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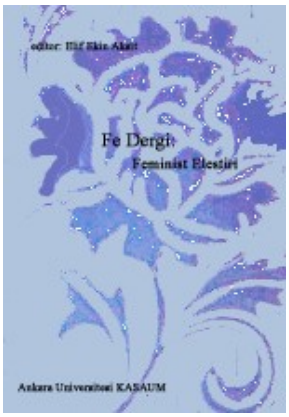

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From power to safety and respect: the changing meaning of empowerment in women's reproductive health care in the U.S.

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From power to safety and respect: the changing meaning of empowerment in women's reproductive health care in the U.S.

Ayse Dayı[*]

The U.S. Women's Health Movement (WHM), which was launched in the late 1960s and early 1970s, aimed to decrease the medicalization of women's reproductive lives and increase women's control over their bodies and health. Its main aim was to empower women in health services. Addressing the gap in the literature on the in-depth exploration of empowerment as it relates to the movement and as perceived by the women receiving reproductive care, I conducted a study between 2001 and 2002 that investigated the legacy of the WHM in the 21st century through the operation of two women-controlled agencies in the Northeast of U.S. My focus was on how women receiving care themselves defined and experienced empowerment as affected by agency, community, and societal factors. I found that empowerment in birth control and abortion care was experienced and defined not as control but as safety and respect. Women discussed aspects of access and service delivery characteristics mainly within the framework of respect and humane care, revealing that women receiving care recognize the ethics of care (that are emphasized in feminist models of care) and its intricate relation to feeling empowered. Their references to vulnerability, and judgmental, directive and inhumane care in other providers and the emphasis on safety though point to the ongoing influence of medicine and the antiabortion movement on the Women's Health Movement and women's sense of empowerment in reproductive health care.
Keywords: women's health movement, empowerment, abortion, birth control, ethics

Güçten güvenlik ve saygıya: ABD'de kadınlara yönelik üreme sağlığında güç kazanmanın değişen anlamı

1960'ların sonu 1970'lerin basinda ivme kazanan Amerikan Kadın Sağlığı Hareketinin amacı kadınların üreme hayatlarındaki tıbbileşmeyi azaltmak ve kadınların kendi bedenleri ve sağlıklari üzerindeki güç ve haklarını arttırmaktı. Esas amaç kadınların sağlık hizmetlerinde güç kazanmaları idi. Kadın üreme sağlığı literatüründe güç kazanma kavramının (empowerment) Amerikan Kadın Sağlığı Hareketi ile ilintili olarak ve özellikle de çalışanların degil de hizmet gören kadınların gözünden yeterince araştırılmamış olması üzerine, 2001 ve 2002 senelerinde, Kadın Sağlığı Hareketi'nin 21. yuzyıldaki mirasini araştırmak ve kadınların güç kazanmayı nasıl tanımladıkları ve deneyimlediklerini bulmak icin Amerika'nın kuzeydoğusunda iki kadın saglığı merkezinde araştırma yürüttüm. Bulgularıma göre kadınlar doğum kontrolü ve kürtaj hizmetlerinde guc kazanımını kontrolü eline almak degil de kendini güvende hissetmek ve saygı duyulmasi şeklinde yorumluyor ve deneyimliyorlardı. Kadınlar, genel literatürde hizmetlere ulaşım (access) ve hizmet dağılım şekilleri (service delivery characteristic) olarak tanımlanan boyutları, saygı ve insancıl bakım olarak yorumladılar. Bu da feminist sağlık hizmeti modellerinde vurgulanan hizmet/bakım etiğinin ve bunun guc kazanımına yakın ilişkisinin kadınlar tarafından da tanındığını gösteriyor. Fakat, kadınların güç yerine güven üzerinde duruşları ve bu merkezler dışındaki jinekolojik ve kürtaj hizmetlerinde hissettikleri savunmasızlık ve onları yargılayan, onlara hükmetmeye çalışan, ve insancıl olmadığını düşündükleri deneyimleri, Amerika'da tıbbın ve kürtaj karşıtı hareketin Kadın Sağlığı Hareketi ve kadınların üreme sağlığında güç kazanımları üzerindeki etkisini gösteriyor.
Anahtar kelimeler: Kadın Sağlığı Hareketi, güç kazanımı, kürtaj, doğum kontrolü, etik

The U.S. Women's Health Movement: Herstory, goals, and accomplishments

Dating back to the 1830s and 1840s,[1] the U.S. Women's Health Movement (WHM) was launched in the late 1960s/early 1970s as a grassroots organization of women fighting for abortion rights, reproductive freedom, and

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[1] Mary K. Zimmerman, & Shirley A. Hill "Reforming gendered health care: An assessment of change" *International Journal of Health Services 30*, no. 4 (2000): 771-795.

dignified and affordable care[1]. The WHM advocates formulated an extensive critique of women's health care in the areas of doctor-patient relationship, contraceptive safety and access, sterilization uses/abuses, medicalization of childbirth, and excessive and unnecessary use of gynecological and breast surgery.[2] Feminists in the movement found that these problems were due to larger social and historical forces such as the medicalization of normal female reproductive events, the ascendance of males in (and systematic exclusion of females from) medicine and gynecology, the biomedical model of health, androcentric bias in medical education and medical research, and the growing relationship between capitalism, medicine, and patriarchy.[3] Based on this critique, WHM activists fought for:
Increased control for women in decision and actions affecting their bodies and health.
The de-medicalization of women's life events and problems.
An emphasis on information around women's health issues, prevention and less invasive treatment.
An atmosphere of interpersonal respect between physicians and patients, regardless of gender, class, and race.
The centrality of a sociomedical as opposed to a biomedical model of health.
Increased number of female providers, including physicians and paraprofessionals.
Increased research on women's health research, including allocation of more funds to women's health research.
A commitment to health care as a right, including legislative efforts to ensure women's reproductive right and access to physicians and hospitals regardless of financial or insurance status[4].

In terms of accomplishments, as Morgen[2] states, "women today can receive more information about their bodies and reproductive health care, and in some settings they are encouraged to participate actively in their own health care by questioning their providers and asserting their own preferences and opinions." In terms of health policies, WHM was effective in the adoption of informed consent procedures to protect women from sterilization abuse, medical experimentation, and unnecessary medical procedures.[5] The WHM also helped extend women's right to know through FDA requirements for package inserts with information about the side effects and contraindications of prescription drugs, including oral contraceptives and hormone replacement therapy.[6] In women and medicine, there are increased number of women (including women of color) in medical education and practice, increased federal money to women's health research, the establishment (by NIH) of the Office of Research on Women's Health, and the NIH-mandated inclusion of women in all research grants[7].

Despite these accomplishments, WHM did not lead to a major change in the medical establishment (medical education, training, and practice) and did not succeed in de-medicalizing reproductive events. Zimmerman and Hill[8] conclude that due to the health care reforms in the U.S., medicalization of women's health is increased, especially in the areas related to appearance (weight control, fitness, dieting, and cosmetic surgery) and fertility where women are the primary clients[9] and vulnerable to fraud and overtreatment by medicine. Provision of alternative services did not threaten or change established medical institutions.[10] Morgen[11] argues that the "control of women's health care still remains in the province of physicians and other health professionals, who, although they manage patient care differently than before, still manage it nevertheless." Although the movement led to an increase of women in medicine, women are concentrated in low-paying, low-status jobs and medical education and practice is still fraught with gender inequities.[12] Affordable, accessible respectful health care (especially for poor and uninsured women) is still an ongoing challenge.

Underlying the critique of medicine, the main of the WHM was to empower women in the areas of reproduction and sexuality, especially as users of health and reproductive health services.

Within the research that investigates the legacy of the WHM on women's reproductive health care through studying the women-controlled (feminist) health centers[3], the focus is more on the organizational factors

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[2] Sandra Morgen. *Into our own hands: The women's health movement in the United States, 1969–1990* (New Brunswick, NJ: Rutgers University Press, 2002, 149).

[3] Morgen, *Into our own hands.*
Wendy Simonds. *Abortion at work: Ideology and practice in a feminist clinic* (New Brunswick: Rutgers University Press, 1996).
Ruth Simmons, Bonnie Kay, & Carol Regan "Women's health groups: Alternatives to the health care system" *International Journal of Health and Services* 14 no 4 (1984): 619-634.
Jan Thomas "Everything about us is feminist: The significance of ideology in organizational change" *Gender and Society,* 13 no. 1 (1999): 101-119.
Thomas "Incorporating empowerment into models of care."

than the care aspect, and except for Thomas'[13] work, there is no in-depth investigation of the concept of empowerment as it relates to the WHM. Including Thomas work, when feminist care or empowering care was evaluated, it was done so from the perspectives of women's health activists and workers, and not those of the women who receive the services. In order to address these needs, I conducted a study that investigated the legacy of the WHM in the 21st century through the operation of two women-controlled agencies with a focus on how women receiving care themselves define and experience empowerment as affected by agency, community, and societal factors. In this paper I discuss the findings that relate specifically to the changing meaning and experience of empowerment for women in reproductive services and its implications for reconceptualizing empowerment in relation to empowerment literature and the Women's Health Movement[14].

Conceptualizing Empowerment

As discussed in the fields of education, psychology, sociology, anthropology, feminism, theology, nursing, public health, prevention, and social work/human services, the essential components of empowerment emerge as having control over one's life and decisions, having choice, having a voice, and holding self-efficacy beliefs (beliefs that one can make a change). Within the context of human services, these translate into sharing power with the people (instead of giving power to them), view of clients as resources (instead of needy individuals, objects, or passive recipients of services), listening to and learning from the people, and view of professionals as collaborators or partners instead of experts.[15]

Empowerment is also found in what I name as the models of empowerment, which emphasize the multilayered process of empowerment. Organizational models[4] of empowerment, which include feminist models such as Ruzek's[16] ideal health types of health care worlds and Thomas'[17] model of empowering care, focus mainly on the institutional (and interpersonal) factors impacting empowerment. The systemic approaches to empowerment analyze power at the interpersonal, institutional, and societal levels, and include quality of care perspectives (e.g. Simmons et al.'s, strategic approach' to contraceptive introduction[18], and Bruce's quality of care framework in family planning services) and ethical approaches.

Three dimensions of empowerment emerge from these models: access to services such as distance, cost, and time (waiting time and time in services), service delivery characteristics such as providing correct and adequate information with advantages, disadvantages and side effects of methods in an interactive, nonjudgmental, peer-oriented way. This dimension also includes choice of methods provided, preference for barrier methods over hormonal ones, dominant relationship between provider and client, the division of labor in the agency, follow-up mechanisms, management of space, assignment of risk, and staff training and support.

The third dimension of empowerment is ethics of care where aspects of access and service delivery characteristics are interpreted as ethical issues. According to Kols et al.,[19] the principle of justice demands that risks and benefits be equally distributed in a society and that everyone has access to services. In women's health care, this means that it is a matter of justice that clients have access to services that are affordable, reliable, and without barriers. Thomas[20] names this "dignity and respect" seeing it reflected in feminist centers' dedication to serve all women regardless of their income status. Both Kols et al.[21] and Sherwin[22] consider information provision as an ethical issue as well. "Respect for autonomy" requires that a client be provided full and correct information and be respected in her decision-making ability and the decisions. Being treated with respect also includes courtesy, confidentiality, and privacy[23], providing women with non-oppressive options and the opportunity to develop the skills that are necessary for making informed decisions.[24]

Methods

Settings

During 2001 and 2002, I visited two women's health centers (Feminist Health Center and Women's Health Center[25]) in the Northeast region of the United States, staying two weeks at each site. Both centers were established (in 1974 and 1978) by women closely following Roe v. Wade decision to legalize abortion in the U.S., to provide low cost abortion care in their communities. Feminist Health Center (FHC) had the more

[4] The conceptualization and naming of "organizational models", "systemic models", "quality of care perspective" vs. "ethical approaches" are mine. Please see Ayse Dayi "The Empowerment of Women in Reproductive Services: A Poststructural feminist case study of two women's health centers in U.S." Doctoral Dissertation (2005) for an in-depth discussion of these models.

explicit feminist aim of establishing a clinic "run by and for women in a nurturing, respectful, and empowering manner, that encouraged taking charge of one's own body and life." Both centers are women-controlled settings where women occupy key positions and run the clinic. Both centers provided medical abortions (with the pill or shot), surgical abortions,[26] and expanded gynecological care that included routine gynecological exams, colposcopy, STD checks, and birth control counseling, provision and renewal.

Main differences between the two centers were in the organizational structures, especially the hierarchy and the level of medicalization. At the time of the study, FHC operated as a collective with no board of directors and an executive director assigned for legal purposes. WHC on the other hand, had an external board of directors and an executive director. While the doctors in both centers had implicit power, FHC took measures to decrease doctors' power, such as not allowing doctors to vote and encouraging staff to challenge doctors to advocate for the women. In WHC on the other hand, doctors were included explicitly in the organizational structure. Another difference between the agencies is in their non-profit (FHC) versus for-profit (WHC) statuses.

Data Collection

The data collected from the two sites consist of: (a) semi-structured face to face interviews with staff (n= 21) and women receiving birth control and abortion services (n=24), (b) observations of pre-abortion counseling sessions, and gynecological visits (n=16), (c) field notes on staff-staff, staff-client interactions, protesters, spatial arrangement of the centers, and conversations with staff, and (d) a review of agency forms and archival materials[27]. This was a feminist case study with ethnographical components and poststructural influences. The poststructural feminist framework led to rejecting objectivity and neutrality, and emphasizing instead personally and politically engaged, accountable research, where I claim to present only a partial (historically and temporally situated) truth about empowerment in reproductive health in two clinics. I used the Grounded Theory Approach to qualitative analysis to analyze the data.

Empowerment as safe and humane care

The results showed that for women receiving birth control and abortion care, at the core of empowerment were safety and respectful humane care. Safety has both physical and emotional dimensions. Humane treatment means receiving dignified, egalitarian, individualized, and holistic care. Even though safety and humane care were mediated by agency, community and societal factors, I restrict my discussion here to the meanings of safety and humane care.

Seeking safety

Physical safety. Both WHC and FHC had direct contact with Operation Rescue[28] in the forms of blocking of entry to the center (FHC) and a blockade and occupation of the center (WHC). FHC experienced two arson attacks, a butyric acid attack ("stink bomb"), and the picketing of the house of the medical director, and WHC was subjected to antiabortion vigils, marches, pro-life newspaper ads, and the harassment of its doctors and their children. Due to these attacks and possibly to the awareness of attacks on abortion providers at the national level, both centers had adopted high security measures including cameras and asking for IDs at the door (in both), and a locked entrance to the surgery and aftercare area (WHC).

In FHC, women scheduling abortion or gynecological visits were told over the phone and in letters sent home about possible protesters. Women were already aware of the possibility and worried about being subject to protesters violence. Their expectations derived from the media images and previous personal or vicarious (friends and family) experiences with these and other centers. Women were not only aware of –and expected- protests, but compared clinics in terms of "relative safety".

Well, I figured it was probably the SAFEST PLACE TO GO[29]. Since there is more violence in [Names the neighboring state], at the clinics. Would probably been a little bit closer I would think. UHM BUT it was- it was just here in the news about you know violence. AND THIS- I checked it out on line and it seemed like the best place to go

Jane, FHC, Received medical Ab[30]

Women were angry at the protesters because they did not "know about the woman's situation/her reasons for abortion." Made to feel unsafe and vulnerable, women liked the security measures adopted by the centers.

However, the mere existence of such measures was also a constant reminder of possible violence, keeping women from feeling completely safe.

I was a little nervous because they were asking for the ID number, that you have an ID. I was VERY WORRIED. Because it seemed like there's tight security. That's very good and it's important but I was like "oh GOD. I wonder if there's like security issues", like people trying to get in or something.

Andrea, FHC, Received Gyn

Physical safety also referred to receiving safe abortion care. In both agencies, one of the main concerns of the women receiving abortion services was the risk of possible complications, including infections and infertility. These concerns were addressed by providing information and pre-abortion counseling, as well as through mechanisms such as the 24-hour hotline for emergencies and required follow-up exams. In WHC, safe abortion care was also secured by requiring the women who choose IV sedation to have a designated driver with them on the day of the abortion, and requiring women whose uteri were unable to contract and thus retained blot clots to go through a re-evacuation followed by a D & C (Dilation and Curettage).

Emotional safety: Comfortable/comforting (addressing vulnerabilities).The homey atmosphere of the agencies and the friendly, welcoming, supportive behavior of the (medical and non-medical) staff comforted and soothed the women for whom both abortion and gynecological procedures were sites of anxiety, discomfort, and vulnerability. The homey atmosphere consisted of pastel colors, home-like decoration of the waiting room, counseling rooms and the after-care areas, pictures on the walls, mellow lighting, music or TV in the waiting room and music in the exam room. This homey atmosphere, which the women compared to the "sterile" or "professional" atmosphere of doctors' offices or hospitals, helped set the women at ease and distracted those who were too worried.

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

Jane, FHC, Received medical Ab

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

I think it's fantastic that they keep the speculums in a warm blanket. MAKE IT A VERY, PRO-WOMAN ENVIRONMENT.

Eileen, WHC, Received Gyn + Ab

The homey, non-medical atmosphere of the centers provided women with a vision of how reproductive services can be.

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

Sally, FHC, Received Gyn

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

Emotional safety: Non-judgmental care. Women's responses showed that in addition to feeling vulnerable, they also felt judged by other providers, for using abortion and birth control services (which also implied sexual activity, especially for young –unwed?- women), and for asking questions. In regard to abortion, women talked about the "silence over abortion" in the society, and felt judged by society, by parents (especially mothers), partners, and even their own Ob/Gyn providers or family practitioners.

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

Frances, FHC, Received Ab + Gyn

before I went to [WHC], I was seeing a doctor out in the west of town. The doctor was a male. And he kind of made me feel really uncomfortable. Then when I did find out that I was pregnant I TALKED WITH HIM about the possibility of terminating and THEY TREATED ME (PAUSE) NASTY [ ] EVEN THE WOMEN IN THE OFFICE, like I felt they were like (Ayse: judging) JUDGING ME. Because I- I'm in the situation and I NEEDED SOME OPTIONS.

Susan, WHC, received Ab + Gyn

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

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

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

Christa, WHC, Received Ab

For women receiving gynecological care in both centers, judgment meant being judged for using birth control (which for young women implied being sexual active), and for asking questions to the providers.

Like my very first gynecologist was a mean man. You know when I was sevenTEEN and he was just this angry like "oh you shouldn't have sex and tatatata" I come here with like crazy questions (LAUGHS) And they answer them so.

Sonia, WHC, Received Ab + Gyn

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

Validation: "They made it ok to decide". Women's responses to unwanted pregnancy and the consequent decision to abort ranged from complete confidence in one's decision to denial, confusion, guilt, feeling irresponsible and being disappointed in self. Due partly to these mixed emotions women sought validation of their decisions. Even the women who thought that the abortion was the best option for them needed to hear that what they were feeling and doing were normal and ok to do. Validation provided both a safe space to sort conflicting emotions and a space to make a decision without being judged. Going through abortion in a safe space where women felt validated did at times change or lead to the questioning of their anti-abortion views. There also emerged a group of women for whom abortion was an empowering experience.

Actually, coming here made me feel stronger. Like after the abortion, cause it's- it is hard thing to do. I feel I don't know I feel lot stronger now, having gone through it. And knowing that I can handle it. But like every once in a while, it bothers me, ESPECIALLY NOW, because MY BROTHER AND HIS WIFE, they found out, SHE WAS PREGNANT when I was having my abortion. SO now she SHE ACTUALLY IS DUE when I would have

been due. So I don't know if it's bad karma (S LAUGHS A LAUGHS TOO). But you know what I mean though.

Susan, FHC, Received Ab + Gyn

Going through with abortion also made some women aware of the importance of the right to abortion.
it- it- it has REALLY confirmed, MY, BELIEF, that uhm, abortion should be safe and legal. I can't explain how, how thankful my fiancée and I both were that, I had a place to go THAT WAS SAFE. ON A LARGE SCALE, just sort of reaffirming the fact that this place and places like it are (PAUSE) so needed.

Eileen, WHC, Received Gyn + Ab

Although empowering and enabling the recognition of a right, the preceding quotes still show women's ambivalence toward abortion.

Confidentiality: "They will never know". Confidentiality was another factor in relieving the fear of judgment and making women feel emotionally (and physically) safe from those who judged or harmed them. Many women at both centers chose the centers because they wished to stay anonymous.
[you mean the ob/gyn] in D-town. I didn't even go to her. I think because I didn't want my family to know. I didn't want them to know I was pregnant. They still to this day they don't know about it

Susan, WHC, Received Ab + Gyn

oh how you don't really wanna go back to your obstetrician and ask for an
abortion you know (LAUGHS) you wanna go somewhere where they're not gonna KNOW YOU. Someplace you haven't been before.

Frances, FHC, Received AB + Gyn

Specialized in pregnancy prevention: "You are in the same boat". The desire not to be judged for using birth control or abortion was also evident in women's choice of the centers for their specialized care: having staff with specialized knowledge and skills in contraceptive and abortion services, and specializing in preventing pregnancy.
Uhh, I think the environment here is fine. Because you are in a room with bunch of people in the same boat as you. And when I go to a regular doctor's offices think like the people are looking down on you like if there is a pregnancy test, like if they're older married women, like how old is this girl? She's taking a pregnancy test. But when you come here, it's all people that were probably women my mom's age, coming for abortion, and you're not gonna feel like an (outsider?).

April, WHC, Received Gyn + Ab

It's just- it's kind of a COMFORT LEVEL. [the city Ob/Gyn] IS MUCH MORE GEARED TOWARDS like older couples and like for the people- it's more of a kind of starting a family type thing. I kind of got the impression that women there had children or were looking to start a family ?? and I COME HERE it's the opposite.

Mary, FHC, Received Gyn

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

Seeking humane care
Humane treatment aspect refers to receiving dignified, egalitarian, individualized, and holistic care.

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

The staff provided information by explaining all options of abortion and after care, and birth control and side effects, by walking women through gynecological and abortion procedures, by explaining reasons for gynecological problems (e.g., vaginal discharge, clotting of the uterus, pimples around the breast during pregnancy), and by giving clear care instructions to the women. Explaining reasons included going beyond answering women's questions to informing women on their bodies.

Being informed also referred to how the information was provided. It was important that it was provided in an interactive way (where women had the time for and felt comfortable in asking questions, voicing concerns), tailored to the specific needs of the woman and explained in non-technical language.

Sally [the physician assistant] made me feel so comfortable. I adore her so much. She just SAT WITH YOU and she wasn't you know she didn't have the big lab coats on. She wasn't you know HOW A LOT OF DOCTORS ARE. Very specific on what they do. (IMITATING A DOCTOR'S VOICE) "ok now you do this. Thisthisthisthis" and rush you out the door. SHE sat with me explained you know what was happening, WHAT WAS GONNA HAPPEN YOU KNOW, and then she was just very, she was just wonderful.

Sheryl, FHC, received medical Ab

Dignified care: Time. Women brought up the importance of time: staff's having time to listen to women's concerns, answer questions, and going through the counseling, gynecological and abortion procedures at a comfortable pace.

The counseling was, uhm, they took as long as they needed with each individual. However long the person needed, they got it. They asked you questions to so they have an idea what you feel like. And they made sure that when we had questions, they were answered.

Keri, WHC, Received Ab

you know I didn't feel like I was being rushed through. Which I sometimes feel like it you know there's LIKE A LONG LINE and you're kind of rushed through it. I felt like I could take my time. Ask as many questions as I wanted to that was very good.

Sally, FHC, Received Gyn

Time also meant respecting women's time: accommodating women's schedules in scheduling them, decreasing waiting time, and returning calls promptly.

Dignified care: Not a number. The most telling component of dignified care was being treated as a human being and not a number. Abortion or gynecological experiences elsewhere reflected becoming numbers in mass-produced service settings.

[in the previous clinic where I had an abortion] there was nothing personal. You didn't have a name, you got a number. I wasn't like who I am, I had no identity, I've been number 19. Uhh so that's difficult. Difficult. You think you're being poorly treated because of the situation you are in. LIKE like punished

.

Claire, FHC, received medical Ab

I was in that clinic from age 18 until age 25. I did not like that AT ALL. Because it was more like a birth control factory. You know, you go in there and they don't make you feel as warm, possibly like what you're doing is wrong. It's like an income-based thing where you go in and if you are just working part-time, then you only pay like 5 dollars FOR YOUR PILLS. THEY WERE GIVING, written information, telling you the risks, of being on

the birth control pill. They would give it to you and ask you to read it. But they weren't- they would just say do you have any questions. And I FELT LIKE, they were just, rushing people in and out.

Emma, FHC, Received Ab + Gyn

"Becoming a number" was closely linked with feelings of degradation, punishment and with dehumanizing/demeaning care. Agency factors in WHC and FHC, such as the homey atmosphere, the nice gowns, the chit-chat with the women, taking care not to show bloody instruments, and talking to the woman dressed first (before a gynecological exam) made the women feel treated in a humane manner.

Egalitarian care: Treated as a peer. Even though women did not express a desire to be more equal with their practitioners, they did notice and appreciate the peer approach seen in both centers in the friendly attitude of the staff and the encouragement to call the staff (including the doctors in FHC) with their first names.
[the staff was] JUST, VERY GENTLE. Almost like, like sisters type ?? NOT (Ayse: more like friends) But they're professional in that THEY DO THINGS WELL but- but the way they talk to you is like treat you like a peer. Very remarkable.

Emma, FHC, Received Ab + Gyn

Individualized care: Treated as an individual. There were individual differences among the women in their knowledge, experience, what they wanted, and their physical and emotional reactions to abortion and birth control. Women entered the services with different knowledge bases in abortion, birth control, pregnancy or childbirth and with varying good and bad experiences in previous gyn providers. This, I predict, is why women want care tailored to their specific knowledge, experience, and needs, which requires time.
[an ideal care for me] would be RESPECTING WHERE THE WOMAN IS AT you know (PAUSE) IN TERMS OF EVERYTHING LIKE, EMOTIONALLY, physically, mentally. Just trying to ASSESS where a woman is at and then work with her. AS OPPOSED TO LIKE FORCING your own agenda on someone you know. Before the woman walks in you know some doctors think they know what's best for women. And I think the most important thing is listening to people. And LIKE TRUSTING that THEY KNOW. If somebody came in. Somebody who doesn't know ANYTHING ABOUT ANY FORM OF birth control comes in AND IS TREATED THE SAME [ ] it JUST MAKES YOU FEEL kind of like they're not listening to you. You know. Or that they're not RESPECTING LIKE your knowledge you know. Just having a conversation with them first uh WHICH I GUESS lot of providers don't do it cause it TAKES TIME. They figure it's just easier to disperse the same information to everyone.

Sally, FHC, Received Gyn

Individualized care also meant privacy: receiving services in private and not feeling "herded". As discussed under "safety", for some women it felt good and safe to be in a place specialized to prevent pregnancy. Some others, though, still felt the stigma of abortion and wanted more private and individualized care, as opposed to group care which they viewed as "herding". Being in the waiting room with other women who came for abortion (in both places), watching a video in groups (in WHC, and previously in FHC as well), recuperating with other women in after care area (in WHC) were the activities that brought this "herding" feeling. These women viewed abortion as a "personal" and "private" issue.
Holistic care: Treated as a whole person. The last dimension of humane care refers to being recognized as a whole person. This was accomplished through having pamphlets and books on women's well-being in general (e.g. on violence against women), through providing non-reproductive services such as general counseling in WHC and massage in FHC, and through providers' emphases on women's overall health.

Reconceptualizing empowerment from an ethical perspective
In contrast to the definition of empowerment that emphasizes control (over one's life and decisions), these findings show that women define empowerment in reproductive services, not so much as control, but as safety and respect. The only three aspects that allude to power and control are receiving non-directive care without being cajoled into a decision in birth control and abortion services, the sense of empowerment that came from making the abortion decision and going through with it in a safe, validating environment, and being treated as a

peer. Even these are discussed within the contexts of safety and respect and without any direct mention of a sense of control.

Within the dimensions of empowerment, in terms access, time emerged as the main indicator of empowerment. Time in services and respecting women's time signified "dignified care" for the women. An aspect of empowerment, which in the literature reflects "access", is defined by women as an indicator of respect, care, and dignity; for women, recognition of their time and being given time meant being cared for and respected.

In terms of service delivery characteristics, women emphasized the importance of being informed and the way the information was provided. "Being informed" was an indicator of "humane care", of being "treated with dignity", supporting the "ethics of care" models where provision of information is an ethical issue.[31] Kols et al.[32] state that being treated with respect requires that a client be provided with full and correct information, courtesy, confidentiality, and privacy. Women in this study discussed information, courtesy, and privacy within the domain of humane care (respect). "Confidentiality" came up but was related to "emotional safety".

Women interpreting aspects of "access" (e.g. time), and "service delivery characteristics" (e.g. being informed, being provided choices, individualized care, and peer services) as ethical issues (as indicators of dignified, individualized, and egalitarian care) shows the need for reconceptualizing empowerment in reproductive health care as an ethical issue. While this might be more of a news for non-feminist/mainstream studies of 'quality of care', it nevertheless provides significant support for feminist researchers, practitioners, and ethicists who work on feminist models of care, revealing for the first time recognition by the women receiving reproductive care, of the ethics of care and its intricate relation to feeling empowered.

Empowerment and the Women's Health Movement

The centers stood out for the ways they addressed safety and dignity issues. While the centers addressed these issues, women's references to feeling vulnerable and receiving judgmental, directive, and inhumane care by other providers, where they felt rushed and treated like a number, means that after thirty-some years of struggle by the WHM's advocates, women still do not feel in control of their bodies and health in mainstream medicine. Instead, they feel vulnerable, judged, unsafe, and not respected by their providers. The need for physical safety -from violence- and fear of being judged for having an abortion, on the other hand, shows the success of the anti-abortion movement in stigmatizing and criminalizing abortion. Together these show the continuing effects of antiabortion movement and medicine on the WHM and women's sense of empowerment[33].

Women's empowerment and Medicine

Vulnerability. In the present findings, one of the components of "emotional safety" is "comfortable/comforting care" that address the vulnerability women felt in abortion and gynecological procedures, procedures that women perceived as uncomfortable, anxiety provoking, and sometimes abusive. At both centers, the homey atmosphere, the little extra touches such as tea and crackers in after-care, empowering messages on the walls, nice gowns (instead of paper gowns) for gynecological exams, and the behavior of the staff were strategies that alleviated the sense of vulnerability - the discomfort, anxiety, and nakedness. At both centers, women who received gynecological exams for routine care or for abortion follow-up care were dressed up when they first saw the provider. This sensitivity though lacked in abortion procedures, where women were already in the gowns (so half-naked) when they met the physicians for the first time.

These strategies also related to the "humane care", making women feel respected as human beings and not treated as numbers or medical objects. The relationship between vulnerability and respect is supported by Thomas'[34] study of fourteen feminist health centers, where she found that providing colorful gowns, mittens on stirrups, and allowing clients to be dressed up when first meeting the provider, constitute an important dimension of empowering care, which is treating all women with "respect and dignity." On vulnerability and medical control, interviewing female college students at SUNY Geneseo Campus about their interactions with their gynecologists, Griffith[35] found that women felt vulnerable, yet adopted a passive role in the interaction and did not challenge the medical authority of their gynecologists. The vulnerability women experienced derived from feeling "physically and psychologically exposed" to the gynecologist, caused by the nakedness and the powerless position (laying down with one's feet on stirrups and not being on an eye-level with the doctor), exacerbated by the fact that examination room was the first place they met the doctor while already naked and in a prone position. The women who saw themselves as active participants (asking questions or demanding more time with

the doctor) attributed it to personal strength rather than a recognition of the power imbalance in the situation and exercising their (collective) right to challenge the doctor's power. This, Griffith thinks, shows the failure of the WHM ideas and goals in reaching the current generation of young women.

Demedicalization. Increasing women's control over their bodies and health through demedicalization of women's life events and problems was the main aim of the WHM. In her analysis of the WHM, Ruzek[36] listed five main strategies women's health activists used to restructure health care and deinstitutionalize medical authority: (1) reducing the knowledge differential between patient and practitioner, (2) challenging the license and mandate of physicians to provide certain services, (3) reducing professionals' control and monopoly over related goods and services, (4) altering the size of the profession relative to clientele, and (5) transforming the clientele from an aggregate into a collectivity.

In order to reduce the power difference between professionals and women clients, women's health activists employed strategies like educating patients, practitioners, and law-makers, selective utilization of practitioners, and self-help activities.[37] Findings show that women clients value the provision of information, however they perceive as related to respect instead of power.

Except for a woman who was a nurse and wanted to be able to have over-the-counter Depo shots to give herself, none of the women brought up the importance of self-help. Between the two centers, only FHC had an explicit emphasis on self-help, which was realized in the past by both the information provided in their quarterly journal on a multitude of women's health issues (e.g. how to prepare your own menstrual pad, do your own cervical examination, fertility awareness, etc.), as well as by the groups held on such topics as cervical exams, lesbian health, endometriosis, hysterectomy, PMS, women and alcohol, etc. Both the groups and the journal were discontinued over time. Self-help was applied at both centers only at the level of information-providing. Except for the breast self-exams, there existed no self-help activities such as teaching women about cervical self-exams, taking one's blood pressure and pulse, or inserting a speculum, etc[38].

In order to challenge the license and mandate of physicians to provide certain services and reduce the professionals' control and monopoly over related goods and services, feminist institutions utilized paraprofessionals and lay women to challenge professional mandate and license of physicians. Thomas[39] found that most feminist centers that had empowering care used lay workers to reinforce the belief that women can learn about their health care from each other. In this study, only FHC used lay women in counseling, lab work, phones, and as technical and emotional help during abortion. The findings suggest that, even though the women recognized and appreciated the peer-like approach in both centers, they were not aware of the significance of having non-medical staff (lay workers) provide most of their care and did not interpret it as demystifying health services for them or as decreasing the doctor's power over their health. This vision of the WHM was lost to the current generation of women.

Regarding the last strategy, the "transforming the clientele from an aggregate into a collectivity", one of the goals of the staff at both centers was to have the women talk about abortion and participate in pro-choice rallies. Even though some women mentioned the need to talk about abortion openly, the findings discussed here such as women's judgments of self and others 'deserving an abortion', the ambivalence over abortion, and the overwhelming wish for anonymous and individual services (where abortion was seen as a personal/private issue and collectivity was seen as 'herding') reflect that women did not think of themselves as a collective force in reproductive services.

The antiabortion movement and empowerment

In her survey of fifty Women's Health Movement organizations, Morgen[40] found that among the three external pressures (the anti-abortion movement, the state, and the health care establishment), anti-abortion movement exerted the most negative influence on their structure and work. In this study, the effects of the antiabortion climate and violence on the work of the agencies and women's sense of empowerment are evident in the emphasis on physical and emotional safety. The security measures centers adopted as responses to attacks addressed these concerns, yet also became constant reminders of their unsafe and defensive status. I believe that such security measures, while necessary, sadly contribute to what I call 'recriminalization of abortion' and 'normalization of violence'. The senior staff at both centers recalled the traumatic transition from providing abortions without any safety concerns to providing them under high security and constant concerns.

The recriminalization of abortion and normalization of violence reveal the success of the antiabortion movement in putting the WHM, its movement organizations (i.e., women's health centers), and the women receiving care on the defensive where violence against abortion is normalized. For a generation of women in reproductive care, who do not have the memory of the earlier times when security was not a concern at clinics, the current high security might give the impression that something wrong, even criminal, is done in these settings. It is the women -and their providers- who are under lock and key to provide/receive a service that is protected by law. Moreover, the violence became normalized. Women expect protests in front of centers, comparing centers in terms of relative safety. The influence of the antiabortion movement in the society at large and within medicine can also be seen in women's experiences of judgment by other providers (including own ob/gyns) and their family for using abortion services, and their internalized judgments on themselves and other women for "deserving reasons" for abortion.

The results of this study, women's sense of empowerment (as safety and respect) and its implications for feminist ethics and care are context-dependent; they are meaningful within the socio-historical context of U.S., that comprises a highly privatized and medicalized (and technomedicalized) health care system and an organized violent anti-abortion movement. I would like to raise the need to explore how women in reproductive care perceive empowerment/dignified care and existence of and possibilities for feminist care in non-U.S. (Turkish, European and other) settings. Without having done a thorough study of the Turkish health system historically or in its current status (which would be my next project), based on reproductive care experiences I hear and my impressions, I would predict that the meaning and experience of empowerment (including safety and respect) would be quite different in the Turkish system which is becoming increasingly privatized (with private hospitals, clinics and insurances), where women's health is not as overly medicalized as in the U.S. though shows of some signs in that direction, especially in the increasing rates of 'elective' C-sections, where abortion has not been politicized, there is no organized anti-abortion movement, yet women's sexuality (especially those of young and unmarried women's) is strictly regulated by family, schools, government, and doctors. I think that varying by socioeconomic class, age and marital status, women might emphasize the need for confidential and non-judgmental services from providers. Yet, as different from the U.S. where abortion is mostly provided in clinics and thus is in the public eye, confidentiality and judgment for Turkish women who receive abortions from private gynecologists or hospitals might be more related to provider and family attitudes on/attempts to regulate their sexuality. In a discussion on a Turkish feminist listserv to which I belong, through a staff member of a woman's organization in the Southeast of Turkey who recounted her experiences with three women in the city of Van who got help for abortion, and an article another person sent from www.sendika.org,[41] I learned that women who needed abortions in Istanbul were increasingly denied services in public hospitals who required wedding certificates and/or signatures of the husbands, all of which is reported as illegal and due possibly to the increasing neoliberal policies of the current government. In this sense, there is a need to study the attitudes of providers in a larger context, exploring the links between neoliberal policies (which blend privatization and social conservatism) and reproductive health in settings where abortion (or birth control) had not been previously politicized.

Increasing privatization could lead to reproductive services with limited access and higher inequalities in care. Increasing privatization and medicalization could together lead to services where women feel rushed, not provided with adequate information, and treated as numbers and not humans in a mass-produced service setting, bringing up again the need for dignified care. Since, to my knowledge, there has not been an organized women's health movement in Turkey, it would be interesting to explore existing feminist or pro-woman reproductive care (where it happens, what type of care it entails) and possibilities for creating new models.

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[2] Linda Gordon, Woman's body, woman's right: Revised and updated) Birth control in America (New York: Penguin Books, 1990). Sheryl Burt Ruzek, The women's health movement: Feminist alternatives to medical control (New York: Praeger Publications, 1978).

[3] For a more recent theorizing/critique of medicalization in the U.S. that charts the transition from medicalization to biomedicalization and technoscientific biomedicalization, please see Clarke, Adele et al, "Biomedicalization: Technoscientific transformations of health, illness, and U.S. Biomedicine" *American Sociological Review* 68 (April 2003): 161-194

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[5] Morgen, Into our own hands.

[6] Judy Norsigian "The women's health movement in the United States" in Man-made medicine: Women's health, public policy, and reform, ed. K. L. Moss, 79-97 (Durham: Duke University Press, 1996).

[7] Morgen, *Into our own hands.*

[8] Zimmerman and Hill, "Reforming gendered health care".

[9] In the U.S., individuals receiving health care are referred to as 'patients' (in the medical system), as clients (in the human services system) and as customers (in the insurance system), all of which are problematic, especially from the feminist perspective, for their definition of women as either dependent on the medical system or as the so-called agents/choice makers within a free-market system. To get away from medicalization, the staff of the feminist centers I researched, especially FHC, referred to women as their 'clients' which, though better than consumers, is still trapped in a capitalistic discourse. As my friend and colleague Brigitte Marti points out, due to human service connection serving disadvantaged populations (e.g. homeless, immigrants, public aid recipients), term client might also be actually more disempowering, for its association in a capitalist system, with more dependency and stigma than a customer. Throughout this paper, I use 'clients' as the scholars used it in literature but as 'women receiving care' when I discuss my own findings.

[10] Gordon, *Woman's body, woman's right*.
Norsigian, "The women's health movement in the United States."

[11] Morgen, *Into our own hands,* 149.

[12] Zimmerman, "Women's health and gender bias in medical education"

[13] Thomas "Incorporating empowerment into models of care."

[14] **A note to readers on the U.S. Health 'System'**

The United States health care system is a private employment based system, built on incomes rather than needs, where people obtain insurance through full-time employment or as dependents (spouses or children) of employees. This creates huge health care inequalities, leaving those who are unemployed, work at jobs that don't provide health insurance, women and others –such as immigrants- who work in the informal sector (including 'domestic' work/working as housewives or maids, etc.) to lack health care.

The three publicly funded but weak safety nets are Medicaid, SCHIP (State Children's Health Insurance Program) and Medicare. Medicaid and SCHP provide care for extremely low income families, allowing access only to only a limited number of doctors who *accept* to see this deprived population. Populations under these two programs are stigmatized and women who, generally, have lower income security, are particularly in danger of receiving little to no care. Medicare is a government program for people over the age of 65, which through the privatization of some of its services led to a decline in the coverage of elderly people with limited revenues.

The history of the privatization and consequent commodification of health care and health can be tracked to the Reagan administration who, believing that the free market would solve the problems of cost and accessibility of health care, put together a business plan inviting investors and venture capitalists to invest in health care. The traces of this rationale to privatize could be found in a 1961 dated report "Annals of the American Academy for Political and Social Science, v. 337" as beliefs that: (1) the private insurance industry would respond quickly to a changing medical economy, (2) the US with its developed private resources was more prepared than other nations to provide real alternatives in health care, and (3) it was just a matter of time for the private insurance industry to achieve its full potential. Exported to the developing countries through the World Bank and IMF (e.g. through the Structural Adjustment Programs), this belief system –of health care and health as commodity/commerce to be regulated by financial and not health institutions- became globalized and lead to privatization of curative medicine, including charging of user fees in public clinics, etc.

Clarke et al. (2003) discuss this commodification process within the major transformations of the U.S. medicine. She discusses three transformations as: (1) medicalization (1980-1945) where allopathic medicine and its allied fields of nursing etc, were established as the legitimate medicine (pushing out of the field women who practiced medicine as healers), (2) biomedicalization (1945-1980) where medicine fused with biological sciences grew as an institution through major private and public investments and larger areas of life (deemed healthy or ill) became under medical jurisdiction, and (3) technoscientific biomedicalization (1985-present) where medicine was transformed inside out, with increased privatization and commodification of health, centralization of services (that led to health monopolies but not to efficiency), increased use of invasive technologies in health care, and health becoming a personal moral responsibility of the individual and not that of community or government.

In terms of the last stage, Clarke et al note the transition from public to private funding of medical research (e.g. research funded by pharmaceutical companies), especially problematic given that industry-sponsored research is 3.6 times more likely to produce results

favorable to the sponsoring company, and do suppress researcher access to and use of data.

Health care industry is big industry in the U.S., where the system is expanding globally through the privatization of public services (including health) through Structural Adjustment Programs imposed on other countries, and through the multinational pharmaceutical companies. According to a 2000 study of the National Policy Forum, U.S. accounts for the largest proportion of the world market of pharmaceuticals. Inside the U.S., health care spending makes up 15.3 % of the GDP (Gross Domestic Product), with profits due to capitation on health care dollars, denial of treatment, enrollment to health care private plan with restrictions link to pre-existing conditions (e.g. a C-section might be considered a pre-existing condition).

While Americans pay the highest money for health care, the system is very fragmented (with multiple insurers and regulations varying state by state) and offers limited guaranteed care. According to OECD, the United States ranks 37th in health care in the world with the highest maternal and infant mortality rates in the industrial world. In terms of women's health, 21 million of women and girls are without any coverage. Women are more likely to be dependent than men when private insurance covers a family. Including a very limited public option and requiring everyone to purchase insurance in an already privatized system, the recent Health Care Reform bill that passed the Senate in Dec 2009 unfortunately may not lead to a major change in the existing health care structure.

Contraceptive and Abortion Care and Feminist Health Centers

As with general health care, reproductive health is also not covered universally. Women's access to contraceptive and abortion care are affected by insurance coverage, medical training and practice, and legal regulations. In terms of coverage, while almost all insurance plans cover prescription drugs, many still do not cover the range of FDA (Food and Drug Administration)-approved contraceptive drugs and devices (devices like the IUD, patch, etc). Even when 27 (of the 50) states require insurers who cover prescription drugs, to provide coverage for the full range of FDA-approved contraceptive drugs, devices, and services, 20 of these do allow employers and insurers to refuse to comply with this mandate based on religious ground (Allen Guttmacher Institute, Dec 2009). Studies conducted by the Kaiser Family Foundation and Allen Guttmacher Institute show the range in abortion coverage by insurers (private and public) to be between 46% (found by Kaiser) and 87% (Allen Guttmacher Institue, 2009).

In terms of legal regulations, abortion is federally protected by the 1973 U.S. Supreme Court decision on Roe v. Wade, which recognized that women, in consultation with their physician, have a constitutionally protected right to have an abortion in the early stages of pregnancy –before viability. The framing of women's right as a 'right to privacy' between a doctor and a woman, and until viability, left open for many restrictive regulations starting immediately with the Hyde Amendment (1976) prohibiting federal funding of abortions, to more current laws adopted by states on requiring only physicians to provide abortions (38 states), putting a ban on late term abortions (16 states), requiring women to go through counseling (17 states) , wait 24 hrs (24 states), and minors to get their parents/parental guardian's consent for an abortion (35 states), to the current attempt with the 'Stupak-Pitts Amendment' to the health care reform bill in Nov 2009, to prohibit private insurance coverage of abortion, which passed the House but not the Senate. Abortion access is also limited by lack of providers (87% of all U.S. counties lacked an abortion provider in 2005) which is tied to abortion not being a required part of ob/gyn training in U.S., the stigma attached to the practice in medicine, and the reality of violence against doctors performing abortions, especially visible in clinic practice.

It is in such a legal and privatized medical environment that feminist health centers operate. Founded mostly in early 70s following Roe v. Wade, to provide low-cost abortion and gyn care to women in a nonmedicalized manner, these centers navigate the state laws, private insurance system, competition with others including Planned Parenthood a national organization with more funding and visibility, the lack of abortion providers, and anti-abortion attacks, to provide their feminist mission and services while keeping afloat and being able to pay for their staff. Women can receive abortion or gyn care from their obstetrician/gynecologist (ob/gyn), hospitals, Planned Parenthood clinics, or feminist centers. While all of these facilities offer abortion care, the majority of abortions (93%) are performed in the U.S. in clinics, with 5 % performed in hospitals, and 2% in physicians offices (Allen Guttmacher Institute, 2009). Young women, low-income women, and women of any economic background who do not want to go to their own ob/gyn for confidentiality or fearing their judgment, use these clinics (feminist or Planned Parenthood) for abortion. Young women also use clinics for confidential contraceptive care.

In my research, WHC operated in a state which had laws on mandated counseling, 24 hr waiting period and parental consent for minors. FHC was in a state without these restrictions and did not have physician-only clause, which would allow them to train their physician assistant to do abortions, which was not possible due to refusal of their physician who was the medical director of the center. For FHC, the laws regulating gyn exams, liability issues and reimbursement from insurance, also disabled them from using lay women (without a medical background) to do cervical exams and fit women with diaphragms, which was important to show women that such practices were unnecessarily mystified by medicine, and could with training, be provided by women for women.

While I put together the information on contraceptive and abortion care and the centers, the information on the U.S. health system was compiled by Brigitte Marti, a health scholar and activist, co-chair of the Conversation Coalition (www.conversationcoalition.org). I am indebted to Brigitte for this information, and share her perspective on the need to have health systems where health (and as relevant to here, women's health) is treated as a human right and not a for-profit endeavor, a commodity. The latter perspective leads to dehumanized and inefficient health care, as seen in the U.S. and increasingly in other countries through capitalist globalization.

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[21] Kols et al. "Ethical foundations"
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[23] Kols et al. "Ethical foundations"
[24] Sherwin "A relational approach to autonomy"
[25] "Feminist Health Center" and "Women's Health Center" are pseudonyms used to protect the confidentiality of the staff and clients of these centers
[26] In terms of surgical abortions, FHC provided first-trimester abortions with local anesthesia and WHC provided abortions up to 16 weeks with local or full anesthesia.
[27] Staff interviews included questions on the history, organizational structure, aims of the agency, on the services (birth control and abortion options provided, waiting times, what happens in typical gynecological or abortion visits, etc.), as well as personal demographics, support from other staff and clients, beliefs on reproductive issues, and personal goals and motivations. Interviews with women included questions on demographics, how the women chose to come to the center, services received, views on the center environment and staff treatment during visits (and comparing these to other providers), description of the last visit, sources of information on reproductive issues, and description of their ideal reproductive service. Women I interviewed and observed were mostly White, ranged in age between 18 and 40, with the mean age for interviewees being 28 for WHC and 29 for FHC. Women at both sites were mostly single (unmarried or divorced) with the overwhelming majority (10 and 11 out of 12) being in stable relationships. Out of the 12 women interviewed at each site, five in WHC and six in FHC paid for services out of pocket, three in WHC and five in FHC paid with insurance.

[28] Founded in the U.S. in 1986 by Randall Terry, Operation Rescue is an extremist antiabortion organization that is involved in sit-ins, protests, as well as blockades and occupation of women's centers that provide abortions. The recent killing in May 31, 2009, of Dr. George Tiller of Wichita Kansas, was by Scott Roeder, who was affiliated with Operation Rescue. Dr. Tiller was one of only three physicians in the U.S. who provided abortion services for women who were beyond twenty-six weeks pregnant. Tiller was targeted by the group for a long time. His Wichita clinic was bombed in 1986, and he was shot five times by an antichoice extremist in August 1993 during Operation Rescue's "Summer of Mercy" (Angie Young "Abortion, Ideology, and the Murder of George Tiller" *Feminist Studies* 35, no. 2 (Summer 2009).

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[29] The capital letters in quotes denote the places in the interview where the speaker raised their tone of voice.
[30] All staff and client names used here are pseudonyms. Ab, Gyn, or Ab + Gyn refer to whether women received from the agency only abortion services (Ab), Gynecological services (Gyn), or both (Ab + Gyn).

[31] Kols et al. "Ethical foundations"
Sherwin "A relational approach to autonomy"
[32] Kols et al. "Ethical foundations"
[33] In the larger study, I discuss in more detail how both centers negotiated the pressures from state, antiabortion movement, and medicine in their attempts to provide empowering services to the women.
[34] Thomas "Incorporating empowerment into models of care"
[35] Pamela J. Griffith "Medical and social dynamics of college women's interactions with their gynecologists" *Sociological Inquiry*, 67 no. 4 (1997): 397-408.

[36] Ruzek, *The women's health movement*.
[37] Ruzek, *The women's health movement*.
[38] In discussing the absence of self-help activities, I wonder whether medical abortion can be considered a form of self-help.
[39] Thomas "Incorporating empowerment into models of care"
[40] Morgen, *Into our own hands.*
[41] For the article in Turkish, please see http://www.sendika.org/yazi.php?yazi_no=23136