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In Another's Voice: Making Sense of Reproductive Health as Women of Color

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In Another's Voice: Making Sense of Reproductive Health as Women of Color

by

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A thesis submitted in partial fulfillment
of the requirements for the degree of
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DEDICATION

For all the Women and their stories.

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Thank you to all the Women who participated in this project, who shared with me their stories, and who helped me make sense of chaos. Thank you to my generous and patient committee members who have all opened my mind to new ways of inquiry. Thank you to my parents, whose shoulders I stand on. Thank you to Noorie, without whom I would not have made it through the hours of writing. Lastly, to sweet Bria I am endlessly grateful. This project would not have been possible without you and all the existential places you take me. You teach me how to witness kindly and live bravely. Thank you.

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ABSTRACT

The goals of this project are twofold. The first goal is to articulate my sense making of reproductive health for Women¹ of color in the United States as a postcolonial condition; one that I trace back to the logics of elimination of settler colonialism (Wolfe, 2006) and frame as maintained through the colonial institutions, or racial projects (Omi & Winant, 2015), of the Prison Industrial Complex, the welfare system, and the health care system which create and perpetuate dominant cultural narratives of “the welfare queen”, “the negligent Black mother”, and “the wily patient”. I show how these narratives colonize the minds of health care providers and contribute to the current stratification of health care.

My second goal with this project is to show how postcolonial interpretive ethnography can be used as a narrative medicine educational intervention for providers. Currently, Narrative Medicine asks providers to read themselves, their patients, and their interactions as literature to emphasize the personal and interpersonal tensions that are often lost in the fast paced biomedical world (Charon, 2001). With this project I aim to expand the field of Narrative Medicine to consider the ways patient-provider interactions are postcolonial, and how analyses of these interactions can be a method of decolonization. I do so by analyzing three interpretive

¹ While I aimed for this project to be inclusive of trans and gender non-binary identities, I did not recruit inclusively enough, thus all of my participants were cisgender Women. Since the term “Woman” does not include every person capable of bearing children or who require the reproductive health services I discuss, the use of it in this project to refer normatively only to those who do is a level of erasure of trans and non-binary identity and experience (Ross & Solinger, 2017, p.7). I am still learning how to be inclusive in the arguments I make and felt that I was not inclusive of trans identity here. In this project I use the word “Women” to refer to the cisgender Women of color I interviewed, capitalizing the “W” to refer to the identity category which discrimination is based on, but also recognizing the layers of discrimination that exist within who is considered normatively to fit into that category. Similarly, I capitalize “Black”, “Latina”, “Brown”, and “White” to refer to the dominant identity categories and not to individuals, noting also that this action is colonizing in itself for it erases and essentializes racial experience, as does the term “of color” (Ross & Solinger, 2017).

ethnographic narratives that I have created which story my interactions with three Women of color: Tiffany, Rose, and Jane. I then analyze each of these interactions for colonizing and decolonizing sense making.

INTRODUCTION

When Donald Trump won the presidency, Women around me began to worry about birth control access. I was told by many Women, “get it while you can”, and “you never know what’s going to happen.” I was nervous about it. I had bad experiences with birth control in the past and having a looming deadline made me even more nervous. I wanted to know if others were experiencing what I was, and in what ways my own privileges of having reliable health insurance, having parents who were physicians, and fitting fairly well into a white normative society in my language, education, and career choices kept me safe from the dangers of a Donald Trump presidency (Mann, 2013). I figured that I could understand how this political moment had changed sense making about reproductive health, thus I asked the question: “How do patients of color make sense of their reproductive health in the current political climate?” However, as I began to talk to Women of color about their sense making, began to learn about postcolonial theory, my sense making of reproductive health and this project shifted. I realized that I could not isolate the ways in which reproductive health was political in this moment, if I did not attend to the ways it has always been political. I began to understand reproductive health through postcolonial eyes, began making connections between the goals of settler colonialism and current institutions that enact reproductive health today such as the prison industrial complex (PIC) and the welfare system (Wolfe, 2006; Solinger, 2005). Thinking postcolonially about reproductive health led me to make sense of how the narratives about Women of color that come from postcolonial institutions like the PIC and the welfare system colonize the minds of individuals to

justify the ways Women of color's reproduction is degressed and stratified (Roberts, 2017). My understanding of how the minds of healthcare providers specifically are colonized with dominant narratives came from working closely with Brianna Cusanno, whose thesis IRB was joined with mine, and whose original question was, "How do providers make sense of providing reproductive health care to patients of color in the current political climate?" Through conversations with Brianna about her data, I found that I wanted to attend specifically to how narratives colonize minds, and to understanding how the creation of such narratives were colonial. She told me of the ways that providers would tell her narratives about patients that were negative, that fit within the "wily patient" narrative, but when she asked them specifically of if they had an experience like that with a patient they would say no. This made me consider the ways we rely on dominant narratives despite our own experiences, and why, which lead me to consider how narratives colonize the mind.

While this project originally was aimed to be a thematic analysis of the ways that the Women, I interviewed made sense of reproductive health, the time constraints and my changing perception of methodology have led me to consider a subset of the twenty interviews I conducted. My understanding of my research question evolved from "How do patients of color make sense of reproductive health in the current political climate?" to, "How do I make sense of Women of color's reproductive health?" I decided to portray this sense making through postcolonial autoethnography, which I then analyze for the colonizing and decolonizing sense making my participants and I engage in. I believe this method of postcolonial autoethnography and analysis could be used to create a narrative medicine educational intervention for medical students, who are asked to story themselves and their participants, but never to consider how those stories have already been half-crafted colonially through the unquestioned narratives

employed in their sense making of patients. Chapter one articulates my postcolonial understanding of reproductive health and the stratifications within it as postcolonial, situated within Wolfe's (2006) settler colonialism's logic of elimination and Omi Winant's (2015) racial projects, and how racial projects function to colonize minds with negative dominant cultural narratives of Women of color, particularly Black women. Chapter two describes how these dominant cultural narratives play out within healthcare and how providers employ these narratives within their interactions with patients. Chapter three discusses the methods I use within this project, applied in Chapter four which consist of three interpretive ethnography narratives I crafted: Tiffany, Rose, and Jane. In Chapter five I analyze these narratives for colonizing and decolonizing sense making.

CHAPTER ONE

LITERATURE REVIEW

Within the United States exists significant disparity between men and Women's health care (Berotti, 2013). This disparity is largely due to the manner in which Women's need for unique reproductive health care is managed through inequalities in power (Sen Östlin, 2008). Sen and Östlin (2008) note that gender inequality, constituted by gender power relations, are "among the most influential of social determinants of health" (p.7). In addition to a natural need for unique reproductive health care given Women's menstruation cycles and reproductive capabilities, there exists a particular pressure on Women to carry the reproductive responsibility, and child care responsibility, of heteronormative relationships (Dudgeon Inhorn, 2004; Collumbien Hawkes, 2000; Bertotti, 2013). This responsibility creates significant disparities in health care; Bertotti (2013) notes that 40% of cohabiting or married couples use female sterilization methods of birth control while only 15% use vasectomies, despite female sterilization procedures being much riskier, more invasive, and less easily reversible than male sterilization procedures. Sen and Östlin (2008) write that the "gendered structural determinants of health" are further constituted by how gender intersects with "other bases of discrimination and bias such as economic class, race, or caste" (p.11), evidenced by even more disparities that exist in reproductive health for Women of color (Harris Wolfe, 2014). Black and Latina Women experience more severe rates of cervical cancer, maternal mortality, pregnancy complications, preterm delivery, low birth weight delivery, stillbirth delivery, and a lack of access to prenatal

care (Dunlop Everett, 2012; Spong et. al., 2011; Anachebe Sutton, 2003; Gadson et. al., 2017; Callaghan et.al, 2012; Beavis et.al., 2017). These health disparities exist within a long history of stratified reproduction in the United States, beginning with a history of forced sterilizations.

History of Forced Sterilizations

In her book, “Pregnancy and power: A Short History of Reproductive Politics” (2007), Dr. Rickie Solinger discusses practices and laws contrived to reaffirm Black inferiority and justify slavery, such as barring Black people from public places and denying Black men who were granted freedom for serving in the American Revolution the right to citizenship or property. Solinger argues that these laws and practices constricted Black and native Women’s reproductive autonomy, denying their ownership over their own bodies, sexualities, as well as their children; this degradation of Black Women is what Solinger calls “the foundation of the slavery system” (p. 30). The “Trail of Tears”, which forced Cherokees to march and relocate to the Oklahoma territory, consisted of several practices to limit and control native reproduction, including disrupting traditional pregnancy routines and separating children from parents (Solinger, 2007).

The value in Black and Native bodies during slavery was rooted in their capitalist potential as commodities; Women slaves were an even more valuable commodity because they produced more workers, or property, for slave owners (Solinger, 2007). Therefore, Black and native reproduction was highly encouraged, particularly Black reproduction, from 1803 to 1833, between the end of the slave trade and the end of colonial slavery, when the only source of new labor was slave reproduction (Harris Wolfe, 2014). J. Marion Sims also found value in slave Women as bodies to conduct medical experiments on. In his search to find a surgical treatment for vesicovaginal fistulas, tears that occur between the bladder and vagina often during labor, Sims experimented on Black slaves without anesthetics, claiming that they did not experience

pain like other Women due to their race (Spettle White, 2011). The end of slavery signaled the end of commodifying Black bodies, as well as a renewed White fear of becoming outnumbered by minority populations (Solinger, 2007). This not only concerns the growing Black population, but the growing population of other minority groups as well, particularly Latinx and immigrant populations. This fear manifested in a long history of stratified reproduction and eugenics. Coined by Shellee Colen in 1986, “stratified reproduction” refers to the power dynamics in which “the fertility, reproduction and maternity of some people are valued, and the fertility of others is not” (Harris Wolfe, 2014, p.541).

I understand this devaluing of Women of color’s fertility, maternity and stratified reproduction as enacted through the institutions of healthcare, the prison industrial complex, and the welfare system. In this section I connect Wolfe’s (2006) settler colonial “logics of elimination” with and Michael Omi Howard Winant’s (2015) conceptualization of “racial projects” to show how these frameworks together can illuminate the goals of the institutions of the prison industrial complex, the welfare system, and the healthcare system to limit and control the reproduction of minorities.

Logics of Elimination and Racial Projects

Wolfe (2006) writes that the United States is a site of settler colonialism, or colonialism not based on race but on access to territory. U.S. settler colonizers took and pillaged land by means of racializing native people as “Indians” and Black people as “slaves”. This process of racialization in addition to various other aspects of settler colonialism is what Wolfe terms “the logic of elimination.” There are three main aspects of the settler colonial logic of elimination I will attend to and expand on:

- 1) Settler colonialism has “positive” (read: additive, to side step the moral implications of Wolfe’s poor word choice) and “negative” (read: degressive) dimensions. The degressive is the goal of “dissolution of native societies”, while the positively it “erects a new colonial society on the expropriated land base” (p. 388). I apply the understanding of additive and degressive dimensions to the current postcolonial state of the U.S. and the dissolution of minority populations.
- 2) As noted earlier, Settler colonialism racializes in the nature of its targeting as Black people were racialized as “slaves”, while Natives racialized as “Indians.” The logic of elimination racializes people based on “who they are” and “where they are”. I extend this to be “who they should be for the most settler capital gain” and “where they should be for the most settler capital gain.”
- 3) Logics of elimination understand colonialism not as a historical event, but as an ongoing structure. Since the additive aspect of settler colonialism is to erect a new colonial society, it must be a society that continues the logics of elimination which justify the colonizers right to invaded land. (p. 300). The former two aspects mentioned function to maintain the logics of elimination as settler colonialism changes through various historical contexts.

Colonialism as a structure means that a colonial society has set up organized institutions to continue the logics of elimination. These institutions can be understood as what Omi Winant term “racial projects”, or “efforts to shape the ways in which human identities and social structures are racially signified, and the reciprocal ways that racial meaning becomes embedded in social structures” (p. 13). Institutions such as the prison industrial complex, the welfare system, and the foster system are instances of racial projects which create and reiterate

representations and interpretations of people of color, particularly Women of color, and even more particularly Black Women (Omi Winant, 2015; Roberts, 2017; Roberts, 2011). They simultaneously work to distribute and organize political, economic, and cultural resources along racial lines (p 125).

Erving Goffman's (1990) theory of stigma and social identity postulates that as society we form "categories of persons" in which to easily place people, which can function to reduce those people "in our minds from a whole and usual person to a tainted, discounted one" based on stigma, or "an attribute that is deeply discrediting" (p.25). Goffman (1990) notes that while these stigmas may not be accurate to the individual being, they serve to create a "virtual social identity" (p. 25). The representations of Women of color created and maintained by these institutions can be described as dominant cultural narratives, which Fivush (2010) states, are narratives that:

"provide a culturally shared understanding of the shape of a life and how a life is to be understood, and in this way cultural narratives provide authority to define a culturally appropriate narrative of a life, and the power to validate certain narratives over others. (p. 89).

In "*Killing the Black Body*", Dorothy Roberts (2017) outlines the dominant cultural narratives placed upon Black Women that communicate them and their reproduction as a societal burden. Roberts discusses "Jezebel and the immoral Black mother", which relates Black Women to the narrative of the biblical "Jezebel", the wife of King Ahab, who is marked by a lewd salaciousness and uncontrollable eroticism that leads men astray (p. 11). Roberts (2017) also makes note of "Mammy and the negligent Black mother", which makes sense of Black Women as devoted to the care of White children and disregarding of their own children, and who actually

have “no real authority over the White children she raised, or the Black children she bore” (p. 13). These cultural narratives of Black Women as “Welfare Queens” who deviously want to trick taxpayers into providing for them and “Negligent/Deviant Black Mothers” who are incapable of enacting proper motherhood, are all constituted by (and reconstitute), the racial projects of the four institutions discussed next.

Prison Industrial Complex and The Deviant Negligent Mother

The racial project of the Prison Industrial Complex both limits the resources of minorities incarcerated, as well as creates and reiterates narrative representations of them as deviant and negligent mothers. Returning to the logics of elimination, Wolfe writes that “race is made in the targeting” of populations; as discussed earlier, Black people were racialized as “slaves” and natives as “indians” because this suited capital extraction best. As colonialism is a structure that is meant to continue the logic of elimination, once slavery ended, a new structure needed to be created (Wolfe, 2006). One such structure is the Prison Industrial Complex (Brewer Heitzeg, 2008). The 13th amendment abolished plantation slavery stating that “Neither slavery nor involuntary servitude, *except as a punishment for crime* whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction.” The caveat “except as a punishment for crime” serves as the new targeting and racializing of Black people. I argue that the answer to “who they can be for the most capital gain” shifted from “slaves” to “criminals.” Brewer Heitzeg (2008) describe this shift from explicit slavery to mass incarceration as:

“a de facto racism where people of color, especially African Americans, are subject to unequal protection of the laws, excessive surveillance, extreme segregation, and neo–slave labor via incarceration, all in the name of crime control” (p. 626).

“Neo-slave labor” and the rise of “the new plantation — prison industrial complex (p. 626) became the new form of commodifying and valuing racial and ethnic minority bodies; they must be incarcerated in order to be profitable from leasing labor and in order for more prisons to be built for profit (Brewer Heitzeg, 2008; Davis, 2000). The creation of the Prison Industrial Complex is an additive aspect of settler colonialism, for a structure is being created to continue the logics of elimination and to target minorities. Indeed, Black and Latinx people are incarcerated at increasingly higher rates than their White counterparts (Pewewardy Severson, 2003; Graff, 2015). A NAACP Criminal Justice Fact Sheet states that “African Americans are incarcerated at more than five times the rate of Whites” and that while “African American and Hispanics make up approximately 32%” of the population they make up 62% of the incarceration population (National Counsel on Crime Factsheet). Maur (2011) states that as of 2011, “1 of every 3 African American males...can expect to go to prison in his lifetime, as can 1 of every 6 Latino males, compared to 1 in 17 White males” (p. 88). The mass incarceration of racial and ethnic minorities lends to and reconstitutes the public perception of minorities as criminal, and therefore of minority mothers as “procreators of crime and poverty” (Davis, 2000, p.61; Brewer Heitzeg, 2008).

Dorothy Roberts (2017) writes, “it is believed that Black mothers transfer a deviant lifestyle to their children that dooms each succeeding generation to a life of poverty, delinquency, and despair” (p. 8). This echoes the previously quoted Justice Oliver Wendell Holmes Jr.’s reasoning for forced sterilizations in the *Madrigal V. Quilligan* case: that the state would not have to “execute degenerate offspring.” Thus, criminality is not obtained through actions against the law, but is an inherited trait that can be eradicated through the control of racial and ethnic minority reproduction. This is achieved in part by the incarceration of Black

Women themselves, who constitute the fastest expanding incarcerated population (Davis, 2000; Austin Irwin, 2012). As of 2011, 1 in 45 Hispanic Women and 1 in 18 African American Women will spend time incarcerated, compared to the 1 in 111 White Women (Maur, 2011).

Incarceration also serves as a tool to surveill and restrict minority motherhood, particularly when it comes to punishing substance abuse (Harris Wolfe; 2014). Herein lies the degressive dimension of the logic of elimination, for the goal is to reduce the number of minority lives.

Harris and Wolfe (2014) write that poor Black Women are “under greater surveillance and treated in a more punitive way than their affluent White counterparts when they become pregnant in the setting of chemical dependency” (p. 542). In their 2013 study, Paltrow and Flavin found that pregnant Women of color are reported and arrested at higher rates for substance use compared to pregnant White Women. Similarly, Chasnoff and co-authors (1990) found that even when substance use was similar between groups, pregnant Black Women were reported at a rate of ten times more than pregnant White Women. Smith (2017) poignantly describes the experience of incarcerated motherhood:

“It is unbelievable that this is my fifth Christmas locked down, not in the sense that the time has been flying, because it has not. On December 12, 1994, still imprisoned, I gave birth to my son. Thirteen days after his birth, I spent Christmas staring at jail cell bars, partially understanding what our ancestors were forced to endure when torn apart from their babies in the Motherland. Longing to be home with my parents, to smell and touch my newborn baby’s skin, I wonder what my fate would be.” (p. 105).

The disproportional incarceration of minorities limits their ability to parent their children, reaffirming the stereotype of minorities as degenerate parents, and this leaves minority youth either to the incarceration system themselves or the foster care system (Williams, 2015; Krisberg

et. al., 1987). Compared to White children, Latinx children are 2.5 times more likely to have one or more incarcerated parents, and African American children are 7.5 times more likely (Williams, 2015). Knott Donovan (2010) found that African American children have 44% higher chance of entering the foster care system than White children. This level of state control and surveillance of minority families hinders social, political, or economic mobility for, as Williams (2015) states, “time spent fighting the state to keep one’s children is time that cannot be spent organizing politically, advancing economically, or even parenting one’s children” (p. 305). Thus, the incarceration and foster care system function to keep minority families from making economic progress, which creates another characteristic of “unfit” to reproduce: “poor” (Price, 2010, p. 57). The cultural narratives that communicate poverty as the fault of Women of color play out within the current welfare system to create stratified reproductive experiences.

The Welfare System and The Welfare Queen

Bridges (2007) writes that the Welfare system is one that is deeply nationalistic and capitalist, figured within a “moral economy of deservingness.” Populations who live in poverty are characterized as the “deserving poor”, or those who deserve assistance and aid because their inability to be capitalistically productive, and the “undeserving poor”, or those who are to blame for their lack of “prosperity” under capitalism (Bridges, 2007). The “deserving” population is made up of those who are physically or mentally disabled, whose conditions are considered not of their own making. Nirmala Erevelles (1996) offers a counter understanding of what constitutes “disability.” Erevelles uses the social construction understanding of disability in relation to the environment made for the typically-abled people majority that then *disables* atypically-abled people. With this shift comes a different understanding of the word “disabled”; it is not an inherent condition of a person, but rather a hindering condition put upon an individual

— it is something that is *done* to individuals structurally. Ervelles extends this understanding of disability to other “differences” such as race, gender, class, and sexual orientation, which can be reconceptualized as structures that disable people. The welfare system works to mask the sameness of physical and cognitive disability and disability through racial, gendered, classed, and heteronormative structural oppression, so that those who experience the latter are subjected to neoliberal logics of deserving their poverty, and being undeserving of aid. Bridges notes that the values of capitalism are in line with the values of nationalism, which are neoliberal values of a hard work ethic, which will bring prosperity, which is truly “American”, and which is discursively and historically constructed as Whiteness. Thus, those who are viewed as willingly not contributing to the labor market are considered “Un-american” and inherently at some distance away from Whiteness — inherently some level of Blackness (Bridges, 2007). Genova and Ramos-Zayas (2003) write,

For African Americans nor for Puerto Ricans does birthright U.S. citizenship secure the status of 'American'-ness, which constitutes a national identity that is understood, in itself, to be intrinsically racialized—as White. (p.72).

Enter once again the logics of elimination of settler colonialism, for the welfare system answers the question of “who should they be for the most capital gain” as “undeserving” poor. Different from the Prison Industrial Complex, which exploits labour of minorities racialized as “criminals” and creates a demand for building prisons, the racialization of “undeserving” poor reiterates the perception of the need for capitalism in the first place. It frames those who do not participate in capitalism as immoral, lazy, societal drains while strategically veiling that their inability to engage in labour is actually the result of capitalism to begin with and the structural oppression that creates the conditions that keep them in poverty. The welfare system is thus a racial project

that understands the right to state aid as determined by racial lines, and which creates representations of Women of color.

Such a representation is the ultimate “undeserving” poor person, the “welfare queen”. In the 1980’s Ronald Reagan popularized the paradoxical image of the “welfare queen,” the poor Black Woman whose economic dependency consisted of: “the lack of a job and/or income (which equals degeneracy in the United States); the presence of a child or children with no father and/or husband (moral deviance); and finally, a charge on the collective U.S. Treasury - a human debt” (Lubiano, 1993, p. 337). The “welfare queen” was not only Black, single, a mother, and poor, but was also morally degenerate and intentionally had multiple children in order to live off taxpayer dollars (Roberts, 1991; Kaufman, 1997). Since the welfare queen source of manipulating the state is understood to be her reproductive capabilities, this becomes the site of targeting for policy. The targeting of welfare towards reproduction can be observed in the stated purpose of the Temporary Assistance of Needy Families (TANF) which states:

The purpose of this part is to increase the flexibility of States in operating a program designed to—(1) provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; (2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; (3) prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and (4) encourage the formation and maintenance of two-parent families. (Bridges, 2007, p. 8)

Settler colonialism and capitalism embedded in the TANF purpose claim that the ways out of poverty are participating in the labour force, and marriage, for both are colonial and capitalist concepts. The focus on marriage, the implication that out of wedlock pregnancy causes poverty,

and the explicit goal of preventing and reducing pregnancies, clearly targets the reproductive autonomy of TANF recipients. The narrative of the welfare queen as the typical TANF recipient means that Black Women's reproduction is being, as a logic of elimination, degressed.

This narrative fueled stratified reproductive policy and reproductive coercion with the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, which implemented a "family cap," a policy that denied additional benefits to recipients of state assistance if they had more children (Romero Fuentes, 2010; Harris Wolfe, 2014; Smith, 2006). In addition to punitively denying assistance to those who had more kids, additional assistance was also offered to Women on state assistance who had the birth control Norplant, a high dosage arm implant (Harris Wolfe, 2014; Burrell, 1995). Jagannathan Commasso (2003) examined the impact of the first family cap implementation and found that while Hispanic and White Women remained generally unchanged, Black Women's birth rates dropped by 21% and Black Women's abortion rates increased 32%. These policies likely work to control and discourage Black reproduction by leveraging their socioeconomic needs against them, and are justified by the narrative of the Welfare Queen, despite the reality that white Women make up the majority of welfare recipients (Bridges, 2007). Why then are these racialized narratives so popular, so easily retrievable from an unquestioned subconscious, if they are not in line with reality? I argue that this is a function of colonizing minds: to rely on racialized narratives that uphold the logics of elimination despite personal, social, economic, and political evidence to the contrary (Cassiman, 2006).

Narratives and Colonized Minds

In his examination of the postcolonial conditions of Africa, Thiongo (1986) discusses how colonization continues on in people's minds after the colonial period ends, and remains unquestioned and unexamined. Merryfield Subedi (2001) note that it is not only the oppressed

people who have colonized minds which can be observed through how American schools teach all students from childhood, a worldview and national history that “rests upon colonial assumptions of European and American manifest destiny and white racial superiority” (p. 282). Students are also given representations of minorities in textbooks that are in line with oppressive dominant cultural narratives (Carleton, 2011). Wolfe (2006) notes that one aspect of settler colonialism logic of elimination is the creation of romanticized narratives that he terms “repressive authenticity” in which minorities identities are museumized and essentialized into what the colonial view/construction of them is. In his 1992 book, *Imaginary Indian* Daniel Francis analyzes the representations of what he terms the “Textbook Indian” who are both uncivilized and violent towards settlers, while simultaneously romantically spiritual and close to nature. Carleton (2011) extends Francis’s analysis by situating these narratives of natives within settler colonialism and the “changing historical and material circumstances of settler society” (p. 104). Through an analysis of history and sociology textbooks, Carleton argues that narratives of natives portrayed in history and sociology textbooks colonize the minds of students to justify settler colonialism. Through the school system, people’s minds are colonized by dominant narratives, which they continue to rely on well after their primary school days and into their adult professions, in which there exists further reiteration and colonizing of these narratives of minorities. Such professions exist within the health care system. Bridges (2007) notes that when the stereotypes of “the welfare queen” and “the negligent Black mother” enter the realm of reproductive health, they are considered “wily patients”. Thus far I have articulated how I make sense of how the racial projects of the prison industrial complex and the welfare system create and perpetuate narratives that colonize minds into justifying the degeneration of women of color’s

reproduction. In chapter two, I show how these racist narratives play out within the health care system.

CHAPTER TWO

LITERATURE REVIEW CONTINUED

Thus far I have articulated how minds are colonized through dominant cultural narratives. In this chapter I make a case for how such colonization of the mind is enacted by providers within their interactions patients to create racial health disparities. Indeed many scholars have examined how provider's contribute to racial disparities. For example, Paradies, Truong, and Priest (2013) conducted a systematic review of 37 studies that examined provider's racist beliefs, emotions, and practices and concluded that there exists statistically significant evidence of each within 28 studies. Van Ryn Burke (2000) examine how provider's perceptions of patients are determined by race and socioeconomic status through providers rating patients on stereotypes including how like patients were to: try to manipulate providers, fail to comply with provider's advice, and exaggerate pain. These authors found that providers were more likely to have negative perceptions of Black patients than of white patients, particularly for compliance with physician advice (Van Ryn Burke, 2000).

In her 2007 ethnography of the reproductive healthcare at "Alpha" obstetrics clinic in New York, Bridges shows how racist beliefs, emotions, and practices that previous scholars have observed are in fact perceptions that rely on the narratives of "the wily patient," Bridges observed the staff attributing "miscommunications" to wily patient attributes such as "stupidity" and "duplicity". For example, Bridges writes that staff will ask patients to fill a urine cup by

stating “Do your urine”, a phrase that Bridges considers a “poorly clarified directive.” When patients either do not know what to do with the cup, or mistakenly fill the cup with feces, Bridges writes that staff attribute this not to their directive being unclear or strangely worded, but rather to the stupidity of the patient. Similarly, Bridges observed various instances of patients not responding to their names being called, which Bridges herself attributes to the long wait times, the poor acoustics in a large room, and the lack of a microphone. The staff however attribute this once again to patient stupidity.

Bridges also notes that staff believe they must be prepared to “defend the clinic against the pilfering of its resources by its patients” echoing the narrative of The Welfare Queen’s desire to drain resources from the state. This belief that clinic’s resources must be defended against pilfering patients of color rests on the belief of the “undeserving” poor, for if one is “pilfering resources” then they are taking something they have no right to, that they do not deserve. Bridges concludes that “while race was by persons in the Alpha obstetrics clinic, it was always extant; it was always there.” and “the implicit racialization of the wily patient and the welfare queen serves to demonstrate that race, as an omnipresent social fact with potent material repercussions, need not be explicitly evoked in order for it to over determine the quality of persons' lives” (p.65). Given the roots of colonial narratives in controlling and reducing minority populations discussed in Chapter 1, scholars have examined the way these narratives are employed by providers specifically in relation to reproductive health and birth control counseling.

Racist Narratives in Reproductive Healthcare

In their 2018 study, Lindsay Stevens interviewed 28 providers on their attitudes about how legitimate their patients’ concerns and dissatisfaction with birth control methods are.

Stevens observed that when patients expressed reluctance or concerns to take birth control, providers “typed” them into two groups: patients whose reluctance was because they were “uneducated and irresponsible”, and patients whose reluctance was because they were “too educated and selective” (p.149). The first type of patient, Steven finds, providers implicitly and explicitly identify as minorities and of low socioeconomic status. Stevens gives the example of a provider discussing how two Black patients who wanted to discontinue the use of a hormonal birth control:

“Unfortunately, they were both African-American and they wanted to quote unquote give their bodies a break and I said, ‘Well, if you get pregnant, are you okay with that?’ And they go, ‘Yeah.’ They are. They may or may not have a successful job.” (p. 150).

Stevens explains the use of “unfortunately” when noting the patient's’ race as the provider “and that she found it distasteful to stereotype patients based on race, but unfortunately believed it was fitting in this case” (p. 150). This use of “unfortunately” is a way for the provider to still rely on racist narratives yet distance themselves from the racism of the act, similar to how saying “I’m not racist but...” functions (Silva Forman, 2000). Stevens attributes the provider’s use of “quote unquote” to the provider’s belief that the patient’s reasoning is not in line with “formal medical knowledge”. Similarly, Stevens also writes of a provider discussing how “cultural superstitions and beliefs” with menstruation and birth control are a hindrance, and how “aunties and grandmas” are responsible for perpetuating cultural thoughts in Latina patients (p.149). Stevens notes that this indicates that this provider believes that Latina culture inhibits Latina girls from making what the provider believes is the right choice about birth control. This provider’s attribution to “aunties and grandmas” being the source of medical misinformation is in line with various scholars’ findings that providers view information patients receive from their social

networks as hindering (Yee Simon, 2010; Mann, 2013; Levy et. al., 2014). Some scholars reiterate this provider belief by concluding in their studies that social network decision making is indeed hindering. For example, Yee Simon (2010) conclude in their study of how 30 Black and Latina Women make contraceptive choices postpartum, that “The social network, including friends, mothers, and partners, were key sources of contraception myths, misconceptions, and vicarious experiences” (p.2). Levy and co-authors (2015) examine how providers engage with patient’s social network influence during visits, during which they found 42% included mention of social network influence, 75% mentioned by the patient while 10% mentioned by providers. These authors found that when providers brought up social network influence themselves it was with close ended questions and in order to either to address a certain contraceptive method’s negative media coverage or to see if the patient had any interest in a specific contraceptive method due to their social networks. Levy et. al. found that when faced with patients who were reluctant about a contraceptive method due to negative narratives from their social networks, providers either offer a different explanation for the negative experience from their social network, reminded the patient that “everyone is different”, or relying on what “most Women” experience to convince them to reconsider. I have always found it counter-intuitive that providers think it is a compelling argument to people who live minority lives that a minority statistic will not apply to them. Cusanno et. al. (2018) found that in response to patients referencing negative narratives, providers would 1) attempt to understand what the patient had already heard about the method by conversing with them more, 2) focus on possible positive outcomes of the method, 3) note that everyone has different reactions to different methods, so what they hear in their social network may not happen to them, and 4) share their own personal narratives or narratives from their own social networks. Techniques 3 and 4 brim with an irony truly worthy of the hypocrisy

of the settler colonial society it is enacted within. These providers seem to fail to understand that “everyone has different outcomes” is just as much a reason to not believe a positive narrative as it is a negative one, and that is why patients fear they themselves will not have the positive outcomes that their provider is describing. Technique 4 exposes that providers actually have no issue with basing decisions about contraceptives on narratives from social networks, but rather have an issue with the choice to not use a contraceptive itself. Consider the following provider’s statement Cusanno et. al. gives as an example:

“Well [staff member] has had a lot of the younger ladies that come in. ‘Girl, my daughter takes the shot, she didn’t gain any weight, you can’t friends tell you.’ ‘For real Ms. listen to what your [name]?’ And they respect [name] so much, and they go for that because they know Ms. [name] is not going to tell them anything wrong.”

This provider tells this patient that she cannot trust a narrative from her own social network from someone she actually knows, but instead should trust the narrative, not even from the provider whom she knows, but from her provider’s social network. Thus, the real issue is not that the patient is using narratives to make decisions, but that the decision the patient is making is to not use contraceptives, or to not remain in line with the dominant narrative of family planning (Mann, 2013).

Family Planning: A Logic of Elimination

Provider’s belief that contraceptives are the best options for patients of color is rooted in the dominant ideology of “family planning”, which forms the basis of most providers’ goals for patient reproductive health, and which denotes that a person plans their reproduction within a White normative lifestyle, which includes education, financial and job security, marriage, and cis-heteronormativity — those who reproduce outside of these norms are considered perpetrators

of “unplanned pregnancy (Stevens, 2015; Kendall et. al., 2009; Lifflander et. al., 2006; Mann, 2013).

Despite constant pressures to rely on these family planning standards, low income patients of color who actually experience unplanned pregnancy make sense of their experiences very differently from how providers make sense of them (Kendall et. al., 2009; Borrero et. al., 2015). Kendall et. al. notes that some “Women are rather accepting of an alternative life course that permits variation in the timing of events” and often live in contradiction to the family planning standards (p. 305). Scholars have found that these dominant concepts of “planned” and “unplanned” pregnancies and their effect on patients’ lives are not in line with what low-income Women of color actually experience (Kendall et. al., 2009; Borrero et. al., 2015) This is evidenced by the statement of a twenty-year-old Woman whose pregnancy was considered “unplanned”. She stated: “My life is more meaningful now. I’m not trying to get the guy anymore, wasting my time. Now I’m trying to get through my classes. I’m more focused. I’ve got to support my baby.” (Kendall et. al., 2009, p. 305). Regardless of patients’ sense making of their unplanned pregnancies, providers believe that patients will not be satisfied unless they achieve the ideal “family planning” life for as it is reflected in the TANF goals noted in the previous chapter, to not achieve these “family planning” goals is considered the reason poverty persists (Bridges, 2007).

Thus, if “family planning” is meant to liberate people of color from poverty, it is meant to keep them productive in capitalism (Harris Wolfe, 2014). In the same way that the welfare system veils that it is actually capitalism that causes the conditions of poverty that keep recipients of color from being capitalistically productive, “family planning” veils that it is conditions of oppression due to capitalism that keep low income patients of color from pursuing

an education, financial stability, and marriage and enacting these very “family planning” goals. (Kendall et. al., 2009; Blanc, 2011; Mann, 2013; Gomez et. al., 2017). Therefore, as welfare does, it traps them between structural oppression and neoliberal logics, and condemns them to the colonized narrative of the “wily patient”, whose reproduction must be, as a logic of elimination, regressed in order to end poverty for their own sake, and of overall American way of life. When providers employ the wily patient narrative to patients of color, they often enact many coercive practices to limit their reproduction, the consequences of which are severely stratified reproductive healthcare for Women of color.

Narrative Based Stratification in Reproductive Health and Contraceptive Counseling

Women of color, particularly Black Women, experience unique vulnerability and stratified reproductive care due to the intersecting narratives and structural oppression described above (Howell, et. al. 2016). Black Women experience high maternal mortality rates, being 4 times more likely than White Women to die from pregnancy-related hypertension, hemorrhaging, pulmonary embolism, and in fact every pregnancy complication including delivery and postpartum complications (Anachebe Sutton, 2003; Howell et. al. 2016; Gadson et. al., 2017; Callaghan et.al., 2012). Studies also note that Black Women do not receive timely preventative and prenatal care that can result in improved pregnancy and birth outcomes (Gadson et al., 2017; Anachebe & Sutton, 2003). Women of color also experience discrimination from providers in regard to birth control and sterilization recommendations. Downing and co-authors found in their 2007 study that providers were more likely to encourage Women of color to limit their childbearing than middle- class White Women. Gomez Wapman (2017) describe the various methods providers use to sway patient decisions on birth control as “implicit pressure,” which include affect and tone of voice, selectively sharing information about specific

contraceptives, and minimizing or not mentioning potential side effects. Dehlendorf, Ruskin, and Grumbach (2017) found that providers were more likely to recommend IUDs for Black and Latina Women of low socioeconomic status than for White Women of low SES. In a study that examined racial differences in the receipt of family planning services, Borrero et. al. (2009) found that Hispanic Women receive sterilization at higher rates than White Women, but do not receive more sterilization procedures than White Women, while Black Women received the same amount of sterilization counseling as White Women but underwent sterilization significantly more often. Similarly, a thematic analysis of interviews with 37 Black and Latina Women revealed that two-thirds of participants felt that IUDs would restrict their agency over their reproductive health due to the inability to remove IUDs without a healthcare provider, and voiced preference for more flexible pregnancy planning (Gomez, Mann, Torres, 2017). While these practices are all rooted in the dominant ideology of “family planning” that providers heavily rely on, providers are not unaware of the racial inequalities that exist within health care and several scholars have sought to address and change the ways the providers communicate with patients to hopefully reduce stratification of their care (Mann, 2013; Mostow et.al., 2010).

Current Understandings of Bias in Patient-Provider Communication

In an attempt to reduce the health disparities experienced by patients of color, scholars have come up with several theories and models. Berlin and Fowkes’ (1983) “LEARN” model focuses on encouraging providers to engage in the skills of **L**istening, **E**xplaining their own perceptions, **A**cknowledging differences between provider and patients, offering treatment **R**ecommendations, and **N**egotiating plans. Levin et. al. (2000) offers the “ETHNIC” model, suggesting that providers seek an **E**xplanation of patient’s illness understanding, inquiring about **T**reatments patients use and expect, finding out about alternative **H**ealers, **N**egotiating options

that include the patient's beliefs, and creating Interventions that are culturally appropriate.

Mostow et. al. (2010) attempt to move beyond the models with a focus on collection of patient information to a focus on power difference, mitigating patients' expectations of being disrespected, and how providers can actively show empathy with the RESPECT model. This model focuses on the verbal and nonverbal behavior that providers can engage in to **R**espect the patient, have the patient **E**xplain their understanding of illness, asking about the patients **S**ocial context, attempting share **P**ower with the patient, showing **E**mpathy, asking about **C**oncerns the patient may have, and building **T**rust. These models all ultimately reconstitute the oppressive colonial narratives that feed bias that they are attempting to deviate away from because they do not address the provider's own mind as a site that needs to be decolonized, and instead reiterate the characteristics of the wily patient as expected. By claiming that physicians must "negotiate" with patients as a skill, they move only linguistically a half step from the previous paternalism of deciding health outcomes for patients. Providers believing they must negotiate with patients might imply that patients inherently want something in opposition to what the provider wants (to what the provider believes is right), and that the goal of a good interaction is to convince the patient to let go of at least part of their opposing beliefs. The acronyms of these models indicates a level of vapidness, where the appeal of the model is more that it is catchy rather than how it functions, to the point where the irony of attempting to be more inclusive by using the acronym "ETHNIC" is lost upon them. While it is the naming of the model, it is also inherently the naming of the patient it is employed upon, and associating their "ethnic" identity with the difficulties experienced in patient-provider communication. It also re-affirms the normative nature of Whiteness, for "ethnic" is only a marker for a distance from Whiteness (Bridges, 2007).

The field of communication has attempted to address these disparities in health care by focusing on the concepts of cultural-competency and patient centeredness. Epstein Street (2011) write that patient-centered communication has the goal of “inviting” the patient into the encounter, and note that a provider could say,

“I want to make sure that I’ve helped you understand everything you need to understand about your illness. Patients usually have questions because it can be complicated. Could you tell me what you understand, and then I can help clarify...?” (p. 101).

King Hope (2013) define patient-centered communication as made of up the following practices: (1) fostering the relationship, (2) gathering information, (3) providing information, (4) making decisions, (5) responding to emotions, and (6) enabling disease and treatment related behavior (p. 390). These are identical to the goals of the three models discussed earlier, which have the same issue: these attempts are all rooted in the goal of patient adherence. Cuevas, O’Brien, and Saha (2019) examined how patient-centered communication can reduce the medical distrust that patients have in their decision-making process. The authors showed participants videos of actor-doctors enacting communication with either high patient-centeredness or low-patient centeredness and concluded that high patient-centeredness resulted in lowering of mistrust, and could therefore lead to better patient adherence. Cuevas et. al. do not examine the reverse of this question: “Does patient-provider communication reduce the mistrust medical providers have in patients?” Communication scholars have failed to examine the ways in which providers’ perceptions of patients and how they are able to enact patient-centered communication is already filtered through a mind that has been colonized to have the main goal of patient adherence. This is counter-productive to reducing the use of oppressive narratives in making sense of their patients since the essence of the wily patient is a lack of adherence. Thus, if a patient is wily

because they do not adhere, and enacting patient-centeredness is tied to the goal of patient adherence, there is no room for patients to both go against provider recommendations and not be considered wily. Or, there is no room for patient-centered communication to un-do the image of the wily patient in provider's minds. This is articulated by the findings in Burgess and co-authors study.

Burgess et al. (2019) shift the lens from patients to providers with their study examining how providers respond to narratives of health encounters about racial disparities. Through semi-structured interviews with 53 providers, these authors sought to find out how narratives could be used to engage and raise awareness amongst providers about healthcare disparities as well as how framing race in different ways within narratives could lead to providers being more open to healthcare disparity discussions. Burgess and co-authors found that all providers were divided between believing if providers played a role in stratified healthcare and if they did not. Those who believe they did were labeled high provider attribution (HPA) and those who believed they did not were labeled low provider attribution (LPA). Burgess et. al. found that while all providers accepted narratives where the provider was able to overcome issues with the patients through patient-centered communication, they were split over narratives where the patient's issues were explicitly tied to racism and remained unresolved. For example, providers who already believed that providers are a low level of attribution (LPA) to health disparities rejected (in the form of blaming the narrator, and identifying with the provider the least) narratives where the provider was unable to solve a racial issue. This implies that provider perceptions of themselves as harmful or not are tied to whether or not the outcome is one where the patient's care is resolved, not necessarily the method of resolving it. Burgess's study provides the basis for understanding

how to engage providers in their racist biases. With this thesis I hope to contribute to that understanding by offering a postcolonial lens to narrative medicine.

Rita Charon's (2001) narrative medicine concept takes a humanities perspective on medicine and illness, on patient and provider communication, noting that providers can engage in reflective writing and reflexive close reading of such writing to "illuminate 4 of medicine's central narrative situations: physician and patient, physician and self, physician and colleagues, and physicians and society." Drawing on this, I write postcolonial autoethnographic narratives of three participants, aiming to illuminate the narrative situations of character and participant, character and self, character and colleagues, and character and society, where the characters are myself and the three participants, Tiffany, Jane, and Rose, that I have narrated in chapter 5. Rita Charon writes that through narrative medicine we can "bridge the divides" that separate us (pg. 1897). I argue that with postcolonial autoethnographic narrative medicine, we can identify how the divides that bridge us are colonial constructs that we reiterate, and can bridge those divides through de-colonizing our storying, which can be done through analysis of postcolonial autoethnographic narratives.

Thus far I have described how I make sense of stratified reproductive health for women of color as a manifestation of the logics of elimination (Chapter 1) which takes the form of dominant narratives that colonize the minds of health care providers into justifying stratified reproductive health (Chapter 2) and articulated the ways the field of communication as addressed this concern thus far through the concept of "patient centered communication." In the following chapter I will discuss my methodology, my shifting sense making of this project, and the creation and analysis of my narratives, through which I address my research question: **How do I make sense of Women of colors' reproductive health?**

CHAPTER THREE

METHODS

I spent a lot of time in the first year of my M.A. program forming many methodological opinions, thinking my way through other people's data and methods, believing that I had a grasp on the linear process I myself would follow. This being my first start to finish project involving data collection and analysis, it was a long process of realizing my opinions were all moot, research is not linear, and time constraints would be my largest methodological reasoning. What this project would turn out to be was not decided until after my data was collected and I trial and errored various methods of making sense of the data I had. I imagined that this thesis would be a thematic analysis of all the themes I found and constructed in these interviews. However, when confronted with a large amount of data, and many thoughts, and a deadline, I focused my project specifically to reflect my sense making of reproduction as postcolonial and how narrative medicine can be used to address this.

Participant Recruitment

This study was theorized with Brianna (Bria) Cusanno, who examined how providers made sense of reproductive health and policy, and our aim was to be as inclusive as possible with the study. We decided to use the language "medically able to use birth control" because we wanted to remain inclusive to trans and non-binary people who may not identify as Women but who require reproductive health care associated with having a uterus. After recruitment, in which all participants that signed up for my study were cisgender Women, I realized that being

explicitly non-exclusionary is not the same as being explicitly inclusionary, and that my attempt to be inclusive was not nearly enough of an effort. I should have instead examined what makes studies accessible or inaccessible to trans audiences, and how space and location may affect this as well. The IRB for this study originally stated that I would be recruiting from three different locations and methods: a low-income clinic in Florida in which a provider has passed out fliers to patients of color, and a flyer sent out to two university listservs. However, all of my participants have been recruited either through one university's listserv itself, or from snowball sampling from a person on the listserv. Participants contacted me through email, where we set up a time and a place of convenience, but most participants preferred for me to choose the location. Interviews lasted between 45 minutes and two hours (average 90 minutes) and participants were informed that they could choose to end the interview, skip questions, or request that recording not be done or be stopped at any point in time. Participants received a \$30 Visa gift card funded by Bria Cusanno's NSF grant. Overall, I conducted 20 interviews with cisgender Women of color between the ages of 18-45. Of these women, three participants were included in this study: Tiffany, a 32-year old Black woman, Jane, a 19-year old Latina woman, and Rose, a 20-year old South Asian woman.

Data Collection

I gathered data by conducting semi-structured interviews, inviting respondents to “describe or interpret meaningful dimensions of their lived experiences” (Lindlof Taylor, 2019, p.229) with reproductive health. Lindlof and Taylor write that the goals of respondent interviews are to:

“(1) Clarify the meanings of common concepts and opinions... (2) “To distinguish the decisive elements of an expressed opinion... (3) to determine what influenced a person to

form an opinion or act in a certain wa ... (4) to classify complex attitude patterns and (5) to understand the interpretations that people attribute to their motivations to act. (2019, p. 229)

For this project, these goals translated to: (1) clarify conceptions and opinions of reproductive health, (2) distinguish what elements take part in sense making about reproductive health, (3) What influences sense making of reproductive health and action related to it, (4) to be open to the complexities of various attitudes embedded in different participants' sense making of reproductive health and (5) to engage in meta-discussion with participants about their interpretations of their sense making process.

This project explores my own sense making process throughout these interviews, and embedded in this methodology described above are the “who, what, where and why” aspects of sense making that I hope to explore. A semi-structured interviewing format allowed me to “address specific dimensions of [my] research question while also leaving space for study participants to offer new meanings to the topic of study” (Galletta, 2013, p.5). This flexibility has created what Lindlof and Taylor (2019) describe as a “wonderful blend of strategic mindfulness and unexpected discovery” (p. 309). My strategic mindfulness is the evolutionary manner of interviewing in which I am crafting interview questions based on themes I have noticed in previous interviews that I anticipate may be relevant, and then make relevant, in future interviews.

Creation of Narratives

Theoretical Grounding: Postcolonial Autoethnography and Interpretive Ethnography

While the methodology I used for creating these narratives is interpretive ethnography, I wrote these narratives considering the tenets of postcolonial autoethnography. In fact I believed I

was actually creating postcolonial autoethnographies until guided by Dr. Aisha Durham to frame my narratives instead as interpretive ethnography, given my focus on co-creation and interaction. Interpretive ethnography stands as a critique to traditional ethnography that considers texts to be a “mirror of reality” (Denzin, 1996). Instead, interpretive ethnography understands that a text is “not a mirror of reality; rather, a text is embedded in narrative logics of science, sexuality, desire, and capitalism (Denzin, 1996, p. 233). By crafting these narratives as interpretive ethnography I hope to emphasize the shift in my sense making from my original research question: How do Women of color make sense of reproductive health? To How do *I* make sense of Women of color’s reproductive health? In this shift in language I hope to embody my belief that there is a difference between representation and interpretation. A representation is inline with traditional ethnography’s belief that the texts we create are mirrors of reality. An interpretation is the understanding that reality is a deeply personal notion and it is impossible to capture a reality outside of ones own sense making. I can never articulate what another Woman of color’s sense making is, let alone several Women of color’s sense making. I can only articulate my sense making of lives outside of my own: my sense making of other’s sense making. I aim to articulate that this is not a project about how these Women make sense; this is a project about how I make sense. This very sense making of mine is one that is inherently and inescapably colonial given my subject position as a Sri Lankan American scholar, and having grown up wanting for nothing materially in the United States. Thus, I am greatly influenced by the field of postcolonial autoethnography.

Postcolonial autoethnography is a developing field in which colonized scholars have sought to decolonize the field of autoethnography, which privileges the stories of White scholars, by writing of their own postcolonial conditions and experiences within Western academy

(Chawla Atay, 2017). Chawla Atay (2017) note that when postcolonial scholars write autoethnography they “interpret, know, and name personal and cultural experience from the standpoint of geo-politico-historic frames of post/ colonialism” as well as “focus upon the kinds of texts that emerge when postcolonial subjects write from, about, and through the liminal, hybrid, and diasporic locations that they inhabit” (p.7). Chawla Atay (2017) also note that a postcolonial shift to autoethnography includes “a resistance of all master narratives with a critique of Eurocentrism as a primary goal” as well as an understanding of the dialectical relationship between the colonizer and the colonized” (p. 5).

My goal with this project is to address these tenants of postcolonial autoethnography by writing with the goal of resisting the dominant narratives rooted in Eurocentrism outlined in chapter 1, as well as analyze the dialectical relationship between colonized and colonizer by showing the manner in which my participants and I both colonize and decolonize. Through this analysis I hope to address the aspect of postcolonial work that Shome Hedgre (2002) write, “theorizes not just colonial conditions but why those conditions are what they are, and how they can be undone and redone” My creation of narratives to be analyzed for colonizing and decolonizing sense making is my attempt to show how these conditions are redone and can be undone (p.250).

Theoretical Grounding: Narrative Medicine

Rita Charon’s (2001) narrative medicine concept takes a humanities perspective on medicine and illness, on patient and provider communication, noting that providers can engage in reflective writing and reflexive close reading of such writing to “illuminate 4 of medicine's central narrative situations: physician and patient, physician and self, physician and colleagues, and physicians and society.” Drawing on this, I write postcolonial autoethnographic narratives of

three participants, aiming to illuminate the narrative situations of character and participant, character and self, character and colleagues, and character and society, where the characters are myself and the three participants, Tiffany, Jane, and Rose, that I have narrated in chapter 5. Rita Charon writes that through narrative medicine we can “bridge the divides” that separate us (pg. 1897). I argue that with postcolonial autoethnographic narrative medicine, we can identify how the divides that bridge us are colonial constructs that we reiterate, and can bridge those divides through de-colonizing our storying, which can be done through analysis of postcolonial interpretive ethnography narratives.

Narrative Listening and Storying Memory

I first considered what it meant to story characters in my mind through my engagement with audiobooks. As I listened to them both actively, and passively I created a version of these audiobooks in my mind. I storied them in a manner in which I can quickly recall plot points, tie together themes, as well as conceptualizing the characters in my mind as people with feelings, experiences, and opinions that influence their interactions in the story. I found that listening to my data in a similar way was the best way for me to make sense of what I had gathered. I was afraid of producing work that reduced my participants down to block quotes, and sought to understand them as whole people, to come to know them. This process of “coming to know them” turned my participants into characters, like the ones from my audiobooks, through what scholars call narrative listening. Polkinghorne (1991) writes of how people make sense of life events through creating narratives from memories, centering them within our concepts of plots that have a beginning, middle, and an end. Clouston (2003) states that when we create narratives from memory, we “put them into the context of the social, cultural and historical fabric of life.” (p. 138). Using narrative is inherently colonial because I cannot escape that my

conceptualizations of “narrative” and “plot” which as Polkinghorne (1991) notes has a temporal structure of a beginning, middle, and end, which are determined by colonial notions of storytelling. However, narratives offer room for decolonizing in that they allow for the narrator to locate them within such “historical fabrics” as postcolonial conditions. Narratives also offer potential for decolonizing because, as Polkinghorne (1991) notes, they are distinctly different from other forms of literature because they remain unfinished, and therefore changeable. This gives room for theorizing and re-theorizing the characters of our narratives and how they engage with the dialectical tension of colonizing and decolonizing. Keeping this concept of narrating memory in mind, I listened to my data with narrative ears: creating plot, characterizing my participants, and making sense of the interaction as a story in the same manner I make sense of my audiobooks.

I constructed each narrative by writing the arch of my story of each participant and transcribing each section of dialogue. My goal was originally to have transcribed each interview, then coded through for themes. However, the time constraints I faced led me to reconsider this method. Because I both wanted to portray my participants as whole individuals, I found that the more I coded for themes, the more I was following a research path that led to using block quotes because I would run out of time in trying to write each participant narratively. I decided then, due to having spent too much of my time coding in a manner not particularly useful to how I ultimately presented my data (but useful for future work, hopefully), to focus specifically on a subset of my data, and to narrate them as the characters I had created in my mind.

I chose the characters of Tiffany, Jane, and Rose because they had become favorites of mine to story. I believe I began listening to them more often than my other data because they were particularly distinct experiences, with Jane sharing having to get an intravaginal ultrasound

to get birth control, Rose sharing a similar cultural experience with reproductive knowledge, and Tiffany discussing how she got pregnant on birth control twice. While there are other participants like this, these three were the ones I felt I could narrate the best. These uniqueness's in their stories made me listen to them more often, and so I characterized them the most compared to interviews I did not listen to as much. With this comes the erasure of other stories and narratives that may stand in opposition to the conclusions I have drawn here. Within these narratives themselves is the erasure of parts of the interview that I chose not to story, or that I could have chosen to story in a different way. I could have crafted various stories from one interaction, but my concept of stories as having to be linear, of having clear subject matter, limits the ways in which I story the interviews. Further research could examine how I could create various narratives from one interview, and the political implications behind those interpretations.

I decided to transcribe the way I write fiction dialogue, so that each narrative could be read as a story. I then listened through each interview again and added in context for the dialogue. I then used the notes that I took during each interview and the reflexive journals I wrote after the interviews themselves in which I recorded as much detail as I could remember about the scenario, body language, and my own thoughts to inform the thick description I use within the narratives. My own thoughts, participants' body language, physical descriptions, are all from these journals and notes. Together, they story my sense making of reproductive health with three participants. However, I feared that characterizing my participants would lead to another form of essentializing them, of being unable to see how my participants live both as the characters I craft but also outside of them – outside of me. I thought if I engage in reflexivity to theorize about the ways the “latent ideological structures that inform our scholarship and practices” and how these colonize and decolonize the spaces we take up (Shome, 1996), then to

think of participants this way would be to wonder about them. Where colonial narratives encourage us to believe we “know” individuals, assuming the realities of their daily lives fit within what we “know” of their lives, to wonder about them feels like decolonizing. Yet, even in this sense making I am inevitably limiting their lives to what I am able to imagine of them, reflexivity about the ways in which those imaginings are colonial does not necessarily open my mind to different imaginings. I imagined them living out the lives they briefly shared with me: I pictured them grocery shopping in ways similar and different to my typical aisle navigation. I imagined them driving through difficult traffic, picturing if they were they types of people who curse when they’re cut off. I wondered what kinds of skies made them stop and take photos, to send to what kinds of people in their lives that beautiful skies reminded them of. However, I am only able to imagine them within my understanding of what daily life in a city in Florida is like, filling in the blanks of my own perceptions with the things they told me about them that I found different from me, and finding decolonizing sense making in those details. I imagine the way Rose’s mornings sound different, waking up in her home in Singapore to a house of parents and siblings, to how she wakes up here, in student housing surrounded by University life. I think of Jane’s relationship with her mother, and how she may feel with how her mother handles her little sister’s dating decisions in the future. I think of Tiffany’s conversations with her daughter in the future, and if Tiffany’s perception of her daughter’s personality as “social” and “diva” would affect how she spoke to her. I wondered at if that affected how she already spoke to her. I wonder at all of these things, while noting how my imaginings are similar and different from my own life. How my difficult relationship with my parents, the pressures to attribute this difficulty to culture, the ways I imagine how I would have dealt with the scenarios in their minds, all constrict how I am able to imagine my participants.

While I am inherently colonizing in the ways my wonderment about my participants can only ever be through my understanding of life and relationships, I believe that wondering about them keeps me from essentializing them as only the characters in my story, keeps my narratives of them from having an “ending”. I felt in doing this I was already engaging in decolonizing them, because for me the decolonizing act of wondering stands in stark opposition to the colonizing act of knowing. To wonder of them in these different ways kept them from remaining stagnant, from their characters becoming caricatures, from my colonial mind from being the first filter through which I view them. While I cannot escape that my colonized mind can only know colonial ways of life that I imagine participants within, wondering is decolonizing because it offers space for endings for narratives that we cannot claim or imagine. Creating this space means that wondering about participants has no end. As my sense making continually changes, as I try to decolonize more unquestioned corners of my life, understanding new ways of doing life, I can continually wonder at how my participants, their characters and their real lives, can be narrated with new sense making.

Data Analysis

Narrative Medicine posits that through the literature methodology of close reading, physicians can examine medicine’s central narratives, which Rita Charon defines as “physician and patient, physician and self, physician and colleagues, and physicians and society” (p. 1897). The method of “close reading” is one in which the reader focuses on aspects of the text other than plot. I draw on two specific aspects of narratives that Rita Charon notes should be attended to in close reading: Form and Frame. Form refers to the aspects of the text that often go unexamined, the pieces that make the whole. In particular I focus on the form of “narrator” in my analysis. A close reading considering the form of the narrator means examining the narrator’s

engagement within the text as well as the narrator's experiential knowledge. A close reading considering frame, or how the text is located in the world, considers where the text came from, how it came to be, what questions it answers, and how it may change how we understand different texts. With a postcolonial lens, I conduct a close reading considering the aspects of form by analyzing for the ways in which I, as the narrator, am engaging within the text in ways that are both colonizing and decolonizing sense making. I consider the ways in which I as a narrator both perpetuate colonial narratives and resist them. I consider frame with a postcolonial lens by examining how the ways in which I, and my participants, make sense in ways that are rooted in a colonial history of reproductive health and identity. By examining form and frame postcolonially I am engaging in reflexivity, examining how my own subject position as both narrator and reader of my characters enact and resist colonized sense making of our own reproductive health. Through this reflexivity I hope to re-emphasize that the sense making being analyzed is my own: what I make sense of my participants sense making as and how my own sense making shapes this process. This is not a project about how these women make sense; this is a project about how I make sense.

CHAPTER FOUR

NARRATIVES

In the following interpretive ethnographic narratives, I narrate my interactions with three Women: Tiffany, Jane, and Rose. Through analyzing for colonial and decolonial sense making through close reading of form and frame, I identify five types of colonizing sense making and two types of decolonizing sense making. The five types of colonizing sense making are: 1) colonizing perceptions of participants, 2) colonized concept of important selves, 3) reproduction centered around colonized timelines, 4) reiterating disbelief in participant sense making, and 5) colonized sense making of “culture”. The two decolonizing sense making I identify are: 1) decolonizing sense making of “culture” and 2) decolonizing trust in healthcare providers. The following narratives are my own colonizing and decolonizing sense making of how these Women of color, Tiffany, Jane, and Rose, make sense of their reproductive health.

Tiffany

I flip through the consent form again, checking each page is there. I check my phone for a text from Tiffany, who should be arriving soon. I spent the previous night obsessively checking and re-checking if my recorders worked, but I worry myself into checking again. I get a text from Tiffany. She is heading up the elevator now and I go to meet her. This is my first interview and my heart rate is faster and my face sweatier than I’d like. I wipe away my sweat, drying my hands on my pants and the elevator door opens. Many people walk out and I am not sure who I am looking for. I realize as people pour out of the elevator that I am just looking for color and I

don't actually know what race Tiffany is. A Black Woman exists the elevator and looks around. We make eye contact and I raise my hand half way, indicating that I might be who she is looking for. As she walks to me I take her in. Her hair is side parted and pulled into a bun. The square frames of her Black glasses rest on the tops of her round cheeks, lifting as she smiles at me and raises her hand to shake mine. She looks very much like a friend of mine who is very chatty. I think to myself that I hope she is just as chatty, as I am afraid of an interview filled with awkward silences and I am not sure how to avoid that on my part yet.

“Hi, Tiffany? I'm Niv,” I say.

“Yes, hi,” she says. I lead her to the room and make small talk, thinking of rapport building, of my qualitative methods textbook, and then chastise myself for not being more present. We sit and I offer her a water but she refuses. I leave them on the table in case she changes her mind and begin to tell her about my research and going through my mental check list of things to say. I pull out my literal checklist after just to be sure. As she fills out the forms I set up my recorders, and then we begin.

“Alright. So uh, if you just tell me a little bit about yourself what you – what you do and how you kinda tend to spend your time?” I wonder if this is open ended enough after I say it.

“I um, I'm currently a staff assistant and I kinda manage business functions for University Department I um, I'm a mother I have two children two toddlers. Um in my free time I nail salon, reading, you know relaxing at home, child activities that sort of thing,” she says. Her voice is even, a distinctly calmer pace than my own.

“Yeah, Yeah, Okay great um so tell me a little more about your kids you have two kids.” I say, trying to speak slower.

“I do I have two children that I got pregnant with on birth control and uh I’ve actually never been pregnant when I’ve not been taking birth control,” her tone tells me she knows how surprising this is and she smiles and nods, eyebrows raised, when my mouth falls open in reaction.

“Wow” I’m not sure what to ask next. I did not expect to hear that, nor did I expect birth control would come up so quickly. I remember that the study flier explicitly mentions birth control and wonder if I should change my interview guide. She saves me by continuing.

“Go figure you know so yeah. They uh, I have one boy and one girl. Could not be more different if I tried. They really are, aside from gender, they are polar opposites just,” she says gesturing her hands in different directions, emphasizing how different they are. Her tone is adoring and it makes me smile.

“Which one is like you?” I ask. She contemplates for a bit and then says,

“My son is more, and he’s the baby, you know. But he’s more quiet, reserved, calculated, you know he has fun on his own,”

“So how is your daughter then?”

“She’s Miss Popularity, mother hen, social butterfly, the diva extraordinaire, wild outlandish personality. And he’s much more...loner, quiet, goes in his room and plays with his things personality so couldn’t be more different,” She says and I like the way her face softens when she speaks of them. I laugh a little and say,

“Ohh, that’s pretty—yeah wow, wow that’s very interesting,” I glance down at my interview guide to see where I should go from here.

“Yes Ma’am,” she says and I look up in surprise. She is several years older than me, and in the brief time we have spent talking I have felt very much like a child, slightly frazzled, in

comparison to her calmness that is distinctly adult. I want to ask her to call me Niv, but then think she should be able to call me what she wants.

“Um, so what is your like primary source of reproductive health care?” I ask with a note to myself to think of better transitions.

“Well currently I have an IUD—another IUD in. Um, I’m not actually in a wrelationship currently where I’m *worried* about birth control so...that played a role in my effect to get back on this particular birth control because I wa—I had a Mirena in when I got pregnant with my son. But I was married at the time so, and when I was pregnant with my daughter I was on Depo so, yeah,” she says the last few words through an exasperated laugh, throwing a hand up and then hitting the table lightly for emphasis.

“Oh wow, oh,” I say, surprised. I had never heard of anyone getting pregnant twice on birth control before and the thought is terrifying. I think of how much this will scare Bria when I tell her. I’ve been considering getting on a birth control method and this makes me wary of the Mirena. I tell her of my own experiences, “Yeah I took the Depo shot I was also on that it wasn’t a good experience for me though,”

“Uh it *worked* for me for the— I got on it because I was told it stops periods,” she says. “That was the reason. No one said, ‘Yes it stops periods...but you’re gonna pop up pregnant.’ So it kinda missed that in there,” her sarcasm is heavy and I find that she is quite funny. “You know and then the same with Mirena ‘oh it lasts for five years there’s no weight gain, 99.9’. I got it, I had it in for almost two years. No problems. And I just happened to go to my well Woman exam and I was pregnant with my baby,” she says.

“Wow,” I say again.

“But I didn’t have a missed period to...to kinda let me know”

“To let you know, wow oh wow,” I think of how this story is going to make me even more uncertain about what birth control to get on.

“Had I never went to that appointment I would have found out when the belly started growing. No morning sickness, nothing.” She says, furthering my fear. I had previously never thought about this aspect of choosing a birth control method that stopped your periods all together—if it failed you wouldn’t even know because you weren’t expecting your period anyway. I had been considering birth control options that would stop my periods all together recently, but Tiffany is making me rethink that.

“So you said that you um you decided to go uh with an IUD right now, uh, because you were in a relationship that you weren’t worried about, what does that—what do you mean by that like...?” I ask.

“Well I’m divorced now so we uh actually separated two years ago but I had this IUD in for three almost four, next month will be four, so I wasn’t, we were in a point where, I hate to say our relationship was over, but we were already like ‘Okay whatever’. We were on our way out, but we were married, so we uh actually did not separate officially, legally divorce until two years ago but when I got it put back in we were—I knew it was over so I wa—you know,” Tiffany says, and gives me

“Mhm, Okay, yeah, yeah,” I say, nodding while she speaks.

“And I’m not in a relationship now. So I just enjoy the benefits of no periods but I’m not worried I’m gonna pop up pregnant so,”

“Very, very true,” I say, thinking that it’ll be a while before I forget the phrase “pop up pregnant.”

“Yes cause if I do get into a relationship I will switch my birth control cause I—I—I — just, no,” She shakes her head.

“So you don’t—but do y—you don’t really trust that you wouldn’t get pregnant on this IUD?” I ask. I begin wondering how her provider manages to give her any birth control advice given how incorrect they had been about how it will work for her.

“I don’t, I don’t, just because I got my son, you know. And they told me it was 99.9 then,”

“Yeah. So what would you do um differently if you were to get into a relationship?”

“If I *was* to get into a relationship,” her tone implying this was unlikely, “I would enforce condoms. And um, I probably just because I’ve been on the Mirena before and I’ve gotten pregnant, I probably would try the implant one. Um I hear there’s one for your arm or a pill maybe. *Something*, even though IUDs are *supposed* to be the strongest form. I just—I don’t see it you know, so”

“Yeah, I see why that—Um wow yeah. So do you feel—do you feel like that would be very easy for you to insist that condom usage should happen and everything,” I ask as I had scribbled ‘enforce condoms’.

“Well, at the start of a relationship you know, everyone, you’re using them. But you know obviously I...dated, we got married, so that kinda went out the window. So I said okay, well we’ll just get birth control so that’s something that’ll be a little bit...I’m not looking for marriage you know, um been there, done that. If it does happen great, but that’s not *my* thought process nor do I necessarily want more children. So that will be something that is more strictly enforced than it would be if I was still in my marriage you know,” she says and she has sent my mind spiraling again. None of my close friends are married, so a marriage dynamic is not

something I hear much of. I think of how difficult it already is when dating to enforce condom usage. I had never thought of how that was probably even more difficult when you are married and it does not make me hopeful. I ask Tiffany if she would stick to condom usage when dating and she says she would consider more permanent options.

“Okay. How do you usually go about looking into—into those things?” I ask.

“I always talk to my um, OBGYN. So, I—I’d like to kinda lean to him for that for that wealth of knowledge and see what he thinks would be best for me, obviously he’s been my provider so you know what will be best for me and my habits so,” She says.

“So you have one OBGYN that you’ve been going to regularly?”

“Yes,” she nods.

“Okay, okay. So how—how has that been for you that kind of relationship, do you feel—how do you feel about that?”

“I actually was seeing—he was my mother’s provider when I was born. He was the provider who delivered me so I actually never saw a different one, so its kinda everyone in our family goes to him. I’m going to him too so. But I do trust his opinions and he’s delivered my children, you know. So I do trust that he knows my care he was there with me the day I was here,” she taps the table and laughs, “so he knows me pretty well so, I do trust him.”

“Yeah that sounds very—very close of a relationship,” I say, thinking of how I had never heard of, or read anywhere in the literature, of OBGYNS who remained in a patient’s life this way and write a note to check for that.

“Yes, he’s been around forever you know when I ne—you know having my first child he was able to recommend a pediatrician you know so I’d like to stay with him and I do trust his judgment,” Tiffany says.

“Wow okay can I ask you what ethnicity your—your provider is?” I ask.

“Um, he’s...Caucasian,” she says.

“Okay has that ever—is that something that ever crosses your mind?,” I ask but she is shaking her head ‘no’ before I finish, “Never?” I say. There is a look on her face of determination that makes me believe she thinks I’m looking for the opposite answer given the focus of race in my study’s recruitment flier. I wonder if I am looking for a different answer and I’m not sure how to differentiate what I expect from what I am looking for, or if there is a difference at all.

“No just because he’s been in my fam—you know my mom saw him and she still sees him so that was my determining factor you know me, you’ve watched me grow as a child so ill see you and then whenever he retires whoever he refers me to will be who I see at that point,” she says and I imagine after knowing her provider since birth, this change might be difficult.

“Mhm okay so how do you feel maybe about um other health care providers versus someone that you’ve known for so long?”

“I have problems with new. I do not like my uh my PCP actually passed last year and granted he was elderly we—you know we—okay no ones gonna live forever I refuse to see a new doctor,” she says.

“Yeah?” I wonder what her other options are, and can’t think of any.

“So Im just kinda hoping I don’t get seriously sick because I have not met his replacement I don’t really s—I have problems with *new* so,” she shrugs in a ‘what can you do’ sort of way.

“Do you mind me asking about—about that, about, I guess what problems you have with seeing someone new?”

“It’s just—Its really just starting all over...and that’s also probably the reason why I’m not dating,” she exhales a short laugh, “because I grew up with *you*, I was married to *you*, I don’t wanna do the dance all over again so,”

“Uh-huh yeah. Do you find it tiring to kind of have to go through that process again?” I say, thinking of how dating is exhausting, but I had only recently begun to go through the process of seeing doctors myself and hadn’t been through enough of the dance to be exhausted by it yet.

“It’s more of a—just fear. I just—I hate the unknown you know and I—you don’t really know me I don’t really know you so now I don’t know if I necessarily trust your medical opinion. Granted I know you obviously went to medical school you have a license. It was a level of comfort with my normal doctor I don’t have that level of comfort. I don’t know you, you don’t know me so now I’m only gonna see you when I’m sick how do I know you’re recommending the best course of treatment. Hmm. I have that problem so,” she says.

“Mhm. Yeah. So how—how do you feel like you— a doctor would have to go about um getting to know you if—if you were to seek care again?”

“Well I do know I would bring my records you know obviously he would review my records but I—I really don’t know aside from just reading that how do we cross that barrier,” she says shaking her head again, “Its never come up I’ve had the same providers forever so...I don’t know where I go from here try—you know even trying to—I cant imagine the day he retires”

“Well I hope that day does not come very soon,” I say and it feels empty, I wish I had read something in all the literature I reviewed that could help her but I think of nothing. This was the gap I suppose I was trying to fill, that I was trying to answer with this project, but that does

nothing for this participant right now right here. I look at her with helplessness and can do nothing but shake my head.

“I hope so too, just please don’t,” she gives another exasperated exhale, “because I can’t I don’t– no.”

Jane

“Uh, hi, are you Jane?” I ask the Woman sitting one picnic table down from me. After five minutes of nervously observing her and hoping for accidental eye-contact, I finally accepted that I would have to swallow my anxieties and ask.

“Um no” she says glancing briefly at me and returning to her phone.

“Ah, sorry!” I hurry back to my table and sit to observe again, my eyes latching onto every young brown skinned Woman who walks by. *This is the worst part about interviewing*, I think to myself. All I know about the Woman I am supposed to meet is that she is young and would be sitting at a picnic table. I suspect, from the last name that she has that she is Latina. I wait for a few minutes, ruminating on how the wind will make my recordings a little harder to hear, when a young Woman sits down at another table near me. She is a light skinned Woman with long brown hair, who reminds me of a girl I grew up with. I glance at her a few times, just briefly enough to not be staring but long enough to notice her mirroring my behavior. She is looking for someone too, but I can’t be sure it is me. Our eyes dance hesitantly, meeting once, twice, and then finally holding eye contact. We speak at the same time.

“Are you...” I say

“Niv?” she points to me.

“Yes!” My relief is so obvious she laughs and I join in as she moves her things to my table.

“I wasn’t sure if it was you, you’re so much younger than I expected,” she says.

“Yeah you know, everyone I’ve interviewed says that,” I laugh again. I give her my spiel about my research while I set up my recorders, how I’d like for her to talk about anything she’d like to, and how she can withdraw consent at any time. She tells me she gets it, she’s done research herself and that’s why she signed up for my study, because she knows getting participants is difficult. I am relieved at the relaxed nature we seem have with each other so far.

“So uh, tell me a little about yourself. You are at [university], Undergrad, what program are you in?” I ask. She tells me she is studying molecular biology and finds it really hard. When I ask if she knows what she wants to do she walks me through her uncertainties of wanting to do pre-med but also really enjoyed her experience with doing research so she is undecided. We chat more research she could do until I decide to dive in to my queries about reproductive health.

“Let’s talk a little about reproductive health. So what does reproductive health mean to you?”

“I feel like its super important just to have that like right and access and um, just that freedom over my own body that I have that peace of mind. Like I choose to be on the birth control methods so that I have all these other things going on in my life, and that’s one less thing that I have to be worried about. Even if like I’m like having protected sex like – just the thought that its even a possibility like, is not a stress that I need in my life. Just for like my overall health and well-being, I have enough stress going on so it’s just super important to me to have that, totally taken care of” Jane says. However when the conversation moves to her experience with birth control, it’s clear that is has been anything but stress relieving. She tells me of her friends who have health problems that make their ability to get pregnant uncertain.

“I can’t imagine if I did have like something that I would have some sort of timeline, because I know – all the Women I’m associated with have really big goals, in academia especially so, I’m really lucky that I don’t have to worry about that timeline but I know a lot of Women do so,” she says. I feel surprised that she knows multiple Women who have this issue, because I can’t think of any that I know. I wonder if it is that the Women I know don’t have similar issues, or if I just don’t know if they do. We begin to talk about birth control and her provider. She tells me of the complications of being away at school, and having a gynecologist in her hometown. “I personally have to go every year to get it refilled. I know some people don’t -- my, my pill refilled, yeah so when I go they do—they do the ultrasound, like *inside*,” she motions with her hand as though inserting an ultrasound wand “and that’s, yeah, and so I was told – and like coming to college when I talk to like, met a lot of girls and like roommates and stuff, and I told them that that happened and they were like ‘I get the pill and I never had to go’ so I was told to get the pill I had to go and get an exam, so that’s what I did” She smiles nervously at the face I know I am making, one of complete shock. I am not sure what to say.

“Huh, okay. That’s very different I’ve never heard that,” I say.

“Yeah, and to get, to keep my prescription, every year I have to go and get that.” There is a brief moment of silence as my mouth falls open.

“You have to get an ultrasound?” Surprise etched into my every syllable. She confirms and tells me that this has been quite a barrier for her since she lives in a different town now and could not make it to a visit over the summer to get in refilled. Her providers gave her what she called an “extension” but impressed upon her that she needed to come get an exam. I backtrack, wanting to know how to found this provider. She tells me that when she and her long term

boyfriend were in high school, and when they began having sex she started worrying about getting pregnant, and her long educational goals made her particularly afraid.

“So my parents...eventually – I have a very...I never got the talk or anything. I’m from a brown family, we don’t talk about that kind of stuff, so like yeah”

“Same,” I say and we share a knowing laugh and eye-roll.

“So a lot of, you know, weird feelings about all of that.” She says. She continues to talk of her boyfriend and how her mother knows that she in on the pill because she eventually got so paranoid about becoming pregnant that she felt she had to get on birth control and told her mother.

“And she was fine with it?” I ask

“She was just like—it was weird, like not fine, but it was manageable. There was some argument, I don’t like—and I was just like, ‘I need to be on the pill’ and she’s like—” Jane sighs and shakes her head in frustration “it was a lot of bargaining and then, okay here is the person, the gynecologist I go to, just make an appointment and I went and I had *that* exam the first day there ever at the gynecologist and they said I had to do that to be on the pill so,” I am silent again, finding this articulation no less shocking the second time. I feel my face is too emotive to not address it,

“So...I’m just really shocked at that. I’m so sorry,” I say. She laughs, and for the first time I notice how much she has been laughing in a way that assuages my discomfort and I am grateful to her for it. I wonder if it is comforting for her, too.

“Yeah, I’ve never met someone who is *so* shocked at it. Cause some people I have met it was like ‘Oh yeah I had to do that too’ but then some people I was—I’ve met have been like ‘Yeah I’ve been on the pill for years and never,’” Jane says.

“Wow. Cause it’s quite an invasive exam...”

“Yeah!” Jane nods with her comforting laugh again.

“Um so its surprising to me to hear that, um, so when they told you that did you understand like, this is an *intravaginal* thing, or?” I make a face when I say ‘intravaginal’ that reifies how invasive I find the procedure.

“Uhhhm, noooo, I didn’t really like originally, but then like when he took it out I was like ‘Oh! Okay,’ and there was like a female nurse in there too and — but she seemed like really like chill like, this is normal, so that chilled me out a little bit. And it’s like a *man*” Jane says the word like a secret and gives me a conspiratorial look that makes me feel closer to her. I grin and nod in understanding. She tells me that she tells her mom about the visit and the ultrasound and her mom tells her that is not typical, but attributed to her doctor trying to explain her body to her because it was her first time.

“What did they tell you?” I ask.

“They were just like, ‘Okay, so you have to have an exam to like’ and I didn’t really know what that was, but then they were just like ‘Okay like just take off all your clothes and put this whatever, robe, and we’ll come back’ and it’s also like a power—“ My face gives me away again and she addresses it before I can, “like I didn’t feel like um, like *mistreated* or anything but it’s also like a power dynamic too it’s like, this is the doctor, what do I know I’m just a kid, like they’re telling me I have to do this so, I guess I’m gonna,” Jane shrugs.

“Did they ever explain why that exam was necessary for *birth control*?” I ask, and then immediately worry I am being pushy or redundant on this topic. Hadn’t she already said she didn’t know why they gave her the exam?

“No, uh, no they didn’t,” Jane’s laughter now clearly marks her own discomfort. She speculates about reasons why, rearticulating her mother’s reasoning that the doctor wanted to show her about her body. She suggests that maybe it was because she had expressed that she wanted an IUD, but he told her that she should try the pill first. “I don’t even know why. I was like I really don’t want to be on hormones, I would really like to do the IUD that — there’s like, you know, one with hormones and one doesn’t— and I was like ‘I’d really like to do that’ and he was like ‘You should really try the pill’ and so I was like,” Jane shakes her head once in time with her shrugging shoulders. Her words are cut with a laughter that rings with sarcasm, “Okay, I guess you’re not giving me an option, um, and the pill worked out so I haven’t had a lot of motivation to switch,” she said. As the conversation moves to what kind of pill she is on, she throws what the “pill working out” means into a much more complicated light. She explains that her motivation to try to IUD was because she is very conscious about what goes in her body and didn’t want to take synthetic hormones.

“So I took the pill. I had a really rough like transition with it, like uh, my like — not like all my hair fell out but like, a lot of hair would come out like I had a picture it was like a huge,” Jane touches the back of her head then hold out her palm as though it is filled with hair.

“Oh my gosh” I say, but internally cringing that I just shed that much hair regularly sans reproductive coercion, but don’t think that is appropriate joke to make.

“Um like I would wash my hair, and I like googled it, like on this pill, and I saw that it was a pretty common side effect and like after a few weeks it would stop and that’s what happened. And it would just make me very emotional,”

“Well, yes, that’s probably what you were trying to avoid with the hormones right?”

“Yes! Uhuh, yeah like you know less stress and that’s causing more stress, but everything balanced out. *And,*” her laugh says ‘you won’t believe this’, “I found this out recently, cause I was trying to get it refilled, um, they accidentally a few months ago — cause I get three packs at a time, so a three month supply at each time I go to the pharmacy — Um, so I guess about six mon—or like a year ago they started filling me on a pill I wasn’t supposed to be filled on,”

“What?!” I exhale at this point in her story, “Like, accidentally?”

“Accidentally. Cau—uh, cau—like it was— the prescription did not match my package. And I called the nurse cause I noticed it the first time it happened and she said ‘Oh no, no. That’s like’ —cause *she* didn’t, she wasn’t there seeing me, I was just telling her, and she was like ‘no, that’s —” Jane embodies the nurse, waving her hands dismissively, “— kinda just like blew me off about it. I was like ‘Okay’. Then finally when I was calling to get a prescription, my most recent refill for the three month um, was here and she was like ‘Uh I can’t refill this because I see that they’ve been giving you the wrong thing.’ And I was like, ‘Well that’s what I feel good on, and I’m not gonna switch again.’ So I was feeling bad this—and it was just that pill— and when they started accidentally filling me for a different pill is the only pill I did well on. So I was like, I don’t care what it is, I need to be on this pill, like I’m not switching again. So even if it’s the wrong one, I need to figure out a way to be on that one. So, I don’t know what happened,” Jane continues on to tell me that her pharmacist, the doctor, and the nurse have treated her as a kid who they should handle things for, leaving her out of the process. The conversation moves on as we begin to talk of her family, but we return once again to this experience with her provider when I ask her what she wants other patients, providers, and politicians to know, she says she wants patients to stand their ground with providers, because she felt that she could not.

“Cause I was like pressured on a time crunch and pressured in this power dynamic and it maybe I had—and I don’t feel like something was taken away from me or I don’t have some like emotional trauma from that but I may have been able to have an easier, less stressful situation and actually get the outcome that I wanted. So I guess just stand your ground with your healthcare provider would be like my biggest thing,” Jane says.

“It’s interesting the differences I am hearing like Women say about what we consider traumatic or negative,” I say, no longer only talking about my participants but what has struck me about all the Women I know, “and you know like, just a healthcare provider not giving you want, you know that’s a negative thing,” I say.

“Yeah, that’s negative, but I don’t feel like traumatized by that,” she says. I worry I have been pushy again, implying that she *should* feel trauma, and backtrack.

“Yeah, which is good” I say.

“Especially because I did have like a positive outcome, maybe if I really didn’t and my hair continued falling out and uh then maybe yeah, but—and it was an accident that I had a positive outcome so, I think yeah if my situation went differently I would feel differently. And as far as the procedure, yes it maybe was unnecessary but he wasn’t doing anything *with* that procedure that wouldn’t be *routine* with that procedure. So what it unnecessary? Yeah probably, uh, but I don’t feel *abused* from it or something. I feel like I didn’t have my like, yeah I don’t think I had my right to choose with that procedure, I did not probably *need* that procedure but at the end of the day I mean yeah he wasn’t, I don’t think abusing his power or trying to like, you know, he’s just an old dude set it in ways and that’s what it was, like I don’t think it was anything more than that. And I felt safe, there was a Woman there, she also happened to be a Woman of color so I had already like vibed with her so, yeah.” As she says this, and I feel a

tension building in me that I am afraid will spill into my words. I had been having many conversations with the Women in my life lately about this, what constitutes abuse and how we can recognize it, and I had heard so many Women I know give answers this way; Answers where ultimately they identify behaviors that made them uncomfortable, but stop short of naming it as abuse. I want to tell her that we can claim abuse in different ways, the way I have been telling my friends with an imploring urgency, but I do not want to make her feel attacked. After all, as comforting as her laugh is, as easily we flowed into conversation, we are not friends. So all I have to offer her after all she has given me is,

“Okay, that’s interesting.”

Rose

I am late and sweaty. I turn the air conditioning up and hold my armpits up to the vent to dry the evidence of my nervousness before I meet Rose, about five minutes late now. My eyes dart between the red light and my dashboard clock. Seven minutes late now. I send her another text message, apologizing. She texts back that it’s no problem, she has just arrived. When I finally get to the building myself, armpits re-drenched, I look around for a brown Woman. I believe she is a Middle Eastern Woman, an assumption I make from her Arabic last name. I see a small Woman walking up to me and my hesitation is not reflected in her sure eyes. She knows who I am and confirms it,

“Hi, it’s Neev, right?” she says, making the common mistake of extending the ‘i’ in my name.

“Niv” I correct, “You’re Rose, I’m guessing?” I smile and we shake hands. “I am so, so sorry I am late. I’m really grateful for your time and I don’t want to waste it,” I say. She reassures me that she was not waiting long. At this point in the interviewing process I had gained

more confidence in interacting with new people, but my lateness makes me feel like this is my first interview all over again and I am more nervous than usual. She can tell. I see her glance at my pit stains as I run my hand through my hair. I drop it quickly and direct her to the room I plan to interview her in. Once we sit and I have actively slowed my heart rate, I observe her more closely. Her features are small and framed against the folds of a soft blue hijab. There is delicateness about how she handles herself that I find nice. I pull out consent forms and recorders. She sits gently on the couch, her hands folded in her lap and listens to me go on about my research, trying to frame the interview as open ended to encourage as much dialogue as possible. She tells me that she is Indian but grew up in Singapore and is an international student here. I gain more confidence as she tells me she thinks my study is important, and that she grew up in a family where reproductive health was not talked about.

“So uh, tell me a little bit about yourself. You are a senior now? In what program?” I say once the recorders are on.

“Um, I’m currently a Chemistry major pursuing a Chemistry B.A. degree but I’m also trying to double major in psychology,” she says. I tell her I also double majored with one degree in psychology, but not in chemistry. We joke about the difficulties of understanding Chemistry, and she tells me that she aims to teach at a professor level, and had planned to go to medical school but changed her mind because it is so expensive and competitive. She says that she might want to do research in higher education.

“So are you interested in the Chemistry behind Psychology?” I ask her.

“More like the Psychology behind Chemistry,” she laughs and speaks to her experience teaching Chemistry as a tutor and to her friends. I tell her I will stick to my social sciences.

“So, talking a little bit about your health care, and your reproductive health care,” I say, having not found a subtler transition thus far in the interviewing process. “Um, so when you came to [University] um, was that something that you looked at here, as something that you wanted — to start going to, maybe a reproductive health provider? Or anything like that?” I stumble through the question; frustrated again at my lack of eloquence.

“Um, yes actually, sin—because that’s uh, I mentioned before that, that’s not something that’s talked about a lot in my family so, I didn’t even know what a pap smear was, a mammogram is, until very recently, like a year or two ago and um, and I really only recently started talking to my mom about reproductive health care, habits and behaviors that are good. Um and we started opening u—opening up about it recently and I guess I just wasn’t really well informed, this is not something we talk about in my family, or it wasn’t something I talked about in school either. Um, cause Asian countries are usually a lot more conservative in that sense. So I never was exposed to the information I would need to know as a Woman to take care of my reproductive health until I came here and it’s funny cause um, I actually got a job at the center for student well-being and one of the cohorts that they focus on, because it’s all about peer health education.”

I realize that she has quite a lot to say and begin scribbling notes to remind myself what I want to ask her as she continues speaking. The first thing I note is ‘informed — formal language’, the second is ‘Asian countries’ I try to continue to listen to her speak as I do this. She continues to tell me about working as a peer health educator and how it has changed things for her.

“I’ve even talked to my supervisors about—which is funny because I talked to my supervisors before I talked to my mom about reproductive healthcare and my co-workers and

everyone. They're very open about—about informing people and talking about what these conversations that I'm not use to so, um, I think that's where a lot of my information came from. Even—cause I'm not sexually active but, a lot of people um still say you should get your reproductive healthcare behaviors done even despite not being sexually active. Um, and that's something I didn't know I was like 'oh, why would something happen to me if I'm not sexually active', right? Like why should I get checked out? Um but just, even just going a doctor and talking about your reproductive health care I think is beneficial for every Woman whether you are sexually active or not so that's something I learned recently as well," She says.

"Yeah, okay, a whole wealth of information, I guess um, when you started looking into that," I say glancing down at my notes, to which I have added the barely legible 'take care of repro health', 'talked to supervisor before mother', and 'repro health vs sexual health.' I decide to follow up about her comments on her family.

"So you said that your family—you don't really talk about that um, why—why is that?"

"Yeah, I honestly don't know. I think um, it's just awkward? It's funny cause um, I'm a majority girl household, I have two younger sisters and my mom. Um, but it's just something that was always, I mean with my sisters I'm a little more open about it but they're younger than me so it's not like they have more experience than me in this department. But with my mom um," Rose pauses briefly to think, struggling to find her next words which I am realizing is a rarity. "Maybe because she grew up in a household where it's not talked about so it kinda carried over into out household too, then."

"Mhm" I say, nodding and thinking about my own mother, and her mother before her, and the silences I have inherited too.

“Even when I got my period for the first time, like, the only reason I knew what to do is because they taught us in school that you know, you get a pad, and you’re gonna be bleeding from down there um, and all I did was tell my mom that ‘Okay, I’m on my period. I—or I think I got my period.’ And I told her to come check my bed and she checked it, and she like secretly gave me a pad in the bathroom and that was the end of it,”

“Oh wow, really?” my surprise is not because I find this strange, but because it is so similar to my own experiences. Rose is the first of my participants whose stories I see my own life mirrored in. This feeling of familiarity continues as she keeps narrating our shared experiences.

“Yeah I guess just in Asian cultures its something that—we’re not use to vocalizing. So, its like getting over the initial awkwardness that’s hard that people don’t want to deal with. And then once you do get over it then its so much easier to talk about it” She says. I tell her how much I can relate.

“Yeah I’m Sri Lankan, so I definitely understand what you’re talking about. My parents and I never talk about this kind of thing, ever, um. Me getting my periods was almost—it was very similar, my mom just kinda gave me a pad and we didn’t talk about it,” I say.

“Exactly,” she laughs.

“Um, yeah, I think the culture is definitely a big thing um, is that something that you kind of noticed being here? And seeing how people talk about things here? Um was it—was it any different?”

“Super different. Like, huge culture shock. I’m just like everyone’s talking about it and like they use the v-word like it’s a regular word. I’m like ‘whaaaat?’” She shakes her head in disbelief. “I—I didn’t even know what ‘coochie’ meant until like, yesterday and I’m like ‘Okay,’”

she says and I laugh, taken aback that she used the word ‘coochie’ after using the euphemism ‘v-word’. I am surprised by her boldness. She laughs with me and says, “So it was—it was—people are a lot more open about it here which I think has its benefits and its like, downsides. Like it shouldn’t be something, I think—I don’t know, maybe it’s just—in a way its good because its educating the men, too. Um, I have friends who use to be so awkward when you bring up like a period, or blood or anything like that, but talking about it became—it—it informed them more too. And I’m like, how do you not know like, a twenty-eight day cycle that a Woman goes through every twenty-eight days that’s like a huge part of her life, how do you not know that cycle? And he’s just like, ‘oh well I never had to go through it.’ I’m like ‘You’re lucky you didn’t. You wouldn’t survive,” she makes me laugh again and I and I am surprised at the shots she takes at men. I realize I find this surprising because I expected her to be a much more passive person. She tells me of her current boyfriend, who is also an international student and whom she has had to educate about menstruation. She notes that he has become a lot more open to hearing about it now because she normalizes it for him, attributing his initial resistance as cultural. I think of how I feel the same way about my own partners, but attribute their resistance to patriarchy.

“And again, it—it goes back to the culture too cause his culture is, uh, Middle Eastern and they’re even more conservative than we are about it. And he grew up in an all male household so,”

“Ah so no clue about it,”

“Exactly, so I had to basically educate the boy, make him a man,” she says and my laughter is now becoming one of discomfort. I don’t know how to ask her what that means, so I ask about her boyfriend specifically.

“How did he take that?”

“It was—at first he would be like, ‘Oh, okay,’ and he wouldn’t talk about it more, until like I explained the biology about it and I was like ‘Literally its just a process that goes on in our bodies that we can’t control. And I know hate blood but it’s a different kind of blood so its okay,’ and just like convincing him to talk about it, its okay—its better you’re informed and you know than the alternative which is you’re just unaware and you’re saying things like ‘You’re on your period that’s why you’re in a bad mood’ you know, at least I have an excuse, what’s yours?” She tells me that she thinks it makes a man better to know these things and I agree.

“So now he’s a lot more open to talking about these things?”

“Yeah, but only with me, he’s still awkward with other girls. It’s like talking about myself like normalized it so, cause uh we pray but when we are on our periods we can’t pray. So, um, usually he’ll be like ‘Oh why aren’t you praying?’, or ‘Do you want to go pray together?’, or ‘Are you fasting tomorrow?’, and I’ll be like ‘I can’t cause I’m ah—I’m on my period,’ and before I’d just like, ‘Oh I can’t,’ and he’d like be like ‘Oh,” and that’s the end of it. But now I’ll be like “Oh I can’t cause I’m on my period, and he’s like oh okay, um, ‘Is that why you’ve been moody lately?’ and I’m like ‘yeah, honestly, that’s why I have been moody lately,” she laughs. I note the contradiction in what she voiced earlier, that this belief that men had was indicative of a lack of understanding, but now is indicative of understanding. She addresses this before I can decide if I should or not, “But he doesn’t mean it in like an accusatory way like a lot of men do, he just means it like ‘okay, like, I understand now. I’ll stay away from you for a while,’ ”she says. She tells me that he gets her medicine but they aren’t at the stage where she can ask him to buy her pads yet.

“Oh yeah that’s always rough. I asked my boyfriend to buy me tampons and he walked in the store, and then walked back out, and was like ‘there are just so many different kinds, there are so many colors’ and he thought that pink was purple, or I said purple and he thought it was pink, and I’m just like, I don’t even—we don’t even see colors the same way? It’s rough,” I joke and she is laughing.

“That’s so funny oh my god, *men*.” She says. She voices that she thinks her boyfriend has come a long way from the beliefs he had from being raised in an all-male household.

The conversation moves to her own experiences with health care, and she tells me that while she has yet to see a reproductive healthcare provider while she has been in the U.S., she has gone to the doctor for other things.

“So what was the first time you went to a provider here like, what is what you expected it to be like, was there any cultural differences that you were like, ‘woah this is not what I’m use to?’ ” I say, expecting to hear that it is but she surprises me again.

“It was pretty—It was pretty okay, it was the same as its been in Singapore, it didn’t feel any different or anything like that. It was pretty normal.” She says. I tell her it sounds like she has good health care experiences here and she agrees. I move specifically to the racial dynamic of her experiences both in health care and her time working as a peer health educator.

“Are you ever um, kind of aware of like your racial identity that other people may put upon you, or see when they interact with you in those...situations?” I cringe again that I have not found a way to be more articulate in asking about racial experiences.

“Um, there’s definitely—cause I’m a Muslim, so it’s kind of like assumed that I’m abstaining. So, I think for some people who are aware of the culture, or the—the kind of norms that we follow, uh, they might be a little taken aback that, ‘well why is she out here talking about

sexual health, that's such a brash and loud topic to be talking about.' Um, especially men. Like, mostly men would think that. They'd be like, 'Why is she talking about this with everybody, like, that's not something you should be talking about that's something Women should keep like hush hush and all these things so,' she says.

“Can you see it on their face or it is something they say, or how they interact with you?”

“It just gets awkward. It gets awkward when they come up to the table and there's like” she pauses and makes a face that I'm starting to associate with her particularly bolder statements, “a big penis on it. And—and we're trynna, or, it's not always me. Like I—I don't do the, the condom demonstrations. But usually there's someone there who is like, 'oh do you want to try to put a condom on?' and its just like that awkwardness. And I'm like, I can talk to you about physical activity. Um, do you exercise? And that's about it,” she laughs, “So, I—I feel uncomfortable like talking to people, um, who get awkward. If it's a Woman and they wanna know how to use a condom I'd be more comfortable talking about it. If they wanna know about different contraceptive methods I'd be a lot more comfortable talking about it. But it its like a guy then I just get—I just like close up right away, I'm like I don't really wanna—” She says and I cut the end of her sentence off with my curiosity,

“Why do you think they get so weird?”

" I honestly don't know, I think it's literally just like a lack of education about it. And guys kinda have a one track mind anyway so I feel like sometimes, with some guys, you never know where that's gonna take them. You know especially if they're talking to a Woman about it. And I know that we've had like presentations on these topics where it could be a really pretty girl who's presenting and—and they could be like a majority male audience and obviously that's gonna get a lot of backlash,”

“Oh—goodness. Yeah.” I say, and I am starting to feel uncomfortable. Until this point I had felt as though we were sharing anecdotes about our frustrations with men in similar ways. Now I felt like we were both frustrated with men, but she believed that men were just that way naturally, while I believed they were made to be that way and aren’t asked, and don’t think, to change. I don’t know if I should address this or not, and feel particularly uncomfortable with the thought of voicing this distinction in viewing men differently because I have yet to figure out how to challenge participants views in general during these interviews, but also because she is a brown Woman and I feel placed within the familiar box of brown acceptability, in which I don’t question things, don’t call things out, don’t voice my differing opinions in case they are viewed as non-*sanskari*, or not in line with brown culture, and ‘too American’ – what my parents deem the worst fate. I bite my tongue as Rose continues.

“So, so just being aware that that’s a boundary I want to—I want to k—maintain like from the beginning i—it can hinder how we talk about it and how I would inform a man about it. So I would prefer it to be this way where the men are talking to the men, just because they listen to each other more. Like a man is not gonna listen to a Woman, let’s just be real, men are not raised that way anymore. And I would be more comfortable talking to a girl about it.” She says. I nod in agreement, even offering a “yeah, unfortunate” when she says men are not raised this way anymore, even though I internally think they never were raised that way. My discomfort grows. I ask her more about her job and she speaks to it having changed her way of thinking about things and educating other people, and opening up about these topics. We talk more about the changes in her thinking, and I ask her about if she would have children, and she says eventually she would.

“Um—Do you think that you would talk to your child differently than how you were raised about these kinds of things?” I ask.

“Yeah, for sure, I would want it to be more um—just, I think because of my education here in all these aspects I would be more confident in talking to my child about it. Um, because one thing that I think with my mom um—her mom wasn’t very educated about this and that just kind of... determined how it was gonna look for her as well. But because, like my mom is more educated than her mom about it and then I’m more educated about my mom about it—or about talking—or I’m just more *comfortable* about talking about it and I’m more use to it and I’m more exposed to it, more exposed to these types of conversations. Um, I feel like I’d be more confident approaching it with my children than my mom was with me and more than her mom was with her and her sisters. So, and I think um, like the way I talk to my sisters about it would be a good precursor for it, I’m basically their mom I basically raised them,” she laughs, and I feel guilt, wondering how her mother would feel about this in the same way I wonder how my own mother would feel when I speak of the ways my older sisters raised me. I find myself wanting to turn the conversation more to our mothers out of sheer desperation to feel known, to hear my own feelings spoken in another’s voice again. I think this is probably selfish of me when I realize I missed her last few words and refocus.

Rose continues, “Um—yeah so I think just because I’m more comfortable talking about it with my sisters and like, I’m comfortable letting them know that okay—make sure you have your boundaries from the beginning, make sure you know what you want, uh communicate that clearly if it’s with a guy, if it’s not, they’re not sexually active either. Obviously they will be in the future with their significant others um, their husbands *hopefully* not anything else. No, I’m kidding,” She laughs and I feel the walls of my brown box of acceptability close in on me. I’m

surprised at this unexpected, out of the way instance of homophobia. I laugh with her and it feels cowardly. She is still speaking but I miss her words again, debating the levels that I could engage. I could tell her I am Q

Queer, make this a moment that seems so easy to imagine from ivory places. But I have had twenty-four heavily surveilled years of fearing that speaking these truths to anyone South Asian would get back to my parents. And so I laugh and I let it go.

CHAPTER FIVE
ANALYSIS AND DISCUSSION

Colonizing Sense Making

Clonized Perceptions of Participants

At the start of each narrative I am relying solely on my colonized mind, and I search for each participant based on a colonized understanding of gender and race (Schiwy, 2007). In Jane and Rose, I search for specific manifestations of “Latina” and “Middle Eastern” based on their last names, which I used as a marker of their race. While gender identity was not explicitly discussed prior to meeting, I assumed each participant embodied “Woman” in a heteronormative able-bodied cis-gendered way and looking for bodies that fit that perception. In Tiffany, I did not have a specific racialization in mind from her name, but instead relied on colonized understandings of “race” as embodied primarily through skin color, reifying the assumption that to be “of color” means to have skin of color by looking for “color” as I was looking to identify Tiffany exiting the elevator (Omi Winant, 2015).

Perhaps the most obvious of colonized understanding of my participant’s racial identity is with Rose, where I reify the narrative of a docile Muslim Woman in my perceptions of her. While Rose complicated my geo-politically flat, colonized assumption that she was Middle Eastern by telling me that she was an Indian Woman who grew up in Singapore, I continue to perceive her in a light that reifies a docile image of her. My descriptions of her “soft blue hijab”,

of a “delicateness” show this leaning in my perception. My continued surprise at her humor, at her boldness, also indicates my assumption that she was inherently not bold or quick to humor.

Colonized Concept of Important Selves

In each narrative, the dialogue I begin with is colonial in its focus on capitalist identity, and places my participants within a colonized structure of “self” (Mann, 2013). In Tiffany, I at least manage to offer the slightly more open-ended “how do you spend your time” but only after framing how the “little bit about” herself that I was interested in hearing were things like what she “does.” In Rose and Jane, I limit their construction of their selves more directly, asking them both specifically about what education program they are in, elaborating on the career paths this may lead them to. By focusing on the aspects of their identities that make them capitalistically productive, I colonize how they are able to communicate what matters to them, and what I can then tie into reproductive health, similar to how providers reconstitute white heteronormative bourgeois norms in their expectations for patients’ lives (Mann, 2013).

Reproduction Centered Around Colonized Timelines

The tying of a reproduction to a capitalist timeline is the essence of what I have reiterated by structuring interviews in a manner that understands Tiffany, Jane, and Rose’s lives only within the frame of education, career, and marriage. Each Woman expresses similar reliance on this capitalist timelines in the sense making of their own reproductive health. Jane expresses that her long educational path was a reason she wanted to get on birth control, viewing pregnancy as a hindrance to her life goals. Jane also states,

“ I can’t imagine if I did have like something that I would have some sort of timeline, because I know – all the Women I’m associated with have really big goals, in academia

especially so, I'm really lucky that I don't have to worry about that timeline but I know a lot of Women do so,"

Here she expresses sympathy with Women who have uncertainty with their fertility, noting that such uncertainty would make them have to re-think their timelines, which have been previously set with their goals in academia. This reiterates the connection between an ideal reproductive self and the capitalist notions of completing an education and joining the workforce before reproducing. Similarly, Tiffany makes sense of reproduction in relation to marriage plans and marriage status. She begins by noting marriage as a marker of her birth control process, stating,

"...I'm not actually in a relationship currently where I'm *worried* about birth control so...that played a role in my effect to get back on this particular birth control because I wa—I had a Mirena in when I got pregnant with my son. But I was married at the time so,"

Given Tiffany's history with getting pregnant on birth control, she has differentiated between the kind of birth control that she would trust in a marriage and the kind she wouldn't, framing pregnancy that occurs within a marriage as more desirable than one outside of a marriage.

Tiffany reiterates this connection between pregnancy and marriage when she states,

"Well, at the start of a relationship you know, everyone, you're using them. But you know obviously I...dated, we got married, so that kinda went out the window. So I said okay, well we'll just get birth control so that's something that'll be a little bit...I'm not looking for marriage you know, um been there, done that. If it does happen great, but

that's not *my* thought process nor do I necessarily want more children. So that will be something that is more strictly enforced than it would be if I was still in my marriage you know”

Here Tiffany articulates that the stages of a relationship, from dating to marriage, dictate one's decisions about birth control because of the expectation that condoms will not be used during marriage (“went out the window”). Tiffany notes that enforcing condom usage is more possible for her when dating than in marriage. In each of these instances with Jane and Tiffany, my lack of questioning such timelines and coupling of marriage and reproduction reiterates, re-colonizes, its normalcy.

Reiterating Disbelief of Participant Perception

A tenet of the wily patient is their untrustworthy account of events. Bridges (2007) notes how staff at the Alpha clinic enter interactions with patients assuming that they are lying and are inherently mistrustful or unable to comprehend the interaction accurately. Within Jane, I enact such mistrust and doubt of Jane's medical experiences with my disbelief of her account. While I do not doubt that what Jane is telling me has happened to her, throughout the narrative I continually seek information that will show her perception of what has happened as a misunderstanding. Once hearing her account of being given an intravaginal ultrasound in order to get a birth control prescription, I ask her,

“Um so its surprising to me to hear that, um, so when they told you that did you understand like, this is an *intravaginal* thing, or?”

While she tells me her story, clearly indicating that she was not given any more information, I still ask her to re-account in various ways. I ask,

“What did they tell you?”

Implying that there is specific language that could have been exchanged with her that she should be accounted for in explaining her sense making. While she answers, still articulating that she was not given information explaining the procedure, I feel the need to ask her to account again as seen in the following interaction:

‘ “Did they ever explain why that exam was necessary for *birth control*?” I ask, and then immediately worry I am being pushy or redundant on this topic. Hadn’t she already said she didn’t know why they gave her the exam?

“No, uh, no they didn’t,” Jane’s laughter now clearly marks her own discomfort. She speculates about reasons why, rearticulating her mothers reasoning that the doctor wanted to show her about her body.’

Although Jane has already articulated to me what the provider said to her, I still ask specifically if anything about birth control was mentioned, still searching for information that shows the provider did indeed give Jane information she is continually articulating she was not given. At this point Jane tries to explain the situation by offering what her mom says, the possibility of her provider trying to teach her about her body, and in doing so joins in the colonization of our understanding of medical providers as having intentions only rooted in educating patients. I only feel bad enough about my mistrustful probing of Jane to note it, but not enough to apologize, to claim what I have done as re-iterating the wily patient narrative, and re-ascribe trust in her by not

making her answer the question, or to attend to the ways in which she already has answered several times and why that has not been enough for me.

Colonized Sense Making of “Culture”

In Rose, our sense making of reproductive health is reliant on a colonized concept of “culture.” While this is also prevalent in Jane in our interaction,

“ ‘So my parents...eventually – I have a very...I never got the talk or anything. I’m from a brown family, we don’t talk about that kind of stuff, so like yeah’
‘Same,’ I say and we share a knowing laugh and eye-roll.
‘So a lot of, you know, weird feelings about all of that.’ She says.”

Rose and I attribute this, which is part of the racialization of being “brown” that Jane mentions, specifically to “culture” and foreignness. Rose first attributes a lack of knowledge about reproductive health to “Asian culture”, stating:

“ ‘Um, cause Asian countries are usually a lot more conservative in that sense. So I never was exposed to the information I would need to know as a Woman to take care of my reproductive health until I came here...’ ”

We further this sense making later in the narrative when we discuss similarities in how our mothers handled our first periods:

“Yeah I guess just in Asian cultures it’s something that—we’re not use to vocalizing. So, it’s like getting over the initial awkwardness that’s hard that people don’t

want to deal with. And then once you do get over it then it's so much easier to talk about it", she says. I tell her how much I can relate.

"Yeah I'm Sri Lankan, so I definitely understand what you're talking about. My parents and I never talk about this kind of thing, ever, um. Me getting my periods was almost—it was very similar, my mom just kinda gave me a pad and we didn't talk about it," I say.

"Exactly," she laughs.

"Um, yeah, I think the culture is definitely a big thing um, is that something that you kind of noticed being here? And seeing how people talk about things here? Um was it—was it any different?"

"Culture" is how we mark behaviors that are being made sense of as a distance from Whiteness and distinctly non-American, and therefore is a way of racializing groups of people as non-White and non-American (Leti Vlopp, 2000; Bridges, 2007). Vlopp (2000) notes that by racializing behaviors of non-White people as "culture" but finding non-cultural non-essentializing explanations for when White people engage in "troubling behaviors", we create an exaggerated construction of inherent difference. As a logic of elimination, the creation of "culture" as an inherent aspect of colonized people served as justification for their elimination and forced assimilation (Volpp, 2000). It is particularly difficult to decolonize the use of "culture" because colonized people have used the notion of having a distinct "culture" as resistance.

For South Asian Women, the cultural purity that is used to construct and constrict what a 'good south Asian Woman' means is tied to an anti-British colonial nationalism which understands South Asian Women as morally "pure", which the West frames as culturally "oppressed" (Chatterjee, 1989). For South Asian Women in an ever globalizing (read:

westernizing) world, they are placed in the bind of “cultural loyalty” being at odds with “gender empowerment” because their “cultures” are viewed as inherently sexist, while the West perceives itself as inherently more progressive and empowering (Patel, 2007). Patel (2007) notes that this logic ignores both the fact that Western culture is just as sexist, and that patriarchal resistance and feminism have always been a part of South Asian culture. South Asian Women are then caught in the bind of being unable to articulate patriarchal oppression without furthering sexist beliefs about “culture.” In the United States, the legal strategy of a “cultural defense” is one in which a person who is racialized to have a “culture”, and therefore as non-American, such as a recent immigrant, can be granted leniency in sentencing due to their actions being in line with their “culture”, and therefore something that could not be helped. In cases of gender violence within Asian-American relationships, Asian-American men are shown leniency for violence against Asian-American Women under a “cultural defense”, resulting in the discursive reiteration of Asian-American men as inherently, culturally, dangerous and oppressive and Asian-American Women as victims of their own culture, their own men. Asian-American Women are left both oppressed by Asian-American men and unable to claim this patriarchal oppression without reiterating racist essentializing of their own culture. We participate in marking others as more distant from Whiteness than our own cultures as well, as can be seen in Rose when she describes her boyfriend:

“ She notes that he has become a lot more open to hearing about it now because she normalizes it for him, attributing his initial resistance as cultural. I think of how I feel the same way about my own partners, but attribute their resistance to patriarchy.

‘And again, it—it goes back to the culture too cause his culture is, uh, Middle Eastern and they’re even more conservative than we are about it. And he grew up in an all male household so,’

‘Ah so no clue about it,’ ”

Here my note that I had previously never attributed my partners’ resistance to hearing about my periods as cultural because I had always dated people that I viewed as distinctly more American than myself, or having a lack of “cultural” pressure, and therefore as Vlopp (2000) notes, attributed their lack of comfort with menstruating to patriarchy and not to culture. Rose attributes her boyfriend’s resistance to “middle eastern culture” which she says are “even more conservative than we are” which when coupled with “culture” can be read as “even less White than we are.”

I myself reiterate this colonized notion of “culture” in my hesitation to voice non-conservative thoughts with Rose. I state:

“I don’t know if I should address this or not, and feel particularly uncomfortable with the thought of voicing this distinction in viewing men differently because I have yet to figure out how to challenge participants’ views in general during these interviews, but also because she is a brown Woman and I feel placed within the familiar box of brown acceptability, in which I don’t question things, don’t call things out, don’t voice my differing opinions in case they are viewed as non-*sanskari*, or not in line with dominant South Asian culture, and ‘too American’ – what my parents deem the worst fate. I bite my tongue as Rose continues.”

I am colonizing here because in interactions with participants that I have not racialized with “culture”, I attribute my lack of confronting differing opinions to my lack of experience as a

researcher. However, because Rose is a brown Woman, and I view us as within the same culture, I attribute my hesitation to the pressures of which I have colonially framed, as I state, “within the familiar box of brown acceptability”: the manifestation of my negotiation between the expectations in behavior that the South Asian community places upon Women as “cultural” and in opposition to the pressures of assimilating. In moments when I do not question our difference in perceptions of men, as well as in my hesitation to out myself as Queer:

“ I’m surprised at this unexpected, out of the way instance of homophobia. I laugh with her and it feels cowardly. She is still speaking but I miss her words again, debating the levels that I could engage. I could tell her I am Queer, make this a moment that seems so easy to imagine from ivory places. But I have had twenty-four heavily surveilled years of fearing that speaking these truths to anyone South Asian would get back to my parents. And so I laugh and I let it go.”

In both these instances I reiterate that “culture” keeps me from challenging Rose, and therefore “culture” makes Rose unchallengeable inherently as a person, despite her articulations to me of the ways in which she actually stands in opposition to what is expected of her “culturally.”

When Rose and I attribute our parents’ lack of open conversation with us about reproductive health to “culture”, and when Jane attributes it to being from a “brown family”, we all reiterate this colonized notion of “culture” and as ourselves as victims of our culture, and reiterates the logics of elimination that justify forced assimilation. What we could say instead, is that these are geopolitically specific manifestations of capitalist patriarchy that are just as prevalent in the White Western world.

Decolonizing Sense Making

Decolonizing “Culture”

While Rose and I essentialize culture and reiterate its colonial use as a marker of distance and difference from Whiteness, Rose's own efforts to change how her family discusses reproductive health as well as her defying the stereotype of a docile Muslim Woman actually decolonize the notion of "culture". Since "culture" is used to describe behaviors that are inherent and therefore unable to change, enacting behaviors that are resistant to the unchanging image of "culture" is decolonizing. Rose discusses how she is resistant to the stereotype of what a Muslim Woman should be like:

“ ‘Um, there's definitely—cause I'm a Muslim, so it's kind of like assumed that I'm abstaining. So, I think for some people who are aware of the culture, or the—the kind of norms that we follow, uh, they might be a little taken aback that, ‘well why is she out here talking about sexual health, that's such a brash and loud topic to be talking about.’ Um, especially men. Like, mostly men would think that. They'd be like, ‘Why is she talking about this with everybody, like, that's not something you should be talking about that's something Women should keep like hush hush and all these things so,’ she says.”

Rose notes what is expected of her by non-Muslim American men that she interacts with as a peer health educator, stating that these men are of the belief that Women, particularly a Muslim Woman, should not be educating other on such a “brash and loud topic”. My own surprise at Rose's humor and boldness is rooted in the same stereotyping of her as docile. Interestingly, according to the “culture as barrier” belief we perpetuate, these American men should be much more accepting of Rose discussing sexuality and menstruation than her own partner. However the following interaction shows differently:

“ ‘So now he's a lot more open to talking about these things?’

‘Yeah, but only with me, he’s still awkward with other girls. It’s like talking about myself like normalized it so, cause uh we pray but when we are on our periods we can’t pray. So, um, usually he’ll be like ‘Oh why aren’t you praying?’, or ‘Do you want to go pray together?’, or ‘Are you fasting tomorrow?’, and I’ll be like ‘I can’t cause I’m ah—I’m on my period,’ and before I’d just like, ‘Oh I can’t,’ and he’d like be like ‘Oh,’ and that’s the end of it. But now I’ll be like “Oh I can’t cause I’m on my period, and he’s like oh okay, um, ‘Is that why you’ve been moody lately?’ and I’m like ‘yeah, honestly, that’s why I have been moody lately,’ she laughs.”

Here Rose articulates that her partner, who is Middle Eastern and supposedly subject to a culture that keeps him conservative, has changed in how he understands her menstruation. Both the ways that Rose stands in opposition to cultural assumptions about who she is as a Muslim Woman, and the ways she articulates her partner acts in opposition to cultural assumptions of Middle Eastern conservatism, decolonize the notion of “culture” as unchanging and inherently more oppressive than Whiteness.

Decolonizing Trust in Health Care Providers

While both Tiffany and Jane rely on their providers for information, both of them decide against what the dominant healthcare system expects of them as patients and advocate for valuing different things. After Jane’s experience of negative side effects on the pill, then being dismissed about her birth control prescription being wrong, she articulates that patients should be more resistant to providers:

‘ “Cause I was like pressured on a time crunch and pressured in this power dynamic and it maybe I had—and I don’t feel like something was taken away from me or I don’t have some like emotional trauma from that but I may have been able to have an

easier, less stressful situation and actually get the outcome that I wanted. So I guess just stand your ground with your healthcare provider would be like my biggest thing,’ Jane says.”

While she states that she does not feel like something was taken away from her, she does feel as though she could have gotten the outcome she wanted by “standing her ground”, an action that to most health care providers would make her a wily patient.

The good colonial health care subject of color would rely, as providers would like, on the provider’s medical knowledge handed to them through the capitalist education system to provide them with reliable health care. Tiffany however looks beyond medical degrees for what makes her trust a provider:

“ ‘ It’s more of a—just fear. I just—I hate the unknown you know and I—you don’t really know me I don’t really know you so now I don’t know if I necessarily trust your medical opinion. Granted I know you obviously went to medical school you have a license. It was a level of comfort with my normal doctor I don’t have that level of comfort. I don’t know you, you don’t know me so now I’m only gonna see you when I’m sick how do I know you’re recommending the best course of treatment. Hmm. I have that problem so,’ she says.’

Tiffany notes that a level of comfort that comes from “knowing” a doctor, beyond their medical degree, is what makes her trust them. She states that a new doctor would only see her when she’s sick, and they wouldn’t “know her”, indicating that healthcare providers see their patients as static sick beings, and not as whole people who experience illness. Both Jane and Tiffany feel they are looking out for themselves by distrusting their providers, in contrast to what providers would prefer. That Tiffany and Jane make sense of this point of view as right for them, and not

as something that may inhibit their health or make them wily patients, is decolonizing sense making.

Discussion and Implications

This project has two goals: to articulate my own sense making of reproductive health as a Woman of color in the United States today and to offer a decolonial narrative medicine methodology. My sense making of reproductive health as a woman of color has been articulated in the first two chapters, which argue that the institutions of the prison industrial complex, the welfare system, and the healthcare system, are racial projects (Omi Winant, 2015) rooted in the logics of elimination (Wolfe, 2006) with the colonial goal of degressing the reproduction of people of color. I argue that health care providers participate in this colonial goal by relying on cultural narratives that have colonized their minds to perceive patients of color negatively; such a narrative is “the wily patient.” I addressed my second goal by creating narratives through interpretive ethnography and then analyzing them for colonizing and decolonizing themes. My goal in doing so is to show that my participants, Tiffany, Jane, and Rose, and I collaboratively construct our reproductive health in ways that both colonize and decolonize, and the ways in which my analysis of them once again colonizes and decolonizes. The themes I identified are: (1) Colonized perceptions of participants, (2) Colonized concept of Important selves, (3) Reproduction centered around colonized timelines, (4) Reiterating disbelief of participant perception, (5) Colonized sense making of “culture”, (6) Decolonizing sense making of “culture”, and (7) Decolonizing trust in healthcare providers. My creation of these narratives and subsequent analysis of them form the methodology I offer to narrative medicine: the use of interpretive ethnography to analyze how interactions between providers and patients rely both on the colonized mind while also offering space for decolonizing sense making.

Contributions and Future implications

Burgess co-authors' 2017 study offers a foundation for the future implications of this study. These researchers examined how providers responded to narratives that depicted patient-provider interactions with confrontations with a patient of color that were either solved through patient centered communication (provider success narratives), or were not solved and explicitly tied to race (persistent racism narratives). Findings show that providers who were already predisposed to agreeing that racial bias played a role in health disparities accepted that racial bias influenced the interactions, but providers who were predisposed to believe health disparities are *not* caused by racial bias rejected persistent racism narratives. Instead, these providers employed colorblind ideology, claimed that any racial issue was due to "racial sensitivity" of the patient, and pointed to differences in their own experiences with that in the narratives. Burgess et. al. suggest that further studies be done in order to examine the role narratives can play in promoting provider acceptance of their racial bias and decreasing racial health disparities. The narrative medicine methodology offered in this thesis of using interpretive ethnography to analyze interactions for decolonial and colonial sense making is one that I believe addresses these researcher's call to action. Currently, narrative medicine asks medical students and providers to read themselves in narratives using literary methods (Charon, 2001). Furthering the scope of narrative medicine, I suggest that medical students and providers story their interactions themselves, and then reflexively analyze them with a decolonial eye. However, this methodology cannot stand alone, and must be part of a larger effort to decolonize medical training and practice. To address this, I plan to take this project further by seeking narratives by patients of color whose medical experiences are marginalized within medical teaching (Washington, 2006), and analyzing them with the same methodology offered in this thesis: examining how they are

colonial and decolonial, how they are part of the larger racial project of health care, and how providers can work towards decolonizing their interactions with patients. I would like for these narratives and analyses to compose a decolonial narrative medicine text that can contribute to the process of decolonizing medical teaching and practice.

Limitations

This study's practical limitations include a lack of inclusion of all participants, who influenced my sense making of reproductive health in various inextricable ways, but whom I was unable to include within my analysis due to my time constraints and large data set. I chose to work with these three narratives specifically because they each struck me in a unique way that kept them on my mind particularly often. Tiffany, as my first participant and one of the only mothers, with her stories of becoming pregnant on birth control that inspired a fear in me within my own decision making with birth control, stayed on my mind significantly throughout this project. Jane stayed with me because of her story in which her provider gave her an intra-vaginal ultrasound each time she wanted to refill her birth control, and the way I was unable to make sense of this occurrence as anything other than unnecessary and inappropriate, but unable to voice this to Jane. I chose to include Jane because this tension of wanting to name abuse but being unsure or unable to is one that is not only prevalent in my own life, but in the larger political moment with the growing "Me Too" and "Times Up" movements. I am not claiming that what happened to Jane was undeniably a situation of abuse, but rather I attempt to call attention to the tensions that arose around the possibility of naming and identifying it as abuse. I included Rose because she struck me as one of the participants who was most similar to me in the lived experience of being a South Asian woman, and caused me to reconsider my notions of "culture" — a reconsideration I hoped to share in attempt to decolonize what we consider

“culture”, what is attributed to it, and in what ways this reiterated Whiteness as the norm. I also felt compelled to share these three narratives specifically because they offered situations that can be considered outside of the norm: Tiffany’s two unexpected pregnancies on birth control, Jane’s provider giving her intravaginal ultrasounds, and Rose’s active engagement with her reproductive health education in contrast to what has been generationally taught to her. I believed these narratives were ones that would provide a challenge for providers and medical students to engage directly with the lives of patients they may not encounter in practice or textbooks often.

While I believe each of these stories offers something unique, it cannot be dismissed that a great deal of my sense making during this project is left out with my lack of inclusion of the other 17 participants. For example, many of my participants were Black women who were studying public health, and who actively engage in an educational role in the lives of their friends and families by keeping them informed about various health issues and concerns, and acting as a reference point when their friends and family have health related questions. This altered my sense making of these Women’s reproductive lives as relationally constructed and maintained, and the ways in which colonial institutions like the Academy create spaces for people of color to engage in promoting dominant knowledge about reproductive health. While a discussion of this was outside the scope of the narratives I chose to include, this understanding of my participants’ experiences inextricably influenced the sense making I describe within this thesis.

Another major limitation of this study is my lack of discussion of the class subject position of both my participants and myself. Because my participants and I all, to varying degrees, partake in and embody a normative lifestyle in line with Whiteness, to not call attention

to class is to erase that class exists and affects our sense making, reiterating that a class subject position that follows Whiteness is the norm. I only briefly touch on class in my analysis of capitalistically productive selves that I focus on, which limits my understanding of class as only within the ways in which they are explicitly tied to capitalism. I am lacking in an exploration of intersectionality (Crenshaw, 1990) and hybridity (Fludernik, 1998) and the ways that class, race, gender, sexual orientation, and other identities emerge not as distinct but as one lived experience, which should include an analysis of the ways I have been colonized to identify certain aspects of my participants as “race” or “class” and why. These questions are ones I hope to answer in future studies with a better theoretical grounding in intersectionality and hybridity. It is my goal to take this project further to offer medical students and providers a methodology to decolonize medical training and practice, as well as sharing intersectionally-attentive narratives of Women of color in a manner that offers them witness – witness of my own, of the academy, and of providers, who all too often shy away from bearing such.

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