships with marginalized clients. First, during in this study, participants discussed the role of Planned Parenthood

employees on their healthcare experience. Employees communicatively constitute the organization, and directly carry out healthcare to clients. Future studies should explore the perspective of employees tasked with carrying out the mission of the organization and directly interacting with clients. This could offer a more fully developed understanding of the nonprofit organization, and the extent to which employees find themselves empowered (or not) to work with clients based on their individually identified needs. It could also enrich the findings of this study by presenting a more complicated depiction of the service-oriented nonprofit and client care. Exploring the perspectives of employees would also better illuminate how nonprofit organizations balance stakeholder needs while keeping the client interest central.

As discussed in the limitations above, a second area for future research would be to explore the national aspect of the organization. This study focused on one regional jurisdiction of the nonprofit organization. Research should explore ways in which a national nonprofit organization manages consistency across centers while staying attuned to the individual nature of clients' needs and expectations. Understanding these dynamics would likely provide important insights into the corporatized nature of widespread nonprofit organizations, and present lessons for maintaining client-centeredness. To this end, investigations of other service-based nonprofits such as the Humane Society, Habitat for Humanity, or Feeding America would provide additional insight into this relationship. Exploring large-scale mission-driven organizations to understand how their stakeholder relationships function would further illuminate the unique relationships these organizations develop.

A third area of future research should examine the image defense elements of Planned Parenthood in the context of stakeholder relations, specifically among their clients. Several participants in this study discussed the negative press Planned Parenthood received as a result of

the Center for Medical Progress video scandal. While participants discussed ways in which they disassociated Planned Parenthood's care from the negative press, further research should explore the image defense strategies of the service-oriented nonprofit to understand how the organization develops communication strategies differently to communicate effectively across stakeholder groups.

Fourth, future research should look at the brand continuity aspects of Planned Parenthood, and how the organization's identity, brand, and reputation impact client relationships. The findings from this study demonstrated clients' desires for continuity across Planned Parenthood clinics. Future research should investigate the impact of organizational identity on client perceptions of the organization. This should be examined in tandem with brand continuity and identification among clients, as well as organizational reputation, to understand the role of nonprofit public relations efforts on client engagement, satisfaction, and commitment.

Participants in this study communicated dissonance between their use of Planned Parenthood and their religious and/or political beliefs. A fifth area of future scholarship should examine service-oriented organizations that are persecuted for their mission, in order to understand how clients reconcile ideological conflicts. This research could provide insights for mission-driven organization that cater to clients struggling with conflicting ideologies. It would be useful to identify ways that organizations could more effectively navigate this dissonance and provide a positive experience for clients while effectively executing their missions.

Finally, this study explored the client perspective of a reproductive healthcare nonprofit organization. Future studies should examine other types of service-oriented nonprofit organizations to provide a richer understanding of these organizations' capacity to empower marginalized clients. Clients of different types of nonprofit organizations will offer different

needs and constraints. Better understanding a variety of nonprofit organizations from the client perspective will highlight ways in which these organizations can effectively fill holes in the government and for-profit sectors while maintaining the agency of underrepresented groups.

Conclusion

Service-oriented nonprofit organizations exist to meet the needs of marginalized populations that are otherwise constrained by existing social structures. However, these organizations serve a variety of stakeholder groups, including donors, volunteers, staff, government agencies, and clients. When the viability of the organization is dependent upon funding and resources, clients are often considered secondarily. However, the needs and experiences of clients are central to the organization's ability to be effective in meeting its social mission. A number of studies have explored the communication (internal and external) of nonprofit organizations that contribute to their ability to function effectively. However, few studies have approached nonprofit organizations positioning clients at the center of their measures of success. The findings of this study offer an important perspective on nonprofit organizations' abilities to incorporate the voices of marginalized clients to better execute their social missions. This study is an important step in assessing the ability of nonprofit organizations to serve as spaces of empowerment for marginalized groups.

APPENDIX A: Interview Guide

Interview Guide

- Tell me a little bit about you're your women's healthcare and when you see a physician.
 - What has brought you to PP in the past?
- Tell me about Planned Parenthood. How often do you visit? For what?
- What does PP do for your healthcare needs?
- How does PP meet/not meet needs?
- What is reproductive healthcare for you?
- Why PP?
- How involved are you in negotiating your healthcare with your provider?
- Do you feel positive? Negative? Neutral? About PP
- Why do you continue to visit PP/Why did you stop?

Follow-up interviews will be used to clarify information provided in the initial interview. This study takes an iterative approach, and as such the researcher will conduct analysis as data is in the collection process. Therefore, unstructured follow-up interviews will be used to clarify information provided during the initial interview and to expand on the questions asked during the initial interview.

APPENDIX B: Recruitment Flyer

You are invited to participate in a research study to better understand the experience women have with the women's healthcare organization.

You are invited to participate in 1 to 3 interviews, each lasting between 30 and 90 minutes.

To participate in the study, you must use Planned Parenthood of SE Michigan as your primary women's healthcare organization. If you qualify and are interested, please call

Debbie Sellnow-Richmond
At
(501) 366-4415

Or fill out the online survey at the link below to confirm eligibility in the study:

https://waynestate.az1.qualtrics.com/jfe/form/SV_57HmR9nIOXNvGoR

Your information and interview responses will remain confidential.

Participants will receive a \$50 Target gift card for the initial interview and a \$25 Target gift card for follow up interviews.



APPENDIX C: Participant Demographic Information

Pseudonym	Age	Race	Annual Income	Services
Lynn	29	White	\$15,000-24,999	Birth control Pelvic exam STD/STI testing Pregnancy testing Abortion services
Amanda	23	African American	\$15,000-24,999	Birth control
Gloria	27	White	\$15,000-24,999	Birth control Pelvic exam Emergency contraceptives STD/STI testing
Margo	29	Native American	--	Birth control Permanent birth control Pelvic exam Abortion services STD/STI testing
Janet	20	White	--	Birth control Pelvic exam Emergency contraceptives STD/STI testing Other
Beth	25	--	--	Birth control Pelvic exam STD/STI testing
Dana	29	African American	--	Birth control
Denise	28	White	\$15,000-24,999	Birth control Pelvic Exam STD/STI testing Pregnancy testing
Heather	29	African American	--	STD/STI testing Other
Liz	30	--	--	Abortion services
Erin	23	White	\$25,000-34,999	Birth control Pelvic exam Pregnancy testing
Isabelle	24	White	\$15,000-24,999	
Ruth	35	White	\$15,000-24,999	Birth control Pelvic exam STD/STI testing Pregnancy testing
Yvette	18	African American		Pregnancy testing
Megan	24	--	\$15,000-24,999	Emergency contraceptives

Shonda	32	African American		Birth control Pelvic exam Emergency contraceptives STD/STI testing Pregnancy testing Other
Clarice	24	African American		Emergency contraceptives STD/STI testing Pregnancy testing
Skylar	24	White/Asian	\$10,000-14,999	Birth control STD/STI testing
Lindsay	19	White		Birth control STD/STI testing
Ruby	40	White	\$15,000-24,999	Birth control Pelvic exam

APPENDIX D: Table for Organizing Findings

Making contact	Developing the relationship	Experiencing relationship	Contribution to understanding
Financial constraints <ol style="list-style-type: none"> 1. No insurance/took mine 2. Free/sliding scale 3. Don't want parents to see 	Accessibility <ol style="list-style-type: none"> 1. They're everywhere 2. Easier to use 3. Affordable 	They listen to needs <ol style="list-style-type: none"> 1. Everything's my choice/ not pushy 2. I can ask questions/ They explain 3. Accommodate when they can't meet needs 	Led to advocacy <ol style="list-style-type: none"> 1. Advocate to others 2. Don't want protesters to win 3. Feminism
Sexually active <ol style="list-style-type: none"> 1. Started having sex 2. Young 3. Needed (new) birth control 4. Pregnancy scare 	Consistency of care <ol style="list-style-type: none"> 1. Relationship with provider(s) 2. Consistent across centers 3. Always been good to me 	Comfortable <ol style="list-style-type: none"> 1. Judgment-free 2. Fosters honesty 3. Make decisions collaboratively 4. Care about <i>you</i> 5. Sense of community 	Learned about own care <ol style="list-style-type: none"> 1. I'm the expert in my body 2. Filled in holes from health ed.
Referred <ol style="list-style-type: none"> 1. Mom's role 2. Friends or siblings 3. Advertising and reputation 4. Impact of family life 	All women <ol style="list-style-type: none"> 1. My concerns pertain to female body 2. They're women like me 3. Champion for women's health 	Barriers to care <ol style="list-style-type: none"> 1. Protestors 2. Can't do everything for me 3. Conflicting ideologies 4. Hours/wait time 5. Paternalistic 	Helped get healthier <ol style="list-style-type: none"> 1. Identified other issue 2. Take up free STI testing 3. Manage ongoing concerns
Women's bodies are unique <ol style="list-style-type: none"> 1. Specialists are better for female body 2. Women need their own space 	Meet most important needs <ol style="list-style-type: none"> 1. Contrast with bad experience 2. Recurring issues 3. Credible/ specialists 4. Lifestyle requires care 		
Conflicting beliefs <ol style="list-style-type: none"> 1. Religious upbringing 2. Impact of politics 			

APPENDIX E: Eligibility Survey

Q1. Research Information Sheet

Title of Study: Interrogating the relationship between nonprofit organizations and individuals receiving services

Principal Investigator (PI): Deborah Sellnow-Richmond
Communication
(501) 366-4415

Funding Source: WSU Department of Communication and Graduate School

Purpose:

You are being asked to be in a research study of women's experience with their women's healthcare organization (Planned Parenthood) because you use Planned Parenthood as your primary women's healthcare organization. This study is being conducted at Wayne State University. The estimated number of study participants to be enrolled at Wayne State University is about 20. **Please read this form and ask any questions you may have before agreeing to be in the study.**

In this research study, you will be asked questions about your decision to use Planned Parenthood as your primary women's healthcare clinic. This will help to better inform the experience women have with nonprofit healthcare centers and how clients of this type of organization experience healthcare. This research will help organizations be more responsive to clients they serve.

Study Procedures

If you agree to take part in this research study, you will be asked to participate in one initial interview to discuss your experiences with your healthcare clinic. It is possible that you will be asked to participate in one to two follow up interviews to clarify what you discussed in the initial interview. You will be asked to meet with the researcher in a mutually agreed upon location (or over Skype) to respond to interview questions that will be audio recorded.

If you take part in the study, you will be asked to

- Meet with the researcher for one to three interviews
 - One initial interview
 - One to two follow-up interviews
- Each interview (initial and follow-up) will last approximately 30-90 minutes
- You will be asked about your experience with your healthcare organization.

Your identity will not be used in transcripts of the data or on the audio recording. Your contact information will be kept in a researcher's locked desk, and only the researcher will have access to this information. It will not be included in the transcripts or the final study manuscript.

Benefits

As a participant in this research study, there may be no direct benefit for you; however, information from this study may benefit other people now or in the future.

Risks

By taking part in this study, you may experience the following risks:

- **Social risks:** A breach of confidentiality is possible. To minimize this risk, your interview will be recorded on a personal recording device and immediately transferred to the researcher's password-secure computer, and deleted from the audio recording device. You will be referred to by participant number, and your name will be eliminated from transcripts of the interviews. Your contact information will be saved on the researcher's password-secure computer, and permanently deleted at the completion of the study.

There may also be risks involved from taking part in this study that are not known to researchers at this time.

Study Costs

Participation in this study will be of no cost to you.

Compensation

For taking part in this research study, you will be paid for your time and inconvenience in the form of a \$50 Target gift card for the initial interview, and a \$25 gift card for each follow up interview. You will receive the gift card upon completion of each interview.

Confidentiality

All information collected about you during the course of this study will be kept confidential to the extent permitted by law. You will be identified in the research records by a code name or number. Information that identifies you personally will not be released without your written permission. However, the study sponsor, the Institutional Review Board (IRB) at Wayne State University, or federal agencies with appropriate regulatory oversight [e.g., Food and Drug Administration (FDA), Office for Human Research Protections (OHRP), Office of Civil Rights (OCR), etc.] may review your records.

When the results of this research are published or discussed in conferences, no information will be included that would reveal your identity.

If photographs, videos, or audiotape recordings of you will be used for research or educational purposes, your identity will be protected or disguised. You will be identified in the research records by a code name or number. Once interviews are transcribed, the recording will be permanently destroyed. Your name will not be available on the transcribed interviews.

Voluntary Participation/Withdrawal

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you decide to take part in the study you can later change your mind and withdraw from the study. You are free to only answer questions that you want to answer. You are free to withdraw from participation in this study at any time. Your decisions will not change any present or future relationship with Wayne State University or its affiliates, or other services you are entitled to

receive.

The PI may stop your participation in this study without your consent. The PI will make the decision and let you know if it is not possible for you to continue. The decision that is made is to protect your health and safety, or because you did not follow the instructions to take part in the study

Questions

If you have any questions about this study now or in the future, you may contact Debbie Sellnow-Richmond at the following phone number (501) 366-4415. If you have questions or concerns about your rights as a research participant, the Chair of the Institutional Review Board can be contacted at (313) 577-1628. If you are unable to contact the research staff, or if you want to talk to someone other than the research staff, you may also call the Wayne State Research Subject Advocate at (313) 577-1628 to discuss problems, obtain information, or offer input.

Participation

By completing the questionnaire and submitting your response, you are agreeing to participate in this study.

- Q2. What is your first name?
- Q3. What is your preferred method of contact? Please provide that contact information here. (For example, if email is the best option, list the email address here; if phone is preferred, list the 10 digit phone number here.)
- Q4. Do you use Planned Parenthood of Mid and South Michigan as your primary women's healthcare clinic?
- Yes
No
- Q5. What services have you obtained from Planned Parenthood of Mid and South Michigan? (Select all that apply.)
- Birth control
Permanent birth control
Pelvic exam
Prenatal programs
Abortion services
Emergency contraceptives
STD/STI testing
Pregnancy testing
Other
- Q6. What is your age?

Q7. What is your race? (optional)

Q8. What is your income level? (optional)

<10,000

10,000-14,999

15,000-24,999

25,000-34,999

35,000-50,000

>50,000

APPENDIX F: IRB Approval

**WAYNE STATE
UNIVERSITY**

IRB Administration Office
87 East Canfield, Second Floor
Detroit, Michigan 48201
Phone: (313) 577-1628
FAX: (313) 993-7122
<http://irb.wayne.edu>

NOTICE OF EXPEDITED APPROVAL

To: Deborah Sellnow-Richmond
Communication
906 W. Warren, 585 Manoojian

From: Dr. Deborah Ellis or designee J. Wirth / 22
Chairperson, Behavioral Institutional Review Board (B3)

Date: November 10, 2015

RE: IRB #: 096615B3E
Protocol Title: Interrogating the Relationship between Nonprofit Organizations and Individuals Receiving Services
Funding Source: Unit: Communication
Protocol #: 1510014378

Expiration Date: November 09, 2016

Risk Level / Category: Research not involving greater than minimal risk

The above-referenced protocol and items listed below (if applicable) were **APPROVED** following *Expedited Review* Category (#6 #7)* by the Chairperson/designee for the Wayne State University Institutional Review Board (B3) for the period of 11/10/2015 through 11/09/2016. This approval does not replace any departmental or other approvals that may be required.

- Revised Protocol Summary Form (revision received in the IRB office 11/03/15)
 - Research Protocol - Dissertation (received in the IRB office 09/30/15)
 - Medical records are not being accessed therefore HIPAA does not apply
 - Behavioral Research Informed Consent (revision dated 10/30/2015)
 - Study Flyer
 - Recruitment Script
 - Interview Guide
-

- Federal regulations require that all research be reviewed at least annually. You may receive a "Continuation Renewal Reminder" approximately two months prior to the expiration date; however, it is the Principal Investigator's responsibility to obtain review and continued approval **before** the expiration date. Data collected during a period of lapsed approval is unapproved research and can never be reported or published as research data.
- All changes or amendments to the above-referenced protocol require review and approval by the IRB **BEFORE** implementation.
- Adverse Reactions/Unexpected Events (AR/UE) must be submitted on the appropriate form within the timeframe specified in the IRB Administration Office Policy (<http://www.irb.wayne.edu/policies-human-research.php>).

NOTE:

1. Upon notification of an impending regulatory site visit, hold notification, and/or external audit the IRB Administration Office must be contacted immediately.
2. Forms should be downloaded from the IRB website at **each** use.

*Based on the Expedited Review List, revised November 1998

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ABSTRACT**"A BARRIER WITH ROSES GROWING OUT OF IT": AN INTERROGATION OF THE RELATIONSHIP BETWEEN A SERVICE-BASED NONPROFIT ORGANIZATION AND ITS CLIENTS**

by

DEBORAH D. SELLNOW-RICHMOND**December 2016****Advisor:** Dr. Julie Novak**Major:** Communication**Degree:** Doctor of Philosophy

Service-based nonprofit organizations exist to meet needs otherwise unmet within the for-profit sector. This study investigates women's decision to visit a specific healthcare site and the relationship they develop with their reproductive healthcare organizations. Focusing on women's decision to choose a healthcare organization that focuses solely on reproductive healthcare and access to care, regardless of socioeconomic status, emphasizes the unique relationship women, particularly women of marginalized status, have with reproductive care in the United States. Importantly, these experiences provide the means to examine the broader context of women's reproductive healthcare access among marginalized communities and the role of nonprofit organizations. This study focuses on the client perspective as a means of assessing the effectiveness of the nonprofit organization in meeting their needs. Stakeholder theory and the culture-centered approach were used to theoretically ground the study.

Twenty women who use Planned Parenthood of Mid and South Michigan as their primary women's reproductive healthcare organization were interviewed regarding their relationship with the nonprofit organization and their ability to have their reproductive healthcare

needs met. Participants discussed their reasons for initiating contact with the nonprofit organization, how they developed and sustained the relationship, how they experienced and negotiated their own healthcare, and how the relationship with the organization contributed to their understandings of reproductive health/care. Suggestions for service-oriented nonprofit organizations and women's healthcare access, as well as extensions of stakeholder theory and the culture-centered approach are discussed.

AUTOBIOGRAPHICAL STATEMENT

Deborah Sellnow-Richmond is an assistant professor in the Department of Communication at Columbus State University. Prior to earning her Ph.D. from Wayne State University, she completed a Bachelor of Arts in political science and gender, women's, and sexuality studies from the University of Minnesota, and a Master of Public Service from the University of Arkansas Clinton School of Public Service. Her research focuses on the relationships that clients develop with nonprofit organizations, as well as the efficacy and/or unforeseen effects of public relations messages in health/organizational crisis contexts. Her research in public relations has appeared in journals including the Journal of Applied Communication Research, Communication Studies, and the Journal of Risk Research. Her research on organizational crisis response has received top paper in the Public Relations Interest Group at the Central States Communication Association Conference. She teaches courses in public relations, organizational, and health communication, and has professional experience in community-centered campaigns at the state-, national-, and international-level.