Permeability of public and private spaces in reproductive healthcare seeking: Barriers to uptake of services among low income African American women in a smaller urban setting

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A B S T R A C T

This study was undertaken in partnership with a publicly funded reproductive healthcare organization to better understand barriers to utilization of its services as perceived by low income African American women in its community and how those barriers might be managed. The study uses a place-based, ecological perspective to theorize privacy challenges across different levels of the communication ecology. Analysis of participant observation, interviews, and focus group data identified three key public-private problematics in African American women’s experience of reproductive healthcare seeking in a smaller urban setting: a public-private problematic of organizational identity, of organizational regions, and of organizational members. Potential strategies are identified for managing these problematics by the organization and community members.

1. Introduction

Publicly funded reproductive healthcare organizations, which emerged in the context of the Women’s Health Movement of the 1960s and 1970s (Nichols, 2000), face unique challenges in their interactions with consumers. Such organizations offer contraceptive care and other reproductive and sexual healthcare services with support from joint federal-state Medicaid; approximately half also receive funding from Title X of the Public Health Service Act (Guttmacher Institute, 2013), a federal program to support family planning services (Gordon, 2002), screening for sexually transmitted infections, HIV testing, breast and cervical cancer screening, and patient education (U.S. Department of Health and Human Services, Office of Population Affairs, 2013). These organizations’ missions explicitly encompass providing education and services to the underserved, including low income racial and ethnic minorities, who are disproportionately affected by unplanned pregnancies (Finer and Zolna, 2011), sexually transmitted infections (Altman, 2008), HIV and AIDS (New York State AIDS Advisory Council, 2005) and reproductive cancers (National Institutes of Health (2006)) — at least in part because of lack of access to healthcare. They are an important source of comprehensive reproductive healthcare services in both urban settings and smaller towns and cities (Frost et al., 2012). However, these providers face challenges in achieving their mission because of the sensitive nature of reproductive and sexual health (Lichtenstein, 2003), which can be further complicated in a smaller urban community setting and the challenges to privacy it presents (Garside et al., 2002).

The study reported on here was undertaken in collaboration with a publicly funded reproductive healthcare provider referred to here as Women’s Healthcare Services or WHS. Located in a smaller urban population center in New York State designated here as Riverton (population approximately 6700), WHS provides comprehensive reproductive healthcare services including contraceptive care, STI screening and treatment, HIV screening, breast and cervical cancer screening, and abortion services. At the time of the study, WHS found its services underutilized, especially by African American women: in a community where African Americans constitute approximately 25 percent of the population and are

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disproportionately represented among the lower income residents of the town (U.S. Census Bureau, 2010), only 8 percent of WHS’s clients self-identified as African American. Because access to specialized reproductive healthcare is limited in the region, and WHS is Riverton’s only publicly funded provider, the center’s continuing viability has considerable significance for the reproductive health of local low-income minority women. The impetus for this study, therefore, was the organization’s desire to better understand barriers to utilization of the healthcare center as perceived by low income African American women in the community, combined with the author’s commitments to engaged research on reproductive health disparities.

2. A place-based ecological perspective on a healthcare organization’s relationship with community members

Understanding the challenges faced by a publicly funded reproductive healthcare provider in a smaller urban setting was approached in this study from an ecological perspective (Street, 2003; Stokols, 1996). Fundamentally, an ecological approach to health is concerned with understanding “interrelationships between organisms and their environments,” including — in the context of healthcare encounters — organizational, cultural, media, and political-legal contexts (Street, 2003, p. 63). Ecological approaches also emphasize the physical dimensions of the organism—environment relationship, assuming the “physical and social facets of settings [to be] closely interlinked and capable of exerting independent as well as joint effects on occupants’ well-being” (Stokols, 1996, p. 286). Thus, from the perspective of the healthcare organization WHS, the members of the community in which it is physically located constitute one of its environments — more specifically, its cultural context — which shapes the meanings that the organization and its activities hold for community members. From the perspective of individual community residents, WHS constitutes part of their environment when they consider where to seek reproductive healthcare services. Environments beyond the local community that influence WHS and its interactions with the community include the professional norms of the clinicians, and the patient privacy rules outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These constitute a political–legal or what some health organization scholars have labeled an “institutional” context (Lammers and Barbour, 2006). The contentious nature of women’s reproductive and sexual health in the political–legal realm (Gordon, 2002), along with media coverage of these issues, represents still another context for the healthcare organization–client interaction, which permeates the local community. Collectively, these proximate and distal contexts may be understood as constituting a particular “space” of interactions related to seeking and providing reproductive health (Cummins et al., 2007). This “space” is in turn tied to a particular “place,” understood as a physical location bound up with subjects’ experience of it and their intersubjective construction of it (Escobar, 2001; Kelly, 2003).

3. The dual public-private nature of reproductive healthcare seeking

A place-based, ecological perspective inherently calls our attention to an organization’s permeability to its environment and thus problematizes the boundaries between public and private. In their overview of ethnographic research on hospitals, Street and Coleman (2012) argue that hospitals are “simultaneously bounded and permeable... both sites of social control and spaces where alternative and transgressive social order emerge and are contested” (p. 5). Hospitals, they note, are permeable in the sense of patients and staff moving in and out of them from the surrounding community, as well as being permeable to the culture of the society in which they are embedded; at the same time, they are highly regulated, bureaucratic organizations. While WHS is not an in-patient facility, it displays these same characteristics.

The dual public–private nature of healthcare organizations assumes particular significance in the context of reproductive and sexual health services. As Petronio (2000) explains, “People define personal information as private because it reflects issues that matter deeply to them,” and because “revealing private information has the potential for making us vulnerable” (p. 38). In fact, the U.S. Supreme Court’s ruling in Roe v. Wade, affirming a woman’s right to choose to terminate a pregnancy, is grounded in the argument of a right to privacy (Roe v. Wade, n.d.). When the reproductive healthcare organization’s setting is a smaller urban population center, and the healthcare seekers are low income African American women, the public–private nature of healthcare seeking assumes additional complexities.

4. Low income African American Women’s privacy concerns with reproductive health

While all women’s bodies are potential sites for struggle over privacy and autonomy, Holloway (2011) observes that intersectionalities of race and gender produce different effects for white women and minorities; she traces the compromising of African American women’s bodies with respect to privacy back to the (public) economic interest in their reproductive capabilities under slavery. Crenshaw (1991) reads African American women’s reluctance to report domestic violence as an effort to redress this compromised privacy. She sees this as part of a “generalized community ethic against public intervention, the product of a desire to create a private world free from the diverse assaults on the public lives of racially subordinated people” (p. 1257). Therefore, seeking services from a healthcare provider under public scrutiny may feel particularly problematic for African American women, especially when that scrutiny takes the form of public condemnation of the organization by some members of the community (both white and African American) for offering services that they associate with private sexual (mis)behavior: contraceptive care for teens, STI testing and treatment, and abortions.

In addition, African American women may accord special significance to privacy in the context of reproductive health issues because of the ways their sexuality has been culturally constructed in the United States (Rose, 2003). Collins (2000) argues that African American women’s “holding fast to privacy” is the product of “a U.S. culture that routinely accused Black women of being sexually immoral, promiscuous jezebels” (p. 125). Class represents another powerful dimension of intersectional identities in reproductive health matters. Poverty disadvantages women in relationship to the healthcare system in the United States in terms of inequities of knowledge, power, and access (Holloway, 2011). In turn, privacy, understood as control over personal information, may assume greater importance as a resource in personal control for women who are otherwise under-resourced (Trethewey, 1997).

At the same time, low income African American women must not be essentialized. Historically, African Americans’ responses to family planning clinics introduced with support from Title X funding have ranged from enthusiastic approval as resources for improving poor women’s reproductive health to condemnation as tools of genocide (Gordon, 2002). As this study’s findings affirm, low income African American women may differ markedly in their positions on such matters as youth sex education and abortion. Crenshaw (1991) contends that “intersectionality [is] broadly useful as a way of mediating the tension between assertions of multiple
identity and the ongoing necessity of group politics” (p. 1296), which in the context of this study is linked to the construct of reproductive minority health disparities. It is these systematic differences in the incidence and outcomes of reproductive and sexual health-related diseases that impels investigation into the use of the WHS health center and its protection as a resource for low income African American women.

In summary, low income African American women of Riverton face multiple potential threats to their privacy, which are intertwined with the public-private nature of reproductive healthcare seeking and the particularities of their community. Viewing their experience of seeking reproductive healthcare through the lens of a place-based ecological perspective, the research questions that this study asks are

RQ1: How do low income African American women socially construct the experience of seeking reproductive/sexual healthcare services in a smaller urban setting (both generally, and from the local publicly funded provider more specifically)?
RQ2: What privacy concerns do low income African American women in a smaller urban setting express in connection with seeking reproductive/sexual healthcare services (both generally, and from the local publicly funded provider more specifically)?

5. Research procedures

5.1. Research setting, participants, and data collection

Consistent with the study’s place-based ecological perspective, data for this study included participant observation within the organization (52 h over 4 months in 2006, from the vantage point of a volunteer), field observations in the organization’s community setting, 28 interviews with local African American women, and 2 focus group discussions (1 with 10 African American women residents in public housing, and 1 with 8 African American women from the wider community, who were recruited with the assistance of the leader of a local culture and arts association). The WHS health center was located on the outskirts of Riverton on a busy suburban street with multiple businesses and shopping centers nearby. It was the sole commercial tenant of a building separated from the street by a large parking lot. On entering the center, clients encountered a reception area where they were asked to sign in, complete necessary intake paperwork, and wait to be called into the clinical area, which was separated from the waiting area by locked doors. The health center’s staff, at the time of this study, included two African Americans – the center manager and one nurse; the rest of the staff – a physician, physician assistant, nurse, and receptionist – were white.

With approval from her university’s Institutional Review Board and the research office of WHS’s parent organization, the author recruited participants primarily through flyers and tabling in Riverton’s public housing complex, where a large number of the city’s low income minority women reside. Most interviews were conducted in the community room of the public housing complex for the convenience of participants. Alternative locations, at participants’ request, included the author’s office, participants’ homes, and an office at WHS. Participants were informed of the purpose of the study and the measures that were being taken to ensure the confidentiality of their responses. Because of the potentially sensitive nature of reproductive health concerns, no identifying information was collected for any participants, and the women chose their own pseudonyms. Demographic information collected included participants’ ages, whether they were currently getting annual gynecologic check-ups, their form of health insurance (if any), and whether they had any relationship to WHS. Most interviewees were insured through Medicaid. Participants’ ages ranged from 18 to 68, with an average of 41. Interviewees included 3 current WHS patients, 5 former patients, 8 women with family members who were former patients, and 12 women with no connection to the health center.

The interview schedule, developed in collaboration with WHS, asked participants to identify where they obtained reproductive health services (if anywhere), how they came to use that provider’s services, and to describe the quality of their interactions with the healthcare organization and its staff. Participants were also asked for their perceptions of WHS and to identify any reasons why they would choose or not choose to use its services. Typically, interviews lasted approximately 20 min though several were significantly longer.

The focus group guide, to protect participants’ privacy, posed general questions on what participants looked for in choosing a provider of reproductive healthcare services rather than questions on their specific experiences. In addition, it included discussion of advertisements produced for local media channels by WHS. Focus group discussions lasted approximately 1 h; one took place in the public housing complex community room, and the other at the offices of the culture and arts association. All interviews and focus group sessions were audio recorded and transcribed in their entirety, resulting in 271 pages of single spaced transcripts.

5.2. Data analysis

Analyzing discourse elicited in interviews as a means of understanding women’s choices in accessing reproductive healthcare is rooted in a social constructionist and symbolic interactionist orientation to language and human social life, which links meaning to action, both in how meanings are produced (through social interaction), and in how meaning guides action; i.e., “human beings act toward things on the basis of the meanings that the things have for them” (Blumer, 1969, p. 2). The interview, as a method of data generation and collection, is understood to be an “active,” “interactive, interpretive activity” (Holstein and Gubrium, 2004, p. 140). Thus, the interactional interpretive activity that takes place during the interview is understood as a process not apart or different from other sense-making activities of participants, but rather as another occasion to utilize and display the procedures and resources used to apprehend, organize, and represent reality (Holstein and Gubrium, 2004, p. 149). At the same time, this perspective also recognizes the importance of the materiality of WHS and its surrounding environments (Orlikowski, 2007; Stokols, 1996); for example, where in the community the health center is located, the configuration of its parking lot, the size of its waiting room. In sum, the analysis, while emphasizing the importance of place to healthcare seeking, is at the same time grounded in the assumption that places “are intersubjectively as well as culturally constructed, tak[ing] us beyond consideration of the physical space in which people live and seek healthcare” (Kelly, 2003, p. 2280).

Analysis of the interview and focus group transcripts and field observations was a multistage process informed by the grounded theory or “constant comparison” approach (Strauss and Corbin, 1990). As Clark (2007) elucidates this approach, “theorizing is generated by tacking back and forth between the nitty-gritty specifics of empirical data and more abstract ways of thinking about them” (p. 424). Although the grounded theory method is intended to be primarily inductive, and Strauss and Corbin (1990) exhort researchers to attempt to bracket existing notions about a phenomenon, the method does not preclude the use of previous theoretical and empirical research to heighten what they refer to as the “theoretical sensitivity” of the researcher. Moreover, they
advise that seeking out such research also should not be confined to the pre-field or pre-data collection phase of the research process; it should be on-going throughout the research process. The source of categories is thus both emergent from the data and informed by existing research.

As with most qualitative research, giving a complete account of the entire analytic process is beyond the scope of this report. To give a sense, however, of how the analysis evolved toward the findings presented here, I present a simplified and truncated version of the process, which reflects the “tacking back and forth” described by Clark. Initial coding of participants’ responses used the major categories of (a) clinician preferences (with respect to race and gender); (b) experiences of WHS clients; (c) factors in choosing a provider; (d) perceptions of other African American women in the community; (e) perceptions of WHS by women who were not WHS clients. Perceptions of WHS by clients and non-clients were consolidated and then categorized into positive and negative constraints. As privacy emerged as a theme of significant interest, clinician preferences with respect to race and gender dropped out as a relevant category for the purposes of this report, based on the content coded in this category. A set of interim coding categories is presented in Table 1, which formed the basis for theorizing the set of public-private problematics described in the findings below. The delineation of the physical regions of the clinic and their relationship to privacy emerged in participants’ talk, as well as through field observations of the author while working at the clinic as a volunteer.

In summary, the methods used in this study comprised an iterative set of processes of data collection and analysis (via coding), consulting research literature, and memoing to track the development of the researcher’s ideas about the data and to exercise reflexivity. NVivo qualitative data analysis software was used to assist in coding and retrieving data. Consistent with the recommendations of qualitative research experts (see Bradley et al., 2007) who argue for the sufficiency of a single researcher conducting all coding, and even the preferability of a single researcher/coder when the nature of a study is such that a researcher brings contextual knowledge that a second coder could not share, the author developed the coding structure and applied it to the data.

6. Findings and interpretation

Initial data analysis revealed four main potential barriers to use of WHS services by low income African American women. First, 25 percent of the women interviewed individually reported not obtaining reproductive health services at all in the preceding year; the barrier, therefore, was declining to seek routine reproductive healthcare in general rather than at WHS in particular. Second, the healthcare center’s location on the outskirts of town — not within walking distance of the public housing complex — made access difficult. Third, WHS’s organizational image among the study’s participants was complex, including both a prominent identity as a crisis care provider (i.e., a place that treats STIs and offers abortion services), as well as a caring and compassionate provider of reproductive and sexual healthcare services. Fourth, as residents of a smaller urban center, African American women in Riverton reported strong privacy concerns in seeking reproductive healthcare. Because privacy concerns emerged as such a prominent and complex issue in the context of this community, further analysis foregrounded that theme and its relationships to the physical location and configuration of the health center, and to WHS’s organizational image.

The iterative analysis of field notes, interview accounts, and focus group transcripts resulted in identification of three public-private problematics in African American women’s experiences of reproductive healthcare seeking in a small urban setting. To provide context for these problematics, I first present an overview of WHS as a material and social environment, and the environments that surround and interpenetrate it. Fig. 1 presents a graphical representation of these elements.

The clinical area of the healthcare facility is at the center because this is where the activities take place that are at the heart of WHS’s mission and identity, and that represent the ultimate goal of reproductive healthcare seeking. From a place-based ecological perspective on relation to privacy concerns, in this area, health information is closely controlled by organizational and institutional rules. Proceeding outwards, the next environment is the WHS waiting room area, which is physically a part of the healthcare center but identified as a separate environment from the clinical

<table>
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<th>Table 1</th>
<th>Interim coding categories.*</th>
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<tr>
<td><strong>Category</strong></td>
<td><strong>Subcategory</strong></td>
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<tr>
<td>Factors in choosing a provider</td>
<td>Recommendations from friends/family&lt;br&gt;Privacy safeguards (keeping your business out of “the street”)&lt;br&gt;Location/accessibility&lt;br&gt;Quality of communication/Continuity of care</td>
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<td>Perceptions of WHS</td>
<td>Negative associations&lt;br&gt;Crisis care provider (abortion and STI treatment)&lt;br&gt;Targeted by picketers&lt;br&gt;Privacy concerns (because of being seen by other community members there as patients, or by clinic employees who are also community residents)&lt;br&gt;Focuses only on teens/encourage teens’ sexual activity&lt;br&gt;Positive associations&lt;br&gt;Helpful/caring/community resource&lt;br&gt;Protects your privacy&lt;br&gt;Safe place/trust/comfortableness&lt;br&gt;Always there for you/you can just talk</td>
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<tr>
<td>Perceptions of other African American women in the community</td>
<td>Into each other’s business/judgmental&lt;br&gt;Not taking care of themselves/not seeking healthcare services&lt;br&gt;Anti-abortion/conservative&lt;br&gt;Polite/friendly</td>
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* The four most commonly coded subcategories are presented in each category.
area because of the differences in boundary permeability, its relationship to other environments, and the (in)ability of individuals to control information about themselves. The next environment is the community itself: the city of Riverton and its residents, including residents who sometimes picket WHS at the edge of its parking lot, and the low income neighborhood where most of the study’s participants resided. Participants frequently referred to the public dimension of their local communicative environment as “the street.” The graphical representation of WHS and its environments indicates where one environment is most permeable to another environment (with the understanding that all spaces associated with healthcare organizations are to some extent permeable to extra-organizational actors; see Quirk et al., 2006; Stoller, 2003; Street and Coleman, 2012). The nature of these permeations and their implications for privacy are discussed in the context of three public-private problematics: organizational identity, organizational regions, and organizational members.

6.1. Public-private problematic of organizational identity

The public-private problematic of organizational identity in the context of this study refers to the tensions between the social constructions of WHS’s identity in the public sphere of the community and WHS’s own expressions of organizational commitment to providing fully comprehensive reproductive/sexual healthcare while safeguarding its patients’ privacy. Put another way, this problematic reflects the tension between the publicity of the contest over the organization’s image, and the intensely private nature of the services that the organization provides, which has significant implications for women considering seeking services there.

All organizations have as one of their tasks communicating an identity to an external audience, addressing questions such as “who are we,” “what services do we offer,” “what values are we committed to.” However, an organization’s audiences may also articulate their own versions of an organization’s identity (Cheney and Christensen, 2001). Competing constructions of WHS’s identity existed within the public sphere of the community. Its supporters discursively constructed the center and its staff as caring and compassionate, and offering care without judgment, which has been identified as a key concern in seeking reproductive healthcare services, especially among younger women and adolescents (Olsen et al., 2002). As one young woman in this study noted, “Even if it wasn’t a situation about sex, you could go and still talk about anything and have the confidence of knowing that they were going to be there for you” (Mickey). Adjectives that recurred frequently in participants’ characterizations of WHS were “helpful” and “understanding.” Those who used the center’s services also underscored its commitment to privacy. A former teen peer educator noted that it had been stressed to her “that even being a peer educator, you are not like seeing patients but what people tell you, you can’t repeat. Or you can lose your job. Yea, I am pretty confident [that WHS protects patients’ privacy]” (Cookie). The author’s own training as a volunteer likewise heavily stressed the organization’s commitment to absolute confidentiality in its services. Some participant discourse also praised WHS’s mission to “provide education” and “give you resources you might need in order to help make a decision health-wise… they are a resource. A health resource” (Kim).

WHS’s matter-of-factness about human sexuality and reproductive health problems, consistent with its roots in the Women’s Health Movement (Nichols, 2000), thus created an organizational environment into which it was known that women could bring their problems without fear of judgment by members of the organization. At the same time, however, the publicity of its organizational commitments also attracted negative construals in the public sphere, which constituted a potential threat to individuals
using the center’s services. Several study participants mentioned the picketers that sometimes appeared at the edge of WHS’s parking lot.

If they could stop the people from standing on the side of the road — with the signs, I think that would be — it would be much better. I mean if you or I were on the road and see somebody with the fetus hanging on a carboard. I mean, you don’t want to go there. Because you are going to get criticized if you go there...

People have the choice to do whatever they want but you don’t want people standing on the side of the road and you pull up in the driveway... (Anne)

Anne very succinctly identified the issue of competing rights that lies at the heart of this public-private problematic — the picketers’ right to free speech in the public sphere versus the patients’ right to privacy in healthcare seeking at the organization. The challenge in terms of meaning management that this creates for some clients of the organization was reflected in Anne’s construction of the picketers’ presence as a personal “criticism.” Even if she was not personally acquainted with them, they appeared to stand in for community members that Anne does know personally who might condemn her based on their opinion of the organization.

As Kelly’s (2003) study of healthcare clients in rural Kentucky notes, place can enter into the experience of seeking and receiving healthcare services through being identified with a “devalued, marginalized place” (p. 2283), as well as through a “place-based sense of the local community” (p. 2284). Just as Kelly’s rural subjects reported feelings of being treated less than respectfully as a result of being identified with a devalued place, the participants in this study reported concerns about being identified with — as a result of being physically present or emplaced there — an organization whose image in the community is contested, and consequently being disrespected by other residents.

6.2. Public-private problematic of organizational regions (and regions beyond)

The public-private problematic of organizational identity focuses our attention on the interactions between the environments outside the organization and the organization itself as a whole. The public-private problematic of organizational regions focuses primarily on the physical and discursive spaces within the organization — specifically, the clinical area and the waiting room, though the meanings that these regions are given by the study’s participants were also intertwined with the regions beyond the organization’s doors.

The clinical area. From a place-based ecological perspective, it was notable that the clinical area was only very selectively permeable to the immediate community environment. Community members could enter this area only to receive services. Moreover, their interactions with clinical staff were regulated by organizational rules, as well as the institutional influences of (a) the clinicians’ professional codes of ethics, and (b) the patient privacy rules contained in HIPAA. It is, however, worth noting that the premium placed upon patient privacy is itself a place-based construct; overlooking a diverse selection of hospital ethnographies from around the globe reveals significant variation in institutional safeguards on privacy (van der Geest and Finkler, 2004). Professional staff and patients themselves were therefore the primary parties linked to the patients’ private health information. Managed care necessitates sharing information with third parties outside the organization; however, they are in principle bound by the same rules as professionals within the organization (Mattson and Brann, 2002). Overall, participants in the study reported perceiving this region to be the least challenging in terms of public-private tensions (though not entirely so, as will be discussed in the third problematic below).

The WHS waiting room area. The waiting room area represented a liminal region between the clinical consultation area and the community at large, or “the street,” with both private and public dimensions. Patients could reasonably expect that only individuals with medical appointments (or those accompanying them) would be present in the waiting room area, making it less public than the sidewalk outside. On the other hand, the waiting area was not as private as the clinical consultation area. Therefore, the information constituted by one’s presence in that area could come into the possession of other community residents, and be carried back across the permeable boundary between the waiting room and the community into “the street.” In the street, unlike in the clinical area, there are no formal constraints on managing that information. The waiting room thus represented a locale in which a “space of prescription” and “space of negotiation” intersect (Murdoch, 1998). This is significant because, as noted above, the very aspect of WHS’s identity that increased women’s comfort in seeking a full range of reproductive health services — its lack of judgment — led to the organization being judged negatively by more conservative members of the community. These residents labeled it a place that “shouldn’t exist [because] all it does is allow kids to sneak behind their parents’ back” (Stacey), and a place “that is either you’re getting an abortion or you have some kind of STD” (Jane). By extension (at least potentially) the women who might seek WHS’s services could become similarly labeled.

As Goffman (1963) notes in his discussion of stigma and social identity, “social settings establish the categories of persons likely to be encountered there” (p. 2). Thus, to be known to obtain services from a healthcare organization could then lead to being identified with that organization’s image, and to the extent that the image is problematic, contact with the organization is potentially problematic as well, as rendered in the following participant’s account:

And there is a lot of talk. If you ever go to the WHS out there and you come down here, and someone see you go in, the first thing is, oh you know, such and such is pregnant and they went to have an abortion. And it don’t have to be. It could be you just want to get birth control. But they don’t think that way. You know, they always think negative. (Anne)

Other study participants, however, while acknowledging the permeability of the waiting room to the community, as well as the potential negative judgments of other community members, counterposed alternative discourses. Mia, for example, reasoned in a different direction from Anne, demonstrating that, as Cummins et al. (2007) assert, “place and space are not determinative of social activity or of meaning... Rather, the experiences and social relations and the meaning of social activity, take place in the dialectic of production between social practices and social space” (p. 2286).

Even though they said it was confidential, when you see different people that would be here when you got here, you would think, well, they know what I am coming here for. Or you would think that they would tell about you. But it hasn’t been an issue for me at all. I have run into people here that I know and just because we are both in the same area doing the same thing, they are not really gonna say that they were here or I am not really going to say that I was here and saw them. It is all just being confidential, even just with the clinic. So it is not just with the clinic, it is with the people that come here too. (Mia)
Mia agreed that if one was present in the waiting room, one would come into possession of the information that others were there as well. However, she argued that for one woman to disclose about a second woman that she was seen in the waiting room (and perhaps to go on to speculate about the second woman's reasons for being there) would require the first woman to disclose her own presence in the waiting room. In Mia's experience, this operated as an effective constraint.

Linda's account similarly acknowledged the potential compromise to privacy that the waiting room represented (in fact, she even noted that she herself engaged in speculation about other women's purposes for being there when she was in the waiting room). However, like Mia, this did not prevent her from using the health center's services, though she invoked a different counter-discourse from Mia's.

... I guess, when I was going for my annual and stuff, I said, I hope nobody see me because they probably think I am coming here to have an abortion you know. But like I said, I got above that. You know what I am saying. I am here to take care of my needs. The ones that are thinking that, they're not even here. They should be right here with me, taking care of this. So I got over that. (Linda)

The fact that Linda "got above that" suggested that other community members' attributions were "low" or base, in comparison to her own real reasons for attending the health center. That she described herself as there "to take care of her needs" suggested that she was thinking of herself rather than being concerned with what others might think of her or perhaps that her "needs" were legitimate ones ("my annual") rather than ones that would be stigmatized if publicly revealed.

"The street". Participants' accounts constructed "the street" as a material region in the sense that it was physically located outside of the healthcare organization, but "the street" was more importantly a discursive space, in the sense that it could be anywhere that individuals might come into possession of others' personal information yet not be bound by any responsibilities toward safeguarding that information. The street was therefore a "space of negotiation" (Murdoch, 1998), in contrast to the discipline of institutional and organizational rules that prevailed in the clinical consultation area of WHS. As one focus group participant explained, in describing the most important characteristics of a healthcare provider, "You want to have that confidence. You want to have that confidentiality to know that if you go there your business is not floating all in the streets."

Thus, control over one's personal health information was particularly important in the more distal contexts of cultural controversies associated with reproductive health, together with the more local social environment of a tightly knit community. In the words of one participant, "Since it is a small town, you know, you get a whiff of something and the whole community knows what is going on" (Samantha). Participants here expressed a place-based construal of their community as gossip-ridden and critical when it came to matters related to reproductive and sexual health. However, it should also be noted that longer term participant observation in the community (in the context of a follow-on study; see Golden and Matsaganis, 2013) revealed residents to be quick to offer support other distressing situations, such as bereavement.

6.3. Public-private problematic of organizational members

As noted earlier in connection with the problematic of organizational identity, many of the women who participated in this study explicitly constructed the area where clinical services were rendered as a secure private space; moreover, they construed this security and privacy as extending to their health records. Other women, though, while well aware of the official rules that govern the handling of their healthcare information by healthcare organization members, did not assume that these rules were uniformly followed. A particular concern arose when women encountered a healthcare organization employee they knew from another social context. The concern was not only that the individual might access and subsequently divulge sensitive personal information. Some women construed a boundary breach resulting from occupying dual roles — social acquaintances, and healthcare organization member-healthcare consumer — which compromised their privacy even if the healthcare organization maintained appropriate confidentiality:

You know it is supposed to be private but you just you know. Even if they don't say anything, it's just a matter of, I know you. We know each other on a personal level and I just don't feel comfortable with that. (Nicole)

The participant's report of discomfort in this situation implicitly derived from the boundary between the private regions of the healthcare organization and the public regions of the community being rendered undesirably permeable. A friend or acquaintance would involuntarily (for the patient) come into possession of private information, which the healthcare professional has rights and responsibilities toward, but the social acquaintance does not. The close social networks of the smaller urban area created an increased likelihood of encountering this situation, similar to Kelly's (2003) finding of place-based threats to confidentiality in a smaller community because of overlapping personal and professional relationships among patients, physicians and staff.

7. Discussion

At the heart of the public-private tensions that must be managed if WHS is to provide its services to the community, and residents are to access these services, is the fact that in order to accomplish its mission, WHS must remain committed to its publicness. Community members need to know about the full range of services available there if they are to be confident that they can go there without fear of judgment. WHS made clear in its printed and online information that the services it offers include contraceptive care, breast and cervical cancer screenings, STI screenings, and abortion services. It seemed likely, however, given participants’ responses regarding (lack of) exposure to mediated messages from WHS, that most residents actually knew about the center's STI treatment and abortion services through word of mouth. Paradoxically, therefore, although WHS cannot control the uses that community members make of this information (which depends on their own positions on sexuality and abortion), it is important that this information continue to circulate in the community so that women who need their services know that they are available.

Safeguarding patients’ privacy is an integral part of the respect and compassion that WHS promises, yet this commitment exists in tension with the organization’s contested public identity. Moreover, WHS’s waiting room and employees represent means through which the private activity of healthcare seeking assumes a public dimension in the sense of being on view to other community members. African American women who used the organization’s services or were considering using their services constructed the experience as one of managing competing place-based discourses of organizational identity and managing their own identities as they intersected with the organization’s in public and private...
contexts. Management of the public-private problematics encountered by WHS and the community residents who use its services requires that both take action because they are interdependent actors in this social ecology.

7.1. Managing the public-private problematic of organizational identity

In the public arena of the community, outside of WHS’s own organizational boundaries, community residents—both supporters and detractors—communicate in ways that function to define different organizational identities for WHS. This communication about the organization is crucially important because of its potential impact on users of WHS services. In this public arena, there are few rules governing communication about WHS, placing this communication beyond the organization’s control. Moreover, WHS cannot completely control the permeability of its waiting room area to “the street,” and render its waiting room solely a “space of prescription.”

What WHS can do, however, is more actively enter this public arena and communicate its identity to Riverton residents in ways that can impact the meaning of being seen there. Organizations can communicate their identities to stakeholders through more “traditional forms of discourse” like marketing and advertising, but also through “meaning-laden actions” that provide further evidence of qualities valued by stakeholders (Scott and Lane, 2000, p. 51). Many participants, for example, voiced the wish that WHS become more actively involved in the community, beyond its organizational boundaries. Although WHS takes advantage of opportunities to participate in community events (for example, tabling at the annual county fair, marching with other local health and human service providers in holiday parades), these events are too infrequent to serve as platforms for sustained relationship building. WHS might be more successful in connecting with this audience by conducting health education events at locations in the actual neighborhoods where low income African American women live, creating an alternative set of spaces and places for its interactions with residents. Such events could also heighten community members’ awareness of the need for routine reproductive health maintenance behaviors and inform participants that WHS provides these services (and does not only serve women in crisis).

WHS could also enlist supportive community residents as active partners in organizational image building. Women who support and use the organization’s services could be identified to participate in community events by providing testimonials. African American women have a distinguished record of health activism historically (Mele, 2000; Smith, 1995), and WHS may find passionate allies among some members of the community if they are offered an active role, although, as indicated in this study’s theoretical framing with respect to intersectionality, and supported in its empirical findings, low income African American women take diverse positions in relation to the services offered by a publicly funded reproductive healthcare organization like WHS. It is arguably unrealistic to expect that WHS can persuade its most vocal opponents (i.e., the picketers) to leave them alone, or to change the minds of those who speak against education and reproductive health services for teens and abortion within their own social networks. It is, however, possible for WHS to become better known for the full range of routine preventive reproductive health and educational services it provides and not only as a provider of care for women experiencing a crisis in all of its messages, given this study’s participants’ accounts of reproductive healthcare seeking concerns. WHS should continue to underscore its commitment to safeguarding patients’ personal health information (already a routine feature of its messages).

7.2. Managing the public-private problematic of the organizational regions

The identification of women with WHS’s complex image in this community through the women’s visibility in the liminal, semipublic regions of the organization is closely intertwined with the problematic of organizational identity. As Scott and Lane (2000) observe, “an individual’s self-esteem may be enhanced or damaged as a consequence of others’ awareness of his or her affiliation with an organization” (p. 51). The impact of affiliating with an organization on the individual’s self-esteem depends on the organization’s “legitimacy” (p. 49), which is defined as an individual’s own and perceptions of others’ belief that the organization’s values are congruent with the “embedding culture” (p. 49). Thus, to the extent that WHS is able to convincingly demonstrate the congruence of its values with the community, perhaps by undertaking some of the activities described above, this will contribute to managing the public-private problematic of organizational regions. Again, as noted above, community members who are the most vigorously opposed to the most controversial of WHS’s services—abortion—are unlikely to cooperate in this endeavor. However, this strategy could be effective with members of the community who are not opponents of abortion in absolute terms, but who do not wish to be identified (erroneously) as seeking abortion services just because they are emplaced in an organization that is known to provide them.

As part of their community engagement activities, WHS could provide community residents with alternative discourses for the experience of seeking healthcare services at WHS, such as the ones invoked by Linda and Mia. Linda declares, “I am here to take care of my needs,” which constructs a compelling case for preventive healthcare seeking. Mia reasons that there is solidarity among women who meet in the waiting room because “We are both in the same area doing the same thing,” a discourse that could be used to answer concerns about privacy if they are raised by prospective clients. If we understand “spaces” as “configurations of material and discursive practices,” (Street and Coleman, 2012) the waiting area has the potential to be reconfigured, displacing the negative discourse of “the street,” which assumes conditions of deviance among WHS patients, and filling the space with the more positive discourse of “taking care of your needs.”

7.3. Managing the public-private problematic of organizational members

As noted above, another way in which the organization could be made permeable to the surrounding community, in the eyes of its clients, was through the organization’s employing residents of the community, so that women seeking healthcare services might encounter someone in the reception area or clinical area that they knew in a social context. This problematic could be managed by staffing the center with employees from outside the community, when possible within the constraints of acceptable hiring practices. After the data for this study were collected, WHS began to implement this practice in the course of staff turnover and changes at its other locations in the region that resulted in shared staffing arrangements, which increased the likelihood that clinical and reception staff would be non-residents of the community. It must be acknowledged that these goals for staffing exist in tension with the historical commitments of publicly funded family planning clinics to provide employment to the communities in which they are located (Gordon, 2002). It might be argued, however, that the mission of serving underserved women and reducing reproductive health disparities supersedes the relatively smaller economic
impact that a publicly funded health center might have in recruiting more aggressively from the community.

At the same time, however, WHS maintains a commitment to having the diversity of its staff mirror the Riverton community (Chyna, 2001). The impact of patient-provider racial concordance on satisfaction with clinical encounters has received considerable research attention (e.g. LaVeist and Carroll, 2002; Street et al., 2008), with somewhat inconclusive results, but a general tendency to assume the preferability of concordance. Regardless of the specifics of the staff members’ identities, their ability to interact effectively with the center’s clients can be augmented by sensitizing, internal organizational communication to staff regarding the specific privacy concerns of low income African American women in this densely networked community, and their relationship to the organization’s identity and the sociomaterial environment the organization and its surroundings represent.

8. Conclusion

As engaged research undertaken in collaboration with the publicly funded reproductive healthcare provider described here, this study has applied interpretive social science methods to help solve a problem faced by a particular healthcare provider while also generating new and potentially generalizable knowledge about healthcare organization-healthcare consumer interactions (Stake, 2005). Limitations of this study are related to the particular characteristics of this organization (i.e., providing healthcare services that are particularly sensitive and potentially stigmatizing), and the ways in which they interact with the environment of a smaller urban area and particular privacy concerns of low income African American women. Better understanding of the processes involved in these interactions, while not providing universal keys to healthcare organization—consumer interactions, is nonetheless important in the context of reproductive health disparities, and population trends that find more minorities residing outside of larger urban population centers (Frey, 2006).

Moreover, what might from one viewpoint be framed as a limitation—that is, that the study’s findings are specific to a particular environment—is from another point of view indicative of the usefulness of a set of larger principles encompassed by a place-based ecological perspective. This perspective cues us to the particularities of the case, but also to the larger principle of attending to interrelationships between different elements and levels of actors in a case, from individuals, to organizations, to communities.


