

THESIS

UNDERSTANDING THE BODY: LEARNING HOW PUERTO RICAN WOMEN IN NEW
YORK CITY RECEIVE INFORMATION ON REPRODUCTIVE HEALTH

Submitted by

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ABSTRACT

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This qualitative study explores the experiences and stories of eleven self-identified second and third generation Puerto Rican women raised and living in New York City. Through semi-structured focus groups conducted in New York City, this study deconstructs how the women in this study learn and understand their bodies in the context of reproductive health. Furthermore, it aims to be liberatory in nature and to engage in practices that center the voices and experiences of the women participating. This study comprises decolonial and critical feminist frameworks and epistemologies and argues that second and third generation Puerto Rican women raised in New York City understand their bodies in relation to reproductive health in a multitude of ways. This study shows that reproductive health for Puerto Rican women in New York City should not be framed within a victim/agent dichotomy, because the experiences of these women are more nuanced and complicated. This thesis also reveals that transmission of reproductive healthcare resources from medical professionals to these women is severely limited and lacking. It is recommended that the experiences of Puerto Rican women in reproductive health be valued and incorporated into peer-to-peer workshops and *promotora* healthcare models to enhance how Puerto Rican women in New York City receive information on reproductive health.

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DEDICATION

For my mom, Lourdes and my Abuela, Carmen. For all of the women in my family and for the women in this project.

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CHAPTER ONE: INTRODUCTION

For those of us
who were imprinted with fear
like a faint line in the center of our foreheads
learning to be afraid with our mother's milk
for by this weapon
this illusion of some safety to be found
the heavy-footed hoped to silence us
For all of us
this instant and this triumph
We were never meant to survive.
Audre Lorde¹

The process of remembering is a difficult process. It is a journey that often requires those who strive to remember to reach back into the depths of forgotten, painful, and erased memories. To fully understand the scope and importance of this project, it was necessary for me to place and position myself within the nature of the research context. I was resistant at first. I was resistant to the process of narrating my own story and how I understood or learned about my body. My resistance came from knowing that writing out my experiences and the ways I conceptualized my body made the process of remembering real. The process of writing propelled me to reach deeper within myself for words that rendered my experiences, as a Puerto Rican female and self-identified woman, true and alive. It meant that what my body had said to me from the moment I realized it could speak was true, real, unforgettable, and legitimate. The following paragraphs outline and discuss my own process of re-remembering how I came to the context of this project as a young Puerto Rican woman from New York City.

¹ Audre Lorde, "A Litany for Survival," in *The Black Unicorn*, ed. Audre Lorde (New York: W. W. Norton & Company, 1978), 31.

As a second-generation Puerto Rican woman born and raised in New York City, I began this project with a myriad of questions and very few plausible answers. What started as an initial desire to learn more about my own body and answer my own questions, quickly turned into wanting to discover the historical and current relationships between Puerto Rican women, reproductive health, and the body. I first learned about the historical relationship between Puerto Rican women and reproductive health when I was an undergraduate at a small state college in Upstate New York. After watching *La Operacion* (1982), a documentary directed by Ana Maria Garcia that highlights the social policy of sterilization in Puerto Rico, students were asked by the film's facilitators to reflect on their own feelings and opinions towards the documentary.² I remember feeling emotional to the point that I did not have any words to say. When I was called on to share my thoughts with the group the only things I could gather to say out-loud was that I finally understood why the women in my family experienced matters of reproductive health as they did. I saw myself, and the women in my family, in the documentary. *La Operacion* depicted a story that was all too familiar in the fabric of my own family's ties to our bodies and how I was socialized to understand my body as a young girl.

As a young girl, I always heard stories about the men and women in my family. The stories came in the forms of tidbits of gossip or *bochinche* of tales we, *los ninos*, were forbidden to repeat or talk about. Often the gossip was slivers of stories that we did not elaborate on, that were hidden, or the secrets of our family. We were never allowed to "share our dirty laundry in public." The women of our family often sat around the kitchen table drinking *café con leche* and exchanging stories of "he did this" or "she said that." Their stories were remnants of years of both learning and unlearning from their experiences. The women in my family engaged and

² *La Operacion*, directed by Ana Maria Garcia (1982, Puerto Rico: Latin American Film Project, 1982) VHS.

dialogued through their own branch of intellectualism. Talking about sex was taboo and shameful, but the act of mothering was cherished, celebrated, and accepted. While these stories were important in framing my early understandings of myself as a young Puerto Rican girl, they also left me with very few avenues to talk about and understand the implications of gender, sexuality, reproductive health, and ethnicity on my life. It took a long time for me to realize that my experiences with gender, sexuality, and issues of reproductive health were not unique to my family or my experiences growing up. Instead my experiences are connected to a larger societal, historical, and political impact of colonization on the Puerto Rican female body.

This project is an exploratory qualitative study of the lives of eleven self-identified Puerto Rican women from New York City. Their stories and experiences are centered in this study but their real identities remain anonymous through the use of pseudonyms. As a tool for engaging and fostering in critical dialogue, this project aims to construct and understand how Puerto Rican women living in New York City learn to understand their bodies in relation to reproductive health. This project is specifically interested in how the experiences of these women connect to how they were socialized to understand their bodies. Furthermore, it aims to be liberatory in nature and to engage in practices that center the voices and experiences of the women participating.

To contextualize this work, however, I provide background information that introduces the historical relationship between the United States and Puerto Rico. It is necessary to discuss this historical relationship because it has significant impacts in the ways Puerto Rican women were socialized to understand their bodies in relation to reproductive health. Following is a brief discussion of the migration periods of Puerto Ricans to the United States. In addition I have provided an overview of Latina reproductive health in U.S. public discourse and information

about the racial and ethnic healthcare disparities that impact Puerto Rican women's healthcare services in the U.S.

Background

Historical Relationship

In the words of Puerto Rican scholar Clara E. Rodriguez (1991), technically “all Puerto Ricans have been born in the U.S.A.” since 1898, despite the fact that Puerto Ricans did not acquire United States citizenship until the U.S. entered World War I in 1917.³ Since the Spanish-American War in 1898, the island of Puerto Rico has remained a colonial territory of the United States. Although the U.S. government considers Puerto Rico an unincorporated commonwealth territory of the mainland the island's history with the United States, in fact, represents a continual “story of conquest.”⁴ As part of the consequences of the Spanish-American War with Spain, the United States essentially conquered Puerto Rico despite the island having a “strong sense of national identity and political articulation” under Spanish colonization.⁵

During Spanish colonialism, Puerto Rico was a strict strategic military base, but it also developed into a growing trade center under the Autonomous Charter of 1897, which gave Puerto Rico the right to “full representation in the Spanish Cortes,” the right to ratify or reject commercial treaties affecting the island, and the right to structure customs on imports and exports.⁶ Under U.S. occupation, Puerto Rico did not have political or economic autonomy; but instead, Puerto Rico was and is currently heavily dependent on the U.S. both politically and economically. Puerto Ricans who are residents of Puerto Rico today cannot vote in national

³ Clara E. Rodriguez, *Puerto Ricans Born in the U.S.A.* (Boulder: Westview Press, Inc., 1991), 1.

⁴ *Ibid.*, 14

⁵ *Ibid.*

⁶ *Ibid.*, 10

campaigns, send representatives to U.S. Congress, and do not have nearly as much control over commercial outcomes as they previously had under the Autonomous Charter.⁷

Contextualizing Puerto Rico as a contemporary colony of the U.S. requires an understanding of the process of migration of Puerto Rican residents to the United States. Economically, politically, and socially motivated, the process of migration for Puerto Ricans, and especially Puerto Rican women, to the mainland presents a much more complicated scenario than what is often proposed by “push and pull” immigration theorists. As Ramon Grosfoguel (2003) argues, the best way to describe Puerto Rico’s migrational relationship with the U.S. is through framing the historical relationship as representative of dialectical dynamics and not from a “traditional dependency perspective.”⁸ Similarly, Puerto Rico’s migration history is complicated and representative of the political, economic, and societal influences of the times.

Migration

Although Puerto Ricans migrated to cities like New York before the U.S. invasion of Puerto Rico, Puerto Rican migration after 1900 can be organized into three major periods. The first period between 1900-1945 was heavily influenced by changes in land usage and production. Within the first couple of decades of U.S. occupation in Puerto Rico, the island’s economy transitioned from a diversified crop system to sugar acting as the “island’s single most important crop⁹ with “60% of the sugar industry controlled by U.S. absentee owners.”¹⁰

The second migration period, otherwise known as the “great migration,” had the largest percentage of Puerto Rican migration to the U.S. during 1946-1964. During this period, the bulk

⁷ Ibid., 11.

⁸ Ramon Grosfoguel, *Colonial Subjects: Puerto Ricans in the Global Perspective* (Berkeley, CA: University of California Press, 2003), 47.

⁹ Virginia E. Sanchez Korrol, *From Colonia to Community: The History of Puerto Ricans in New York City* (Berkeley, CA: University of California Press, 1983), 20.

¹⁰ Rodriguez, *Puerto Ricans Born in the U.S.A.*, 11.

of Puerto Ricans continued to migrate to New York City.¹¹ In Puerto Rico during this migration period, Operation Bootstrap significantly influenced employment opportunities and housing conditions of many Puerto Rican working-class families. As a new approach, Operation Bootstrap promoted private, domestic and foreign investment with the promise of low wage employment over governmental developed industry. Rather than providing higher employment, the types of industry investing on the island were “increasingly capital intensive” and had “little commitment to the development of the island.”¹² This change of economy and political representation resulted in high unemployment rates and poverty, especially for Puerto Rican women, who were beginning to join the work force after World War II.

The third migration period of Puerto Ricans from Puerto Rico to the U.S. is much more fluid and less stationary in comparison to the first and second migration periods. Puerto Rican migration after the 1960s is categorized as a “circular” migration, in which many Puerto Ricans continuously travel back and forth from Puerto Rico to the United States in search of employment. Puerto Rican migration to the U.S. after the 1960s was influenced by an increase in “capital-intensive industries,” which allowed many pharmaceutical and electronic companies to expand on the island.¹³ In contrast to “labor-intensive” jobs, “capital-intensive industries” did not generate employment opportunities at the same rate. The lack of employment opportunities in Puerto Rico increased the amount of federal transfers from the U.S. but also influenced greater circular migration.¹⁴

While there is extensive research regarding the factors that influenced Puerto Rican migration to cities like New York, this paper focuses on the “great migration” period because of

¹¹ Ibid.

¹² Ibid., 12; and Korrol, *From Colonia to Community*, 27.

¹³ Grosfoguel, *Colonial Subjects*, 59.

¹⁴ Ibid.

its influence on the lives, political consciousness, and reproductive health of Puerto Rican women in New York City.

In discussing reproductive health from the perspectives of New York City based Puerto Rican women, this thesis is divided into four primary chapters: (1) Literature Review; (2) Methodology; (3) Findings; and (4) Discussion.

Chapter one discusses the literature and movements that help frame reproductive health in the U.S. and how Puerto Rican women understand their bodies in relation to reproductive health. The scholars in this section provide a comprehensive overview on the ways reproductive health and freedom for Puerto Rican women are positioned politically, culturally, socially, and economically. Western epistemology is also reviewed, particularly as it relates to how the body is situated in Western society, and thus, affects the ways Puerto Rican female bodies are socially constructed and represented.

Chapter two focuses on presenting a theoretical and conceptual framework that helped guide the methodological process for this project. I explain the rationale for using decolonial and critical feminist methodologies, as well as, how these methodologies informed the use of qualitative research methods for recruitment purposes, data collection, and data analysis. A clear and complete description of the specific steps of my research plan is also presented.

Chapter three explores the findings that derived from the women participating in this study. In this chapter I discuss one overarching theme and four major themes that emerged from the data using methods of grounded theory. I use direct experiences and quotes from the participants to further explain and support each theme and categories within each theme.

Chapter four further examines the implications of how Puerto Rican women in New York City might understand their bodies in relation to reproductive health by providing an analysis of

the themes discussed in chapter three. Also, Chapter four allows the data that emerged from participant responses to be weaved through the literature discussed in chapter two. Throughout an analysis and discussion of the themes provided in the findings chapter, chapter five presents the complicated and myriad ways that Puerto Rican women in New York City learn to understand their bodies and make reproductive choices. As well, I address the limitations to this study and make suggestions for future research.

Taken together these chapters aim to provide opportunities for Puerto Rican women in New York City to relearn and understand how the contexts of our reproductive lives are shaped by historical, cultural, political, and societal forces that affect the ways we might make reproductive choices for our bodies. I use “we” and “our” because my life and reproductive experiences are personally, structurally, and socially connected to the women featured in this study. I do not deny the impact of my own experiences in attempting to understand my body in relation to reproductive health influencing the larger scope of this project, but I also believe that I would not be capable of truthfully and legitimately presenting the experiences of the women in this study if I did not have a personal connection to the larger purpose of the project. While this project cannot offer concrete solutions to how Puerto Rican women in New York City can better understand their bodies in relation to reproductive health, it is the aim and pursuit of this project to create and foster liberatory dialogue.

CHAPTER TWO: LITERATURE REVIEW

This chapter explores current literature in the areas that are significant to the background and theoretical framing of this project. The areas that are explored include reproductive health, reproductive freedom, patriarchy, gender, sexuality, Western epistemology, and the Puerto Rican female body. Each of these areas outline the current literature that helps to provide the context and support for this project.

Reproductive Health

The women whose voices are featured in this study represent a multitude of different experiences regarding reproductive health and reproductive health choices. It is important here to present an overview of the literature in reproductive health because doing so provides a context to how Puerto Rican women experience reproductive health in the United States. Drawing from a reproductive justice framework, as defined by Loretta Ross (2006), this section explores the types of resources and power, if any, Puerto Rican women in New York City have to make sustainable and liberatory decisions about their bodies, genders, sexualities, and reproductive lives.¹⁵

The subject of reproductive health for Puerto Rican women in the U.S. is largely included within the debate of reproductive choice, justice, and freedom.¹⁶ According to Eugenia Acuna-Lillo however, few scholars address the implications of health within Puerto Rican communities

¹⁵ Loretta Ross, "The Color of Choice," in *Color of Violence: The INCITE! Anthology*, eds. Andrea Lee Smith, Beth E. Richie, Julia Sudbury, and Janelle White (Boston, MA: South End Press, 2006), 56.

¹⁶ Iris Lopez, *Matters of Choice: Puerto Rican Women's Struggle for Reproductive Freedom* (Piscataway, NJ: Rutgers University Press, 2008), xi.

or how Puerto Rican women are socialized to view reproductive healthcare practices.¹⁷ In this study, the term reproductive health as defined by the United Nations Population Information Network's (POPIN) is used. The definition provided by POPIN is used because it aligns with the overall purpose of this study in providing a comprehensive approach when discussing reproductive health. According to POPIN,

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life. This includes having access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility. Reproductive health also implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.¹⁸

In addressing reproductive health practices among Puerto Rican women in New York City it is necessary to include a wide array of subtopics that are unique to the Puerto Rican female experience. Included under the subject of reproductive health are the subtopics of sterilization and overpopulation myth. Each of these subtopics presents a foundation towards understanding reproductive health for Puerto Rican women in New York City.

Sterilization

Matters of reproductive healthcare for Puerto Rican women are frequently addressed under the context of sterilization and contraceptive practices. Sterilization, otherwise known as tubal ligation, is a tool for fertility control. Listed by the Center for Disease Control and

¹⁷ Eugenia Acuna-Lillo, "The Reproductive Health of Latinas in New York City: Making a Difference at an Individual Level," *Centro Journal* 2, no. 4 (1988): 30.

¹⁸ Secretariat of the United Nations Inter-Agency Task Force on the Implementation of the ICPD Programme of Action, "Guidelines on Reproductive Health for the UN Resident Coordinator System" in *United Nations Population Information Network*, 2001, retrieved May 1, 2015, <http://www.un.org/popin/unfpa/taskforce/guide/iatfreph.gdl.html>.

Prevention as the “most common method of contraception used in the U.S.,” the process of sterilization or tubal ligation refers to the medical procedure of “tying” or permanently closing a female’s fallopian tubes to prevent unwanted pregnancy.¹⁹

In 1974, approximately thirty-five percent of Puerto Rican women in Puerto Rico were sterilized.²⁰ Additionally, in 1988, thirty-eight percent of all Puerto Rican women in New York City were sterilized.²¹ As the most marketed and available form of birth control for Puerto Rican women both in Puerto Rico and in New York City, the practice of sterilization was a culturally embedded custom in which women “self-selected” to be sterilized. Literature suggests that in the United States, the federal government, and specifically the Department of Health and Human Services, paid for ninety-percent of the cost of sterilization through Medicaid and family planning agency auspices.²² According to a study conducted in 1995, fifty percent of Latinas in New York City were permanently sterilized. With a historically large population of Puerto Rican women living in New York City, the majority of Latina women who were sterilized were of Puerto Rican descent.²³ The 1995 study is the most recent study of the percentage of Puerto Rican women in New York City who are sterilized, but through analyzing the increase of sterilization from 1988 to 1995, it is accurate to assume that the percentage of Puerto Rican women who are sterilized has only increased.

¹⁹ Division of Reproductive Health and National Center for Chronic Disease Prevention and Health Promotion, “Unintended Pregnancy Prevention: Female Sterilization,” in *The Department of Health and Human Services: Center for Disease Control and Prevention*, 2009, retrieved April 11, 2015, <http://www.cdc.gov/reproductivehealth/unintendedpregnancy/Sterilization.htm>.

²⁰ Lopez, *Matters of Choice*, 8.

²¹ *Ibid.*, xiv.

²² Angela Davis, “Racism, Birth Control, and Reproductive Rights” in *From Abortion to Reproductive Freedom: Transforming a Movement*, ed. Marlene Gerber Fried (Boston, MA: South End Press, 1990), 23-24.

²³ *Ibid.*

As Iris Lopez (2008), currently the leading scholar in reproductive health for Puerto Rican women, argues in *Matter of Choice: Puerto Rican Women's Struggle for Reproductive Freedom*, discussions of sterilization and contraceptive practices are concentrated under a framework of reproductive choice/rights and victimization or under the dichotomy of “pro-choice versus pro-life.”²⁴ The “pro-life versus pro-choice” dichotomous perspective provides a way for political researchers to victimize Puerto Rican women under a colonial economic structure through significantly reducing how Puerto Rican women make choices in regards to their bodies. This positioning, however, tends to ignore the agency that Puerto Rican women in the United States have in choosing sterilization to control fertility.²⁵

Overpopulation Myth

The U.S. does not have an official policy on population control, but ideologies influenced by population control affect how control of female bodies of color is maintained. Directly following U.S. possession of Puerto Rico in 1898, U.S. officials revitalized neo-malthusian ideology, based on the ideas of Thomas Malthus, to blame “Puerto Rico’s poverty and underdevelopment on what they defined as an overpopulation problem.”²⁶ Puerto Rico’s colonial relationship with the U.S. significantly influenced how birth and fertility control options were marketed and made publically available. Although there are distinctions between how state officials address birth control and population control policies, there are similarities in how both policies affect Puerto Rican women. As Lopez notes, “birth control developed to meet women’s needs to space births and/or prevent pregnancy.” Further, Lopez argues that population control occurs “when a government of a country implements a strategy to control the birth rate or growth

²⁴ Ibid., 142.

²⁵ Ibid.

²⁶ Ibid., 3.

of a given population either through reproductive measures or migration.”²⁷ Essentially adopting neo-malthusian ideology, efforts to maintain population control are supported through equating population growth with poverty and underdevelopment.²⁸

A fear of “being numerically and politically overwhelmed by people of color” made sterilization abuse and other birth control practices solutions to controlling the growth of population in Puerto Rico.²⁹ Moreover, the “unofficial sanctioning” of sterilization as a form of population and fertility control, caused both medical professionals and Puerto Rican women who migrated to New York City to trust and accept it as a cultural practice.³⁰

Reproductive Freedom

In understanding the ways that reproductive rights affect Puerto Rican women in the U.S., it is necessary to review the concept of reproductive freedom. In the larger context of the reproductive rights movement, the role of women of color was undocumented and framed within an agency versus victimization paradigm. Largely controlled by white women, the mainstream reproductive rights movement organized around the legalization of abortion and identified as “pro-choice.” Few organizations and literature addressed the ways the majority of communities of color were excluded from the abortion discussion and how women of color struggled towards achieving community control over reproduction and their own bodies. To grasp the politics surrounding the reproductive rights movement during the aftermath of the legalization of abortion, it is important to discuss the origins of the reproductive rights movement and the push towards reproductive justice.

²⁷ Ibid., xiii.

²⁸ Ibid.

²⁹ Ross, “The Color of Choice,” 54.

³⁰ Lopez, *Matters of Choice*, 147.

The reproductive rights movement emerged before and after the *Roe v. Wade* decision in 1973. In the 1960s, before the *Roe v. Wade* decision, the reproductive rights movement began as feminists campaigned for legal abortion with an emphasis on “woman’s sovereignty over her reproducing body.”³¹ Before *Roe v. Wade*, advocates of abortion used the term “rights” instead of “choice” to indicate that it was every woman’s “right” to choose not to have a child. However, during the political aftermath of *Roe v. Wade*, advocates for abortion and reproductive rights used the term “choice” in response to anti-abortion backlash.³² The *Roe v. Wade* decision enacted a series of political debates regarding the reproductive choices and bodies of women.

Making abortion legal in all fifty states, *Roe v. Wade*, marked an important time and inspired change for many white, middle-class women and organizations such as The National Abortion Rights Action League (NARAL) to get involved in the reproductive rights movement. While legalized abortion sparked an optimistic and hopeful outlook of the reproductive rights of women in the United States, many white activists involved in the movement neglected to acknowledge the difficulties in acquiring the “right to choose” abortion for poor and working class women of color and white women.³³

As an indication of how the mainstream reproductive rights movement neglected to acknowledge the exclusion of poor white women and women of color in the “pro-choice” discussion, many white, middle-class women ignored the impact of the Hyde Amendment on the lives of poor and working class white women and women of color. Passed in 1977 during the aftermath of the political debate surrounding abortion and the “pro-choice” movement, the Hyde

³¹ Jennifer Nelson, *Women of Color and the Reproductive Rights Movement* (New York: New York University Press, 2003), 139.

³² Rickie Solinger, *Pregnancy and Power A Short History of Reproductive Politics in America* (New York: New York University Press, 2005), 12-14.

³³ *Ibid.*, 20.

Amendment prohibited any federal funding, including Medicaid, to pay for women to receive abortions. While the Hyde Amendment did not spark a backlash from mainstream, white, and middle-class activists, it did affect the lives of women of color and poor white women who could not afford to receive abortions.³⁴

The political positioning of “pro-choice” did not include the rights or realities of women of color. In the realization that the pro-choice movement did not and would not rally against the Hyde Amendment, many women of color activists realized that the pro-choice movement was not concerned with their reproductive needs. The political framework of the mainstream reproductive rights movement maintained its focus on the legalization of abortion without addressing access to abortion or “the larger context of reproductive health” that included the reproductive bodies of women of color. The pro-choice reproductive rights movement of the 1960s and 1970s was a single-issue campaign, and thus, created a very narrow perception of reproductive health and rights.³⁵

In reaction to the Hyde Amendment and the neglect of the mainstream (or pro-choice) reproductive rights movement to acknowledge the effects of capitalism on the reproductive bodies of women of color, many white women and women of color with broader perspectives on reproductive rights, organized for a new and inclusive reproductive rights agenda. In organizing a new agenda, many activists reorganized reproductive rights to include how race and class affected reproductive choices.

As one of the first organizations to adopt a new and inclusive reproductive rights agenda, the Committee for Abortion Rights and Against Sterilization Abuse (CARASA), founded by

³⁴ Jael Silliman, Marlene Gerber Fried, Loretta Ross, and Elena R. Gutierrez, *Undivided Rights: Women of Color Organize for Reproductive Justice* (Boston: South End Press, 2004), 31.

³⁵ *Ibid.*, 32.

socialist feminists who were representatives from the National Abortion Rights Action League (NARAL), NOW-NY, and the Socialist Workers Party (SWP), focused on the economic barriers that affected poor and working class women of color and white women from making reproductive choices. Additionally, the politics of CARASA separated it from other reproductive rights organizations that only focused on single-issues and forms of activism. The politics of CARASA addressed organizing for reproductive choices that were free from coercion. CARASA defined coercion as any form of economic or political environment that prohibited women from making free reproductive choices. As defined by CARASA, the economic or political environments that affected free reproductive choices included, welfare rights, subsidized childcare for low-income women, workplace safety, and sterilization abuse.³⁶

CARASA played an important role in redefining the reproductive rights movement by actively choosing to address “the right to limit fertility and the right to reproduce regardless of race or income.”³⁷ By including the politics of Black and Latina women towards anti-population control methods of sterilization, CARASA focused on building an inclusive reproductive rights framework, a framework that incorporated both the goals and politics of the mainstream reproductive rights movement and the goals and politics of women of color. CARASA understood the importance of demanding access to safe and adequate methods of birth control and abortion, as well as, the importance of addressing the systematic injustice on the reproductive lives of women of color.³⁸ CARASA redefined the mainstream reproductive rights movement and conceptualized new strategies for addressing reproductive rights for marginalized women.

³⁶ Nelson, *Women of Color*, 135.

³⁷ *Ibid.*, 136.

³⁸ *Ibid.*, 137-138.

To understand the role of women of color in redefining reproductive rights terminology, it is necessary to discuss the stance against the reproductive rights movement and the push towards developing a reproductive justice framework. Women of color organizers who organized for reproductive rights redefined the meaning of “reproductive rights.” After the legalization of abortion, many organizations of the abortion rights movement identified under the term “pro-choice.” Working with a broader framework and in realizing that the term “pro-choice” was too narrow, women of color organizations organized under the premise of “reproductive rights,” “reproductive justice,” and “reproductive freedom.” In addition, the reproductive lives and rights of women of color are inextricably connected to and challenged by economic injustice, environmental degradation, sexism, and racism.³⁹

In redefining “reproductive rights,” women of color moved beyond abortion rights towards a reproductive justice framework. Envisioning “the perspectives of women of color engaged in both domestic and international activism” the term “reproductive justice” and the ideology behind it was coined in 1994 by women of color, after the United Nations International Conference on Population and Development in Cairo, Egypt. Reproductive justice aimed to bring “attention to our commitment to the link between women, their families, and their communities.”⁴⁰ Specifically, through working from a reproductive justice framework, women of color activists created new politics of organizing and worked towards a kind of justice that redefined reproductive rights beyond abortion.⁴¹ The term reproductive freedom refers to the freedom to have or not to have children.⁴² In reference to Puerto Rican women in the United States, Lopez (2008) suggests that reproductive freedom means the ability to choose from safe,

³⁹ Silliman, et al, *Undivided Rights*, 4.

⁴⁰ Ross, “The Color of Choice,” 63.

⁴¹ Silliman, et al, *Undivided Rights*, 15.

⁴² Lopez, *Matters of Choice*, 143.

effective, and affordable methods of reproductive choices and birth control. Additionally, the best possible social, political, and economical environments must exist for Puerto Rican women in New York City to realistically have reproductive freedom.⁴³

The “binary model of agency versus victimization” denies the influences of social, historical, and cultural constraints Puerto Rican women in New York City experience. The practices of sterilization is viewed as both an act of agency and as a form of abuse, but as Lopez (2008) argues, Puerto Rican women in New York City would use other viable forms of birth control if they were economically and socially available. Furthermore, the effects of cultural accepted practices and factors also deny Puerto Rican women in New York City full reproductive freedom.⁴⁴

Patriarchy

The effects of living in a patriarchal, and specifically a white male hetero patriarchal, society continues to influence how Puerto Rican women in New York City are perceived and positioned by reproductive healthcare. Further, Puerto Rican women in New York City learn to understand their bodies under the confines of patriarchal norms and expectations. For the purpose of this study, patriarchy is described as what bell hooks (2004) defines as, “a political-social system that insists that males are inherently dominating, superior to everything and everyone deemed weak, especially females, and endowed with the right to dominate and rule over the weak and to maintain that dominance through various forms of psychological terrorism and violence.”⁴⁵ As a social-political system, hooks argue that both males and females are

⁴³ Ibid.

⁴⁴ Ibid., 144.

⁴⁵ bell hooks, *The Will to Change: Men, Masculinity, and Love* (New York: Atria Books, 2004), 18.

indoctrinated into a patriarchal system, and that “patriarchal thinking shapes the values of our culture.”⁴⁶

Gender

A discussion of gender is important when addressing how Puerto Rican women learn to construct and perform womanhood. As Judith Lorber (2010) states, “gender is constantly created and re-created out of human interaction, out of social life, and is the texture and order of that social life.”⁴⁷ As a social construction, gender is the “process of creating distinguishable social statuses for the assignment of rights and responsibilities.”⁴⁸ In a U.S. Western context, gender acts as a social stratification system in which gender roles are also influenced by race, class, culture, age, and ethnicity.

Women of color in the U.S. are represented by very specific constructs of womanhood. These constructions reflect racialized notions of gender, class, and culture. In understanding the construction of racialized womanhood, it is necessary to comprehend that women of color face multiple identities, thus, influencing consciousness development. Aida Hurtado (1996) in *The Color of Privilege*, argues that a dual construction of womanhood affects how women of color are represented and perceived in a society dominated by white male patriarchy.⁴⁹ Under a dual construction of womanhood, women of color are caught in between implications of the racialized “other” and living within the expectations of a white normative.⁵⁰ Decisions regarding

⁴⁶ Ibid.

⁴⁷ Judith Lorber, “‘Night to His Day’: The Social Construction of Gender” in *Race, Class, and Gender in the United States*, ed. Paula S. Rothenberg (New York: Worth Publishers, 2010), 54.

⁴⁸ Ibid., 60.

⁴⁹ Aida Hurtado, *The Color of Privilege: Three Blasphemies on Race and Feminism* (Ann Arbor, MI: University of Michigan Press, 1996), 152.

⁵⁰ Ibid., 156.

healthcare and healthcare practices for Puerto Rican women are often made with these assumptions about gender, constructions of womanhood, and sexuality.

In framing how social constructions of gender are influenced and affected by particular political and socio-economic contexts, discussing gender as a component of reproductive health is important when addressing how Puerto Rican women are positioned in their families, communities, and the larger healthcare industry. Gender constructions in Puerto Rican communities are frequently positioned by scholars under tenets of machismo and marianismo. Often referred to as “two sides of the same coin” by Latin American scholars, Rosa Maria Gil and Carmen Inoa Vazquez (1996), machismo and marianismo are commonly described as sets of behaviors learned and encouraged in Latino communities.⁵¹ While machismo describes a set of “manly” behaviors used to position Latino men as “authoritarian, self-centered, sexually aggressive, and mired in rigid gender roles,” women, under marianismo, are depicted as passive, martyrs, dependent, and asexual.⁵²

As Lopez (2010) argues, the dualistic depiction by both Anglo and Latin American scholars presents a very simplistic picture of the gender roles and identities that Puerto Rican and other Latino communities embody.⁵³ Lopez states, “like Western women, Puerto Rican women have traditionally been socialized to be good mothers, wives, and daughters, to be nurturers, to conform to traditional gender roles, to repress their discontent, and to sacrifice themselves for others.”⁵⁴ Despite processes of gender socialization of Puerto Rican women, Lopez maintains that the binary model of machismo and marianismo “fails to do justice to the complexity of

⁵¹ Rosa Maria Gil and Carmen Inoa Vazquez, *The Maria Paradox: How Latinas Can Merge Old World Traditions with New World Self-Esteem* (New York: G.P. Putnam’s Sons, 1996), 7.

⁵² Ibid.; and Lopez, *Matters of Choice*, 33.

⁵³ Ibid.

⁵⁴ Ibid.

women's lives" and thus, fails to apprehend the complexities of Puerto Rican women's reproductive lives. The roles of gender in Puerto Rican communities and the reproductive lives of Puerto Rican women are instead a combination of traditional expectations, economic conditions, and self-awareness.⁵⁵

Sexuality

A discussion of sexuality is important in framing the ways that Puerto Rican women learn to understand their bodies in relation to reproductive health. As mentioned previously, Latinas in the U.S. are frequently represented in popular media and public discourse as the "passive, childlike females who are subservient to their husbands in particular and men in general" or as "traditional women—heavily influenced by Catholicism and therefore sexually repressed."⁵⁶ When discussed as sexual beings, Latinas, and specifically, Puerto Rican women are depicted as sexually "exotic" and hypersexual. The ways that Latina sexuality is represented is explicitly connected back to their racialized ethnicities.⁵⁷ In sum, Latina sexuality is often defined within a virgin/whore dichotomy and within that dichotomy, sexuality for Puerto Rican women continually shifts and conforms depending on specific historical moments and situations.

Sexuality for Puerto Rican women in the United States is continuously historically represented in hypersexualized images, which helps to classify Puerto Rican women as sexually deviant. As Jael Silliman, et al (2004) argue in *Undivided Rights: Women of Color Organize for Reproductive Justice*, Puerto Rican women in the U.S. are socially and politically represented as

⁵⁵ Ibid.

⁵⁶ Silliman, et al, *Undivided Rights*, 216.

⁵⁷ Ibid.

“exotically sexual beings who carelessly bear many children who will ultimately become welfare dependents and drain social resources.”⁵⁸

Addressing the structural and social position of Puerto Rican women in the U.S., Caridad Souza (2002) shows that sexuality and gender socialization for Puerto Rican women in New York City are also very much dependent on the reproductive work of Puerto Rican women both inside and outside of the home. Critical to household survival, Puerto Rican women are expected to be “*en la casa*” (inside the home or family) to aid in the pooling of resources of multiple “kin and non-kin” households. Being “*en la casa*” or “*un muchacha de la casa*” also translates into abiding by the respectability standards/rules for behavior established by the community. These standards often include cultural norms of chastity, remaining a “good” woman, and maintaining family honor. In opposite terms, being “*de la calle*” (outside the home or “of the street”) for Puerto Rican women in New York City is to also be sexually promiscuous and dangerous.⁵⁹

The Puerto Rican Female Body

Puerto Rican women understand their bodies in several different ways and often in relation to political, economic, social, and cultural factors. In discussing the literature concerning how Puerto Rican women learn to understand their bodies, and thus, make reproductive choices, it is necessary to provide an overview of how the body is positioned and discussed in Western society.

⁵⁸ Ibid., 217.

⁵⁹ Caridad Souza, “Sexual Identities of Young Puerto Rican Mothers,” *Dialogo* 6 (2002): 35.

The body, as a discussion of the “existential self,” is often framed as a cultural phenomenon, as a topic that is fluid and not fixed.⁶⁰ Thomas J. Csordas (1994), one of the leading current theorists on cultural phenomenology and embodiment, argues that there are two distinctions in understanding the body. Making a distinction between “representation of the body” and the “being in the world” understanding of the body, Csordas argues that the body, in a Western sense, should be understood and conceptualized as “fundamentally conditional” which would then encapsulate the “existential immediacy of bodily existence.”⁶¹ Rather than deconstructing the body as an object that is representational, Csordas reviews various ways the body is constructed and discusses the body through existence and “lived experience.”⁶² Disputing the methodological stance of the body as a representation or as representational, Csordas discusses and introduces the “paradigm of embodiment” as parallel or as a “dialectical partner” to the text rather than “allowing it to be itself subsumed under the text metaphor.”⁶³

While difficult to grasp, Csordas presents the body within a paradigm argument as a phenomenological process or the understanding of the body through philosophical and lived experiences. Rather than acting as a representational object, the body itself changes, expands, contorts, and re-positions itself in relation to historical moments and points in society. The body itself and understandings of the body are continual and defined by modes “of presence and engagement in the world.”⁶⁴ The body, in relation to “being-in-the-world” and embodiment re-envisions itself as less of an individual, material response to society and more of a collective site

⁶⁰ Thomas J. Csordas, *Embodiment and Experience: The Existential Ground of Culture and Self* (Cambridge, MA: Cambridge University Press, 1994), 1.

⁶¹ *Ibid.*, 10.

⁶² *Ibid.*

⁶³ *Ibid.*, 12.

⁶⁴ *Ibid.*

of culture and social processes. Through this understanding, the body in Western society acts as an active agent/subject and not as an apathetic or passive object.

Also positioned as a material object, the body in Western thought has “become one of the main battlegrounds” of the struggle to form a critical perspective “of contemporary, social, political, and cultural reality” that informs bodily practices and experiences.⁶⁵ As outlined by Terrence Turner (1994), Michel Foucault’s “poststructuralist body” and the body in the public discourse represented the “site of all controls” or the context of the “discourses of ‘power’.”⁶⁶ Claiming that the body is a “‘materialist’ substitute for the epistemological subject of social consciousness,” Foucault conceptualizes the Western body as more of an “object” and thus as a non-willful abstraction and product of discourse.⁶⁷

According to Peter McClaren in the foreword of *Pedagogy and the Politics of the Body: A Critical Praxis*, written by Sherry Shapiro (1999), Shapiro “admonishes that educational theory doesn’t place much importance on the body.”⁶⁸ Adding an integral part to the field of education, Shapiro’s work focuses on developing a “critical pedagogy of the body” and on arguing that knowledge is “body-mediated” and all learning is “primarily corporeal.”⁶⁹ Central to Shapiro’s argument and pedagogy is decentering dominant, institutional, and structural forms of knowledge creation and contesting “social relations informed by a white-supremacist patriarchal capitalism.”⁷⁰

⁶⁵ Terrence Turner, “Bodies and Anti-Bodies: Flesh and Fetish in Contemporary Social Theory,” in *Embodiment and Experience: The Existential Ground of Culture and Self*, ed. Thomas J. Csordas (Cambridge, MA: Cambridge University Press, 1994), 31.

⁶⁶ *Ibid.*, 35.

⁶⁷ *Ibid.*, 37.

⁶⁸ Sherry Shapiro, *Pedagogy and the Politics of the Body: A Critical Praxis* (New York: Garland Publishing Press, 1999), ix.

⁶⁹ *Ibid.*, x and xvi.

⁷⁰ *Ibid.*, xvi.

Shapiro's work seeks to understand the material, emotional, and feeling body as a central agent in creating knowledge. Shapiro provides an analysis on how bodies (and specifically bodies that are marginalized) are affected by the processes of production, colonization, and everyday systems of perpetuated violence. Specifically, Shapiro expands what it means to "be in the world" and argues that the body is the manifestation of knowledge. Shapiro's analysis of the body is in itself a "reflective practice of resistance."⁷¹ Focused on a "project of liberation," Shapiro centralizes the body as a "site for self and social transformation."⁷²

Shapiro frames the body as subject and explores questions of justice, education, and identity through engaging with bodily experiences and how the body itself feels, remembers, and knows. Through her analysis, Shapiro strives to apply the body as active "knower" to public education discourses, and therefore focuses on creating a "critical pedagogy of the body." In discussing a "critical pedagogy of the body", Shapiro argues that "knowledge is always grounded in bodily existence" and applies this ideology to the ways in which the frameworks of education in this society can be transformed.⁷³ In arguing for "knowing" through the site of the body, Shapiro provides a critical framework for understanding the ways students gain access to knowledge, how that knowledge is created, and how that knowledge can be used to contest dominant/privileged forms of knowledge/bodies.

Using Shapiro's "pedagogy of the body" this project explores how Puerto Rican women in New York City understand their bodies in relation to reproductive health. Previous scholarly work suggests that Puerto Rican women are taught to repress sexuality. Many second and beyond generation Puerto Rican women in New York City grow up without an adequate

⁷¹ Ibid., 10.

⁷² Ibid., 16.

⁷³ Ibid., 40.

understanding of sexuality.⁷⁴ Additionally, ethnographic studies speculate that second and beyond generation Puerto Rican women in New York City lack a sufficient amount of information about their own bodies. Scholars indicate that the lack of information is due to a limited knowledge of contraceptives, a “lack of emotional training,” and not knowing the history of exploitation experienced by Puerto Rican female bodies.⁷⁵

Acuna-Lillo (1988) argues that Puerto Rican women in New York City understand reproductive health and their own bodies through their socialization as the “family caretaker.”⁷⁶ Taught to put every family member before herself, the Puerto Rican woman is reluctant to think about understanding her own reproductive health and body.⁷⁷ Similarly, scholars suggest that while there is reluctance to seek out healthcare, Puerto Rican women in New York City also rarely question what doctors may say, and therefore take certain medical treatments as a cultural truth and legitimate practice.⁷⁸

Although there is little recent literature on how Puerto Rican women are taught to view and understand their own bodies, Flores, Davison, Rey, Rivera, and Serrano (1990) suggest, “the most important site of Puertorriquena struggle is the female body.”⁷⁹ The Puerto Rican female body is a valued and exploited “instrument” for social survival and often an object for social control.⁸⁰ Flores, Davison, Rey, Rivera, and Serrano (1990) provide an in-depth analysis on how

⁷⁴ Lopez, *Matters of Choice*, 39.

⁷⁵ Candida Flores, et al, “La Mujer Puertorriquena, Su Cuerpo, y Su Lucha por La Vida: Experiences with Empowerment in Hartford, Connecticut,” in *From Abortion to Reproductive Freedom: Transforming a Movement*, ed. Marlene Gerber Fried (Boston, MA: South End Press, 1990), 221.

⁷⁶ Acuna-Lillo, “The Reproductive Health of Latinas in New York City,” 33.

⁷⁷ Ibid.

⁷⁸ Ibid., 34.

⁷⁹ Candida Flores, et al, “La Mujer Puertorriquena,” 224.

⁸⁰ Ibid.

Puerto Rican women can achieve empowerment through understanding the ways their bodies have been used, “the purposes it has served, and in whose interests it has toiled.”⁸¹

In 1990, Flores, Davison, Rey, Rivera and Serrano conducted a research project entitled, *Mujeres en Accion Pro Salud Reproductiva: Northeast Project on Latina Women and Reproductive Health*, based at the Hispanic Health Council in Hartford, Connecticut. The researchers stated that sexuality, reproduction, and motherhood needed to be redefined for Puerto Rican women living in the United States due to the “experiences of colonization, inter-lingualism, and the development of capitalism in Puerto Rico.”⁸² Specifically, the project included workshops that distributed “bi-lingual, bicultural education materials” that were sensitive to Puerto Rican women’s needs for information about reproductive health and sexuality.⁸³

The *Mujeres en Accion Pro Salud Reproductiva* Project led the way for an additional support group leadership development model entitled, “*Cosas de Mujeres*” (“Issues Affecting Women”), which was a “bilingual, bicultural support group for poor and working-class Puerto Rican women with limited education.”⁸⁴ The support group leadership development model was conducted under the premise that empowerment, for Puerto Rican women in the United States, occurs when Puerto Rican women have a “heightened” understanding of their own bodies, especially in relation to reproduction and sexuality. A “heightened” understanding gives Puerto Rican women a “greater sense of power” over their sexuality and own reproductive bodies.⁸⁵

⁸¹ *Ibid.*, 225.

⁸² *Ibid.*, 223.

⁸³ *Ibid.*, 225.

⁸⁴ *Ibid.*, 227.

⁸⁵ *Ibid.*, 228.

Flores, Davison, Rey, Rivera, and Serrano found that through the Mujeres en Accion Pro Salud Reproductiva Project and “Cosas de Mujeres,” Puerto Rican women had a broader understanding of who they were as women.⁸⁶ The study also found that “Cosas de Mujeres” helped Puerto Rican women learn about their bodies and “feel they had a right to question their own and others’ actions” in relation to their bodies. Puerto Rican women were able to analyze these actions from “a different ideological framework.”⁸⁷

While the literature in this section discusses how Puerto Rican women in New York City learn to understand their own bodies as it applies to reproduction and sexuality, the authors did not address how Puerto Rican women learn to construct womanhood in contest to colonialism, colonization, and sterilization practices. Specifically, scholars did not address how culturally embedded practices of sterilization, historical colonization, and migration affected the ways Puerto Rican women learn to understand their bodies. There is a need for further research on how colonization leaves a mark on the female body. Additionally, while the researchers in Mujeres en Accion Pro Salud Reproductiva demonstrated the need and importance of offering workshops that addressed the body in relation to reproduction and sexuality, there is no evidence that the workshops continued or expanded. The project and workshops only catered to a small number of Puerto Rican women in Hartford, Connecticut, and Flores, Davison, Rey, Rivera, and Serrano (1990) analyzed the success of the project over twenty years ago.

There is a need for further research and evidence of how similar projects and workshops can be used currently. In addition, further research is needed not only on the success of said projects and workshops, but also on how to deconstruct sterilization as a culturally compulsory practice that is passed down through generations. The literature in this section provides a

⁸⁶ Ibid., 230.

⁸⁷ Ibid., 232.

foundation for future research on how Puerto Rican women in New York City understand reproduction and sexuality and the ways in which Puerto Rican women can reconstruct connections to their own bodies.

CHAPTER THREE: METHODOLOGY

But if hunger and terror tattoo the skins of our genes with outdated survival manuals and a continuous stream of SOS signals, if the conscious acts of human beings to deprive each other of food and safety and life itself, mark us in inheritable ways, surely we can decide to mark ourselves, through an entirely different set of human acts, with messages of solace and solidarity, with a codex of healing.

-Aurora Levins Morales⁸⁸

Aurora Levins Morales (2013), a Puerto Rican scholar, poet, and writer, focuses her work on the processes of healing the Puerto Rican female body. Levins Morales (2013) raises personal and ontological questions on what it means to heal and how to go about the process of healing the bodily experience.⁸⁹ Specifically, Levins Morales (1997) states, “one of the first things a colonizing power or repressive regime does is to attack the sense of history of those they wish to dominate, by attempting to take over and control their own relationships to their own past.”⁹⁰ The process of colonization erases a sense of history and identity for the colonized. Using Levins Morales’ conceptualization of healing and historical identities this project intends to explore how the experiences of colonization and the erasure of historical identity affects the Puerto Rican woman and her relationship with reproductive health.

This project centers the stories and experiences of second and beyond generation, self-identified Puerto Rican women who were raised in New York City. The purpose of this project is to examine how and what second and beyond generation Puerto Rican women from New York City learn about reproductive knowledge. The research questions of this project were developed in part to fill a scholarly gap in understanding reproductive knowledge and the body among

⁸⁸ Aurora Levins Morales, *Kindling: Writings on the Body* (Cambridge: Palabrera Press, 2013), iv.

⁸⁹ Ibid.

⁹⁰ Ibid., 22.

Puerto Rican women in New York City, but also as a result of my own bodily experiences in relation to reproductive health as a second-generation Puerto Rican woman. While I arrived at this research from my own personal reasons and experiences, I believe that there are consequences to the ways capitalism and a history of colonization affect the ways Puerto Rican women are socialized to understand their bodies and view reproductive choices. Therefore, the research questions that guide this study explore how Puerto Rican women gain reproduction knowledge, what Puerto Rican women learn about reproductive knowledge, and how reproductive knowledge shapes ideas of the body in reproduction.

There are specific research questions that guide the focus and rationale for this research study. The goal of this study is to understand how Puerto Rican women in New York City understand and conceptualize issues of reproductive health and how reproductive health and choices are discussed among female family members in Puerto Rican families living in New York City. The specific research questions, which guide this project, are: RQ 1. How are Puerto Rican women learning about reproductive health?, RQ 2. In what ways are Puerto Rican women from New York City discussing reproductive health within their families?, and RQ 3. How are Puerto Rican women understanding their bodies?

The research questions for this qualitative study are grounded in decolonial and critical feminist frameworks and epistemologies. Rooted in critical feminist praxis, decolonial and critical feminist epistemologies also frame the theoretical positioning for the methodology. As understood by feminist scholar Maria Lugones (2010) decolonial feminism strives to reconstruct feminism while also intersecting the effects of poverty, capitalism, and colonization on the female and gendered body.⁹¹ Additionally, decolonial feminism allows researchers to look at the

⁹¹ Maria Lugones, "Toward a Decolonial Feminism," *Hypatia* 25, no. 4 (2010): 746.

subject rather than look at the subject as an object. To think about feminism from a decolonial perspective is to begin to understand the oppression of women through an analysis of “racialization, colonization, capitalist exploitation, and heterosexualism.”⁹²

This qualitative study also draws from an epistemology that is rooted in standpoint feminism as defined and conceptualized by Donna Haraway (1988) and Patricia Hill Collins (2000). Haraway (1988) argues for “critical positioning” and for “politics and epistemologies of location, positioning, and situating, where partiality and not universality is the condition of being heard to make rational knowledge claims.”⁹³ Both Haraway and Hill Collins argue for the use of the localized, lived bodily experience as a form of creating knowledge. This research project stems from an epistemology that argues “for the view from a body, always a complex, contradictory, structuring and structured body, versus the view from above, from nowhere, from simplicity.”⁹⁴ As a feminist researcher, I am interested in building and constructing theory that derives from the notion “I feel” rather than “I think.” Shifting away from a positivist approach to conducting research, this project makes an ontological assumption that there are multiple realities and multiple perspectives towards constructing theory and creating knowledge.⁹⁵ This project centers the voices and lived-experiences of Puerto Rican women in New York City, their understandings of their bodies, and how they obtain knowledge about reproductive health. Therefore, a feminist lens helped frame the focus group questions and provided a structural foundation for analysis and discussion.

⁹² Ibid., 747.

⁹³ Donna Haraway, "Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective," *Feminist Studies* 14, no. 3 (1988): 350.

⁹⁴ Ibid.

⁹⁵ Sandra Harding, *Science and Social Inequality: Feminist and Postcolonial Issues* (Chicago: University of Illinois Press, 2006); and Sharlene Nagy Hesse-Biber and Denise Lackenby, "How Feminists Practice Social Research," in *Feminist Perspectives on Social Research*, eds. Sharlene Nagy Hesse-Biber and Michelle L. Yaiser (Oxford: Oxford University Press, 2004), 209-226.

The following section provides a comprehensive overview of several concepts that helped frame the focus of this study, assisted in establishing a theoretical framework, and guided the construction of focus group questions for data collection, analysis, and discussion.

Conceptual Framework

Western Epistemology

A discussion of Western epistemological hegemony is important here as it contextualizes the ways Puerto Rican women are perceived and represented from a Western epistemological lens. The knowledge that Puerto Rican women create and the ways they learn to understand their bodies within reproductive health are heavily influenced by how Puerto Rican women are positioned in Western epistemological frameworks. It is this project's intention to frame the ways that Puerto Rican women in New York City know their bodies outside of the confines of Western epistemology, and thus, a discussion of Western epistemology is important.

Discussing the politics of knowledge creation includes addressing the process of creating knowledge, how knowledge is accessed, and how the process of distributing knowledge is controlled. As Sandra Harding (2005) conceptualizes, Western formations and understandings of sciences have perpetuated social inequality through epistemological dominance. Through looking at what is labeled as Western science's "political unconscious," Harding argues that the "benefits of modern sciences and technologies have been disproportionately distributed to the already most economically and politically advantaged groups and the costs to the already disadvantaged groups."⁹⁶ Additionally, Harding frames Western science as an epistemological violence through arguing that Western imperialism appropriated knowledge and sciences from other societies and "clear[ed] the field of potential rival scientific traditions" which advanced

⁹⁶ Sandra Harding, *Science and Social Inequality: Feminist and Postcolonial Issues* (Chicago: University of Illinois Press, 2006), 25.

“European sciences and the decline or underdevelopment of scientific traditions of other cultures.”⁹⁷ In addressing the process of creating knowledge it is important to reevaluate the effects of Western knowledge production on the historically colonized and on female bodies of color. Specifically, concepts of creating situated “knowledges” and working from an oppositional consciousness also addresses research as a process and deconstructs Western science as a “real science.”⁹⁸

The argument that many Western and Eurocentric scientists use to rationalize the scientific method as fact comes from a perspective that scientists must maintain an objective viewpoint when conducting “scientific research” to remain neutral in their research and findings. In contrast, it is impossible to remain objective when culture, situated experiences, and emotions “shape sciences” and the outcomes of scientific research. The processes of scientific observation and the role of positivism in science are based on analyses of individually constructed assumptions. Rather than seeking and acknowledging other forms of knowledge as valid, Western productions of knowledge aim to maintain dominance to rationalize economic and political capitalism and control.⁹⁹

Discussing how knowledge is accessed requires understanding the ways “in which the pursuit of knowledge is deeply embedded in the multiple layers of imperial and colonial practices.”¹⁰⁰ Specifically, researchers in communities need to be aware of how knowledge is pursued and how knowledge of reproductive and sexual health is distributed. As Linda Tuhiwai Smith (2012) argues, the process of colonization occurs simultaneously on the body as well as on

⁹⁷ Ibid., 42.

⁹⁸ Ibid., 81-83.

⁹⁹ Ibid., 35.

¹⁰⁰ Linda Tuhiwai Smith, *Decolonizing Methodologies: Research and Indigenous Peoples* (London: Zed Books Ltd., 2012), 2.

the mind. Smith argues that the process of imperialism and colonization “underpinned and was critical” to the development of modernity and the “pursuit of knowledge.”¹⁰¹ Additionally, the relationship “between knowledge, research and imperialism” has determined the “ways of knowing” for the historically colonized.¹⁰² The notions of Westernized epistemology and the process of knowledge production are also addressed within Patricia Gunn Allen’s critique of white mainstream feminism’s interpretation of tribal and indigenous narratives. The Western process of knowledge production is rooted in dominance and power over “subjects” and influences how Western cultures make sense of and assumptions about “the nature of human society.”¹⁰³ The philosophy or epistemology of the “good vs. evil” theme of Westernized storytelling is also representative of how Western science prevails over Western medicine, by viewing certain bodies as “good” and worthy of good health and others as “evil.”¹⁰⁴

In connection to Puerto Rican women and knowledge on reproductive and sexual health, how women of color access information on their bodies is in part affected by the ways female bodies of color were and are historically colonized and controlled. Additionally, the process of colonizing “the mind” has affected the way the bodily experiences of women of color are labeled as invalid forms of knowledge and knowledge creation.¹⁰⁵ The process of colonization has rendered the female body of color as illegitimate of producing valid knowledge from and on the reproductive body.

Experience as Legitimate

¹⁰¹ Ibid., 61.

¹⁰² Ibid., 62.

¹⁰³ Patricia Gunn Allen, “Kochinnenako in Academe: Three Approaches to Interpreting a Keres Indian Tale,” in *The Sacred Hoop: Recovering the Feminine in American Indian Traditions* (New York: Open Road Integrated Media Inc., 1986), 222.

¹⁰⁴ Ibid.

¹⁰⁵ Ibid.

Situated knowledge, or “standpoint theory” as Haraway (1988) argues, is an “epistemology of location, positioning, and situating” where participating in “universality” is not a condition to make “rational knowledge claims.”¹⁰⁶ Haraway considers situated knowledge as a tool to view objectivity as a positional rationality in research processes and knowledge production. Specifically, through discussing objectivity as a positioned rationality, Haraway argues that the body, as “the object of biological discourse,” becomes engaged as an object of knowledge and as an object of knowledge creation.¹⁰⁷ Similarly, Hill Collins (2000) argues that since “elite white men control Western structures of knowledge validation” and “interests pervade the themes, paradigms, and epistemologies of traditional scholarship,” Black women’s social, political, economic, and bodily experiences are rarely considered as valid knowledge.¹⁰⁸

Hill Collins argues for two ways of knowing as key to Black women’s survival and claim to credibility and legitimate knowledge. As part of a framework for Black feminist epistemology, the two ways of knowing include having both knowledge and wisdom, with “the use of experience as the cutting edge dividing them.” Most importantly, Hill Collins conceptualizes experience as a valuable and validated source of “wisdom.”¹⁰⁹ Lived experiences as a “criterion of meaning” invokes credibility and believability for Black women and in communities of color in comparison to those who read about such experiences and “claim to be experts.” As Hill Collins argues, “knowledge without wisdom is adequate for the powerful, but wisdom is essential to the survival of the subordinate.”¹¹⁰ Additionally, the role of community in the production of knowledge illustrates the importance of “connectedness” and relationality. To

¹⁰⁶ Ibid.

¹⁰⁷ Ibid., 351.

¹⁰⁸ Patricia Hill Collins, *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment* (New York: Routledge, 2000), 251.

¹⁰⁹ Ibid., 257.

¹¹⁰ Ibid.

“recognize connectedness as a primary way of knowing” places value on collectivity, sisterhood, and the role of feeling through the body as valid and legitimate ways of producing knowledge and wisdom.¹¹¹ To value the lived experiences of the individual and a form of knowledge production is to also recognize the importance of community knowledge and experiences. Individual knowledge does not exist without the role of community.

Lived experiences as “criterion of meaning” and sources of legitimate knowledge also include the role and importance of self-reflexivity and the “scholar activist.” Specifically, Kum Kum Bhavnani (1994) argues that an analysis of accountability, positioning, and difference must be considered before declaring any body of work as feminist research. Rather than validating a piece of feminist work simply because it was conducted by a woman, it is necessary to view and analyze feminist research as a continuous movement towards decolonizing productions of knowledge and understanding how power dynamics affect the outcomes of feminist research. Part of the process in decolonizing bodies of knowledge and how this knowledge is produced requires evaluating the role of the researcher in acquiring knowledge. It is arrogant for researchers to assume dominant roles in their relationships as a researcher without critically analyzing his or her impact.¹¹²

Critical Feminist Praxis

To do or engage in scholarly work and activism without developing an activist praxis removes the meaning of “doing” scholarly activist work. If scholarly work in an academic context refrains from having a critical praxis, then there is no point in conducting academic research through a feminist lens and feminist epistemology. As an alternative paradigm, a

¹¹¹ Ibid., 251.

¹¹² Kum Kum Bhavnani, "Tracing the Contours: Feminist Research and Feminist Objectivity," in *The Dynamics of Race and Gender*, eds. H. Afshar and M. Maynard (London: Taylor and Francis, 1994), 69.

critical feminist praxis converges theory into practice through utilizing feminist methodologies and epistemologies.

Specifically, using a critical feminist praxis for conducting research allows researchers to engage, facilitate, and appropriately represent the narratives and experiences of their participants. Parts of a critical feminist praxis include, the role of oral histories, writing and performing ethnographies, negotiating space, and participating in active dialogue. The importance of using a critical feminist praxis when conducting research helps researchers fully engage in community activist work and engage in alternative methods of “doing” research, collecting “data”, and writing research pieces.

As conceptualized by Antoinette Errante in “But Sometimes You’re Not Part of the Story: Oral Histories and Ways of Remembering and Telling,” conducting oral histories and oral narratives as ways to collect data centers the voices and stories of the study’s participants. Specifically, Errante suggests that narratives, whether oral or written, are “narratives of identity.”¹¹³ Additionally, Errante also conceptualizes the role of narratives, and specifically oral narratives, as ways that participants can remember and represent realities in “which narrators also communicate how they see themselves and wish others to see them.”¹¹⁴

Important to the formation and representation of oral and written narratives are the ways participants remember the past and how they choose to tell and represent it. Specifically, as framed by Errante, oral narratives and histories provide a somewhat “subaltern dimension” to educational histories that are read and not told. Through broadening “the range of collective experiences accounted for in the historical record,” oral narratives provide a method that centers

¹¹³ Antoinette Errante, “But Sometimes You’re Not a Part of the Story: Oral Histories and Ways of Remembering and Telling,” in *Feminist Perspectives on Social Research*, eds. Sharlene Nagy Hesse-Biber and Michelle L. Yaiser (Oxford University Press, 2003), 411.

¹¹⁴ Ibid.

and focuses on the “experiences of groups whose voices were underrepresented in ‘official’ histories.” The role of oral narratives and histories is to largely present “history-as-lived-experience” rather than as an occurrence that happened in the past.¹¹⁵ Additionally, representing oral narratives and histories as legitimate ways of remembering brings up questions on how oral narratives and histories are works of memory and on the nature of memory itself.¹¹⁶

Writing and performing ethnographies as a critical feminist praxis, engages the researcher within feminist methodologies and writing and representing culture appropriately. As discussed by Carol B. Stack in “Writing Ethnography: Feminist Critical Practice,” writing culture and representing stories appropriately requires flexibility and being open to negotiating space.¹¹⁷ Specifically, Stack argues that in writing ethnography, “the goal is to explore and experiment” while engaging in self-reflexivity and learning as much about “our own understanding of how we locate voice in our writing as possible.”¹¹⁸ Negotiating space and politics within research and in writing is vital when “writing culture” and working within a critical feminist praxis. Stack also argues that it is important for researchers to practice self-reflexivity and examine their positioning within research and that “writing must be finely tuned with respect to the times, the region, the setting, and race/gender politics of the historical moment.”¹¹⁹

Similarly, both Sharlene Nagy Hesse-Biber and Denise Leckenby (2004) in *How Feminists Practice Social Research* address feminist research as a tool for transformation. Utilizing and framing research through a feminist lens requires that the processes of research, from developing research questions to choosing the most appropriate methods of collecting data,

¹¹⁵ Ibid., 414.

¹¹⁶ Ibid., 415.

¹¹⁷ Carol B. Stack, “Writing Ethnography: Feminist Critical Practice,” *Frontiers: A Journal of Women’s Studies* 8, no. 3 (1993): 97.

¹¹⁸ Ibid., 99.

¹¹⁹ Ibid.

be open and willing to change according to the research focus.¹²⁰ Additionally, as a tool for social transformation, feminist research can address the voice of “the Other” while presenting “feminist-based” knowledge and experiences as legitimate and worthy. Addressing lived-experiences as legitimate sources of knowledge presents research that is “for” women and not simply “about women.”¹²¹ One of the most important elements addressed by Hesse-Biber and Leckenby is having an awareness of the power dynamic between researcher and participant. Through a practice of active reflexivity during the research process, feminist researchers engage in “listening” and “feeling” to their participants rather than pushing through collecting data.¹²²

Additionally, using a critical feminist praxis requires that feminist researchers understand their role as a researcher within a community. As Patricia Zavella (1996) discusses in “Feminist Insider Dilemmas: Constructing Ethnic Identity with Chicana Informants,” epistemology, methodology, and method are interconnected within feminist research. Specifically in identifying as an “insider/outsider” researcher, a feminist researcher “doing research” within his or her own community cannot assume automatic commonalities and must be aware of definite differences.

As addressed by Zavella, the construction of ethnic identities and the way those ethnic identities are presented by researchers present a dilemma in feminist research. While researchers attempt to stay close to participant or “informant” responses, Zavella argues that feminist

¹²⁰ Sharon Nagy Hesse-Biber and Denis Leckenby, “How Feminists Practice Social Research,” in *Feminist Perspectives on Social Research*, eds. Sharlene Nagy Hesse-Biber and Michelle L. Yaiser (New York: Oxford University Press, 2004), 212.

¹²¹ *Ibid.*, 217.

¹²² *Ibid.*, 219.

researchers must be aware of how the data is presented back to colleagues and academia.¹²³ Similarly, in staying close to the ethics of feminist research, feminist researchers need to be aware of how presenting specific data might reproduce inequalities and stigmatized representations of already marginalized populations. Part of addressing misrepresentation in feminist research is addressing “the power of epistemology” and how it can affect the process of collecting data while evaluating the relationship between researcher and participant.

The remainder of the chapter outlines the rationale for using tenets of qualitative research and methods, in addition to providing outlines for the following subsections: sample selection, recruitment of participants, data collection, data analysis, issues of trustworthiness, and ethical considerations.

Methods

Qualitative research was used for this study due to the emphasis of qualitative methods to provide in-depth analysis directly from participant responses. Focusing on evaluating and observing “how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences,” qualitative research methods afford this study with the tools to truthfully depict participant responses.¹²⁴ Post-positivist in nature, this study uses inductive versus deductive processes of conducting research. As noted by Sharan Merriam (2009) in *Qualitative Research: A Guide to Design and Implementation*, inductive research allows researchers to “gather data to build concepts, hypotheses, or theories, rather than

¹²³ Patricia Zavella, "Feminist Insider Dilemmas: Constructing Ethnic Identity with ‘Chicana’ Informants,” in *Feminist Dilemmas in Fieldwork*, ed. Diane L. Wolf (Boulder, CO: Westview Press, 1996), 151.

¹²⁴ Sharan Merriam, *Qualitative Research: A Guide to Design and Implementation* (San Francisco, CA: Jossey-Bass Publications, 2009), 5.

deductively testing hypotheses.”¹²⁵ It was necessary for this study to shift away from a positivist approach and use inductive versus deductive processes of conducting research. A positivist approach to research assumes that all knowledge is measurable, fixed, and empirical.¹²⁶ Rather than assuming and arguing that reproductive knowledge can be tested and proven, I intend to ensure the legitimacy and validity of the lived-experiences of the participants in this study. In doing so, this study maintains, as Sharlene Nagy Hesse-Biber, et al (2004) argue, that multiple experiences and multiple realities exist.¹²⁷

Participants

This qualitative study focuses on the personal experiences of self-identified Puerto Rican women who were raised in New York City. For the purpose of this research project, eligible participants met the following criteria: (1) self-identify as a Puerto Rican woman, (2) at least second-generation (3) between the ages of 18 and 30, (4) were raised in New York City, and (5) currently living in New York City. I decided to include Puerto Rican women between the ages of 18 and 30 to focus on second and beyond generation Puerto Rican women whose mothers or grandmothers migrated to New York City. The focus is on Puerto Rican women who are at least second-generation because based on previous research findings; Puerto Rican women who are at least second-generation make reproductive health choices differently than first-generation Puerto Rican women.

Recruitment

Sampling of participants was purposive to locate participants who met the criteria I set for participation in this study. Purposive sampling was the most appropriate for the goals of this

¹²⁵ Ibid., 15.

¹²⁶ Ibid., 8.

¹²⁷ Hesse-Biber, et al, “How Feminists Practice Social Research,” 210.

project because as Merriam (2009) states, “purposeful sampling is based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned.”¹²⁸ The goals of this study are focused on obtaining specific experiences from Puerto Rican women raised in New York City, therefore it was important to use purposive rather than random sampling.

Recruitment procedures included using a method that was considered culturally appropriate. Trusting informal networks of friends and family members are generally how Puerto Rican women in New York City discover new information and resources. Therefore, in addition to purposive sampling, snowball sampling was also utilized for recruitment. Snowball or network sampling involves “locating a few key participants who easily meet the criteria” established for participation, and then asking “each one to refer you to other participants.”¹²⁹ The snowball method is a linear, non-probability sampling technique that is used to recruit potential participants for studies where potential participants who share similar circumstances are hard to locate. For this method, I located a few key participants who met the criteria for this study and asked them to recommend others who also met the criteria. This process continued for each participant selected to participate.

Invitation scripts were sent out to each recommended participant via email to explain the scope of the study and to ensure that each prospective participant understood that participation was strictly voluntary. Invitation scripts allowed each prospective participant to make a decision to participate after fully understanding the study. Once deciding to participate, each participant was sent a cover letter. The cover letter described the goals and intentions of the study, presented a summary of the focus group questions, and notified the participants that they could withdraw

¹²⁸ Merriam, *Qualitative Research*, 77.

¹²⁹ *Ibid.*, 79.

participation at any time during the study. All participation was voluntary and each participant chose to participate in the study because of personal interest in the study's subject.

Data Collection

Methods of data collection included focus groups, personal observations, field notes, and memo writing. According to Kathy Charmaz (2006) in *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*, the process of memo-writing allows the researcher to analyze data and codes “early in the research process” through the process of writing down thoughts, capturing “comparisons and connections,” and forming “questions and directions.”¹³⁰

During the winter of 2014 I conducted two focus groups with Puerto Rican women living in New York City. Utilized to engage in a more participatory process of collecting data, the use of focus groups served as the main component of data collection. The focus group instrument is included as Appendix A. As Merriam states, “a focus group is an interview on a topic with a group of people who have knowledge of the topic.”¹³¹ Therefore, the use of focus groups allowed me to understand how reproductive health is discussed in everyday conversations and to obtain data that was “socially constructed with the interaction of the group.”¹³² It was vital for the purpose of this study to ensure that all participants felt comfortable with the interview process, and therefore, a collective, informal focus group process was selected as most appropriate for the participants and extent of this study. The focus groups consisted of broad and semi-structured questions with minimal prompts to ensure that sufficient data was collected for meaningful analysis. Prompts (probes) are used in qualitative research to “follow up something

¹³⁰ Kathy Charmaz, *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis* (Thousand Oaks, CA: Sage Publications Inc., 2006), 72.

¹³¹ Merriam, *Qualitative Research*, 93.

¹³² *Ibid.*, 94.

already asked” and to seek for greater details and clarification.¹³³ Further, broad and semi-structured questions are designed to allow for flexibility and multiple perspectives from each participant. Semi-structured questions allowed me to respond “to the emerging worldview of the respondent” and “to new ideas on the topic.”¹³⁴

Focus group questions concentrated on significant areas pertaining to the study, including the participants’ personal experiences with reproductive health, relationships between participants and family members, and perceptions of the Puerto Rican female body. Before beginning each focus group, participants were read cover letter forms describing the nature and purpose of the research study. It was at this time that participants were provided with an overall definition of what reproductive health consists of. Participants were also given layered consent forms to keep for their own personal records. A layered consent form is designed to provide participants with a detailed description of the study. This style of consent form allows participants to provide consent on a number of different variables of the study, including, but not limited to: (1) allowing audio-taped recordings; (2) requesting copies of data collection transcripts; and (3) allowing researchers to make further contact in the future. Layered consent forms distributed to the participants described the purpose of the study, explained participant criteria, notified participants of voluntary participation, and stated the necessary time commitment. Each participant was asked to select a pseudonym for data collection and analysis. Layered consent forms were signed with the use of pseudonyms, thus, ensuring that no personal identifying information was collected or recorded to maintain participant confidentiality and trustworthiness. The focus groups were audio-recorded and contemporaneous notes were taken

¹³³ Ibid., 100-101.

¹³⁴ Ibid., 90.

throughout the entire process. Each focus group was approximately sixty to eighty minutes and participants were informed that their participation in the study was completely voluntary.

Data Analysis

As mentioned previously, data analysis was conducted using grounded theory and data for analysis was triangulated using transcripts, observations, and field notes. Throughout the process of data collection and analysis all efforts were made to guarantee participant confidentiality and trustworthiness. Once focus groups were audio-recorded, each focus group was transcribed verbatim via Microsoft Word. Following transcriptions, data was analyzed utilizing stages of grounded theory. As conceptualized by Charmaz (2006), data analysis through grounded research allows the researcher “to *define* what is happening in the data and begin to grapple with what it means.”¹³⁵ Through focusing on the “action and processes” of the data, analyzing data through grounded theory propels the researcher to “interact” with the participants and their stories.¹³⁶ The data in this study was coded and analyzed in several stages. Focus group transcripts were first coded line-by-line and then categorized using a constant comparative approach. Developed by Glazer and Strauss (1967), the constant comparative method is “compatible with the inductive, concept-building orientation of all qualitative research” and therefore was used to derive theory “grounded in the data.”¹³⁷ Line by line coding was accomplished both electronically and by hand and consisted of gerunds or verbs meant to represent actions or feelings in the data. For example codes such as, “hiding”, “embarrassing”, and “learning” were used throughout the initial coding process.

¹³⁵ Charmaz, *Constructing Grounded Theory*, 46.

¹³⁶ *Ibid.*, 47.

¹³⁷ Merriam, *Qualitative Research*, 199-200.

Following the initial open coding process, an electronic compilation of open codes from both focus groups was created to aid in a more focused coding analysis. According to Charmaz (2006), focused coding is “more directed, selective, and conceptual” than initial coding.¹³⁸ Initial open codes were grouped and sorted into several different conceptual focused codes. Focused coding was used in this stage of the coding process by “using the most significant and/or frequent earlier codes” to create conceptual themes and categories for data analysis.¹³⁹ The use of focused coding allowed me to continuously compare each participant’s experiences and to construct themes from a “bottom-up approach.”¹⁴⁰ Each grouping was color-coded and a separate document served as a key to keep track of each grouping’s color. For example, the color pink represented the grouping of “safety/rules for behavior.” Once groupings were assigned colors, I printed and cut out each focused code individually. It was during this moment of the coding process that I conducted a collective coding activity with a few members of a graduate writing group.

During this stage of the coding process, coding was performed collectively with assistance from several members of the graduate writing group. Using the cut out focused codes, the graduate writing group compared the codes and regrouped them into several different categories. The graduate writing group was not informed about the initial context behind the codes. The process of coding focused codes into categories collectively allowed me to view the data from a different perspective, while participating in a collective coding activity also helped establish validity and legitimacy within the themes that eventually emerged from the data.

¹³⁸ Charmaz, *Constructing Grounded Theory*, 57.

¹³⁹ Ibid.

¹⁴⁰ Ibid., 139.

During the last few stages of coding, I pasted each grouping of focused codes on index cards. On the back of each index card I wrote down the grouping's initial codes, focused codes, and initial color-code. For example, the index card for the grouping of "safety/rules for behavior" featured initial codes such as "protecting" and "overseeing," focused codes like "the eye" and "preserving girlhood," and an initial color-code of pink. A final stage of coding was then carried out through comparing each index card back to participant responses. During this stage of coding, original grouping categorizations were categorized into one over-arching theme, larger themes, and subthemes. Each theme was assigned a color, which allowed me to organize and categorize index cards into larger themes. At the end of the coding process each index card had inscriptions of initial codes, focused codes, initial color-code, and final theme color. The coding process ultimately allowed me to frame the responses of the women in this study into clear categories which later informed intersecting themes and subthemes.

Throughout the data collection and analysis process, I referred to Glazer and Strauss' (1967) "constant comparative approach" while reviewing data and providing analysis. In this approach, observations, memos, and field notes played integral roles in constructing categories and themes from the data. Therefore, data collected from the focus groups was triangulated with personal observations, notes taken during the focus groups, and memos written during the entire processes of data collection and analysis. As Merriam (2009) states, "Triangulation using multiple sources of *data* means comparing and cross-checking data collected through observations at different times or in different places."¹⁴¹ The process of triangulation in this study ensured validity and reliability.¹⁴²

Ethical Considerations

¹⁴¹ Merriam, *Qualitative Research*, 216.

¹⁴² Ibid.

Throughout the research study and including data collection, analysis, and findings processes, the primary ethical concern of the researcher was ensuring and maintaining participant confidentiality. Any information that could possibly be linked back to any participant was not presented in the findings. Due to the personal nature of this research, any data with personal identifiers that emerged unknowingly from the focus group interviews was omitted from data analysis. Although minimal risk was anticipated I made the following safeguards: (1) participants were advised of the voluntary nature of their participation and that they could withdraw from the study at any time without penalty; (2) participants were advised that at any time during the process they could decline to answer any questions; and (3) written transcripts and analysis of the data were made available to participants to make corrections and give feedback.

Issues of Trustworthiness

Throughout the process of the study credibility, validity, and trustworthiness were maintained by conducting focus groups in person. By conducting the focus groups in person, I was privileged to observe subtle forms of communication and interaction between the participants. Making in-person observations further guided my ability to immerse myself in the data analysis process, which better informed the themes and subthemes that emerged from the data. Furthermore, each focus group was audio-recorded using both a digital voice recorder and a MacBook. Transcriptions of each focus group were completed personally by me and transcribed verbatim, contributing to the reliability of the data collected and analyzed.

The knowledge that I have regarding both verbal and non-verbal communication styles of Puerto Rican communities in New York City derives from my own positioning as a second-generation Puerto Rican woman from New York City. Having familiarity with how Puerto

Rican women generally tend to interact and communicate added to the credibility and depth of the data collection once analyzed.

CHAPTER FOUR: FINDINGS

The purpose of this study was to center the voices of New York Puerto Rican women regarding their experiences learning about reproductive health and their bodies. The four major themes that emerged from the data are (1) womanhood; (2) reacting to patriarchy; (3) body politics; and (4) transmission of reproductive healthcare resources. All of the themes emerged directly from the focus groups and are explained in the following sections. However, one overarching theme emerged from the data and was evident in all four major themes: learning how to be a Puerto Rican woman. The overarching theme of learning how to be a Puerto Rican woman was important to the overall analysis of this study because it framed how the women in this study learn to understand their bodies in relation to reproductive health.

Womanhood

The first major theme that emerged in data analysis was womanhood, which described the ways women in this study discussed gendering/socialization, motherhood, religious expectations, and sexuality. It is important to note here that while the women in this study discussed tenets of womanhood, their descriptions of womanhood are directly related to the overarching theme of learning how to be a Puerto Rican woman. Womanhood for the Puerto Rican women in this study described a multitude of different understandings of what it means to be a Puerto Rican woman, what it means to act like a Puerto Rican woman, and how it feels to understand reproductive health as a Puerto Rican woman.

In discussing how reproductive health was talked about or understood in their families and communities, the women in the study described moments in their lives that marked transitioning from girlhood to womanhood. Many of the women participating saw womanhood

as a process of socialization, featuring a series of moments in their lives when they were taught and expected to be “good” Puerto Rican women. In describing gender socialization Jen said,

I think sexuality and gender is like taught—whether you realize it or not—like growing up. Um, like boys and girls there is always separation and like boys are not supposed to play with girl toys or like um wear pink and you know vice versa. Um I think it’s a lot like from culturally too, because I remember growing up my grandmother is really old school. I have two brothers and two uncles, so I’m like surrounded by a lot of men. So it would be like, ‘well you go wash the dishes’ because I was the only girl and then like I’m like well no, like I’m not having it, so no. So I think its taught from culture, like sexuality and its like I know like for boys its like no you’re not supposed to dress this type of way, you’re not going to wear like skinny jeans.

While describing her experience in witnessing her sister’s transition to womanhood, Mislá said,

I actually just remembered it being more of a secret. For example, even the period thing, I remember when my sister first got her period, my mom told my dad and my dad called my sister and was like congratulations you’re a woman now.

Witnessing the process of her sister becoming a woman prompted Mislá to view her own experience of transitioning to womanhood as something to hide from her family and community. In realizing the very public nature and process of becoming a woman for her sister, Mislá felt that keeping her body hidden and as a secret was an appropriate response. Describing her own experience, Mislá said,

And so when I got mine I was like oh no no no, you’re not going to tell anyone. So there was this idea that my body was also still a secret and was trying to hide it. Which is hard as a 10 year old with size C boobs, you’re trying to just hide everything.

Keeping the process of transitioning to womanhood a secret or hidden for Mislá suggests that hiding, either in the form of physically hiding or refraining from talking about something, is both an active and interactive process. For many of the participants in this study, the practice of hiding the body in maintaining girlhood or transitioning to womanhood also derives from a

feeling of not knowing what to expect from puberty or the bodily changes that marked womanhood in their experiences. As Sapphire said,

But I remember when I first got my period, that first day I knew what was happening so I went to go tell my mother, and she was like ‘oh welcome to being a woman’ and then as the days kept passing I thought the next day it was going to be over—see I didn’t know that much. I didn’t know—so like the 2nd day I was like ‘I’m still bleeding? What the fuck?! Like what’s going on?’ and she [mother] was like of course. And she’s like of course it goes on for several days. And I’m like couldn’t you have told me this? Wasn’t this supposed to be explicitly said?

For both Mislá and Sapphire, the moments that marked their transitions into womanhood was going into puberty and experiencing their menstrual cycles. For most of the women in this study, “getting your period” was a celebratory moment for the other women in their lives. Culturally, Puerto Rican families view the menstrual cycle as a mark of true womanhood and as a “welcoming” into womanhood. Katerina said,

My period first came down when I was in Puerto Rico and so it was like “hay mira, ya Katerina esta una senorita! [Oh look, Katerina is now a young woman!] And I’m like oh no! Now they’re gonna make the phone calls to New York and they did. And they’re like cocka doodle do!! And I’m like oh my god stop I’m so embarrassed.

Despite understanding the reasons why the women in Katerina’s family were excited about her menstrual cycle, Katerina also knew this was a moment of transitioning into womanhood—something she was not quite ready for. Adding to the confusion of growing up was also Katerina’s experience in getting her period in Puerto Rico. Katerina said,

I was like I hope this is not my period. Because my mom had talked to me about it but I don’t know, I felt like having your period was a sign of growing up because it is, and I was a little girl and I was ‘I don’t wanna grow up yet, please let this not be my period’ And I was like ‘Titi!! There’s blood over here!’ and she was like ‘ohhhh my gooodness!’ [laughter] I was like nooooo! It is my period. And I’m like oh my god in Puerto Rico in all places oh my god.

Like Sapphire and Katerina's experiences, Jen remembers feeling confused about why getting her period was "welcoming" her to womanhood and why her mother did not explain the process to her beforehand. Jen said,

Well I remember like when I got my period—my mom she liked called my grandmother, she called my aunt—like all the women in my family, and I'm like what is this about? And I'm like hysterical because we never really talked about it—my period. Like I knew what it was, but when it actually happened I was like in shock, but I knew like she called all the women in my family—saying I was a young lady that she's so excited—and I'm like okay woman no, I need help here. Then she kind of explained to me that I was a young woman and you know anything that I did from there on out—sexually—there was a possibility that I could get pregnant.

Much of what the women discussed in talking about their bodies in relation to reproductive health brought up questions about mother and daughter relationships or relationships between other women in their families. Many of the women in this study associated learning about reproductive health and their bodies with how the women in their families were socialized to understand their own bodies. Discussions of mother/daughter relationships led to conversations about the process of mothering and what motherhood looked like in their families. In talking about her own "coming of age" experience, Lee said,

Having my period was like a coming of age thing and like a lot of my older cousins got it and we all knew about it because all of my cousins are like all girls. So I was like so excited to have it and like when I did, my mom brought me pads and everything—It was like a big thing and I was really young too—like 9 or 10. But I like I knew about that and I think the reason why she [mother] spoke to me about it was because it didn't involve guys.

For Lee, her mother spoke to her about getting her period but only because the conversation did not include discussing men or relationships with men. When discussing how topics of reproductive health came up in their families, the women participating described moments when the topics of sexuality and womanhood were addressed by their mothers or other women in their families in ways that adhered to Western notions and expectations of patriarchy.

Like Lee, many of the women talked about how “getting your period” became moments in which womanhood was marked differently from girlhood.

Many of the women participating in this study described the role that religion had in their understandings of womanhood. For many of the women learning about womanhood and sexuality went hand and hand with learning about Catholicism and coming from Christian households. Tied with tenets of patriarchal values from a Western perspective, many Puerto Ricans learn to adhere to expectations of womanhood through how religious beliefs expect women to behave. Many of the women in this study talked about learning about womanhood through religious expectations of the Virgin Mary through Catholicism. Katerina said,

With my Puerto Rican grandmother and my mother you know growing up—there were like ‘La virgen maria—La virgen Maria’ [the virgin Mary] and I had long hair. There was like this image of La virgen Maria with the long hair and purity and all that. Especially my grandma—you know—was like oh “tu tienes el pelo como la virgen—muy largo [you have hair like the virgin—very long]. And you’re a virgin too—stay that way” like there was like this image I had to fulfill—I guess. And I was always very proud of that. I was always very proud of like my virginity—I was always like I’m not going to do it—and I didn’t until last year. I didn’t lose my virginity until last year and that was a terrible experience in itself yeah—I wasn’t really willing to do it anyway so. But you know---it was something I always valued—respecting those expectations I guess, because that’s what I was expected—like ‘keep your legs closed. Stay a virgin until you’re married’—and I grew up like that. I had no problem with it.

Katerina also said,

I was like whatever like I don’t need to pay attention. I’m gonna stay a virgin till I’m married right?? [Laughter from group]

Paying “attention” for Katerina meant not fully listening to the lessons her mother and aunts were trying to teach her about reproductive health and her body. Immersed in the socialization of La Virgen Maria [the Virgin Maria], Katerina, like many of the women participating, learned about expectations of womanhood through having Catholic and/or religious upbringings. Womanhood, for many of the women participating, meant understanding

and adhering to a multitude of expectations expected of Puerto Rican women living in the United States.

Reacting to Patriarchy

The second theme that emerged is patriarchy or reacting to patriarchy, describing the ways that patriarchal values affect the women's relationships with reproductive health and their bodies. The ways that the women participating are affected by patriarchal systems are represented by the ways participants discussed needs or feelings to uphold patriarchal values in their lives. Many of the women in this study remember learning about their bodies and reproductive health while simultaneously learning how to protect their bodies from the eyes of men.

Throughout the focus groups, many of the women openly discussed times when their mothers taught them to keep their bodies private and hidden. Describing how her mother talked to her about her private body parts, Lee said,

When I was younger the only thing I knew like about my body parts were like the private ones and my mom would always like—like we had this word for the vagina—was like cookie—and but the reason she would do that was because she didn't want anyone to know when she would say it—because she like always wanted to know and to make sure no one touching me. So she would like always say, 'no one is touching your cookie right?' and I'm like 'no...' I guess that was her way of like protecting me. It didn't involve you know actually being in contact with anyone else—that's why she didn't mind talking to me about that but didn't talk to me about anything else.

Like Lee, many of the other women participating in the focus groups talked about protection or feeling the need to protect their bodies after transitioning into womanhood. For many of these women, learning about their body parts meant learning about privacy and the dangers often associated with living in New York City as a young Puerto Rican girl or woman. A lot of the women described moments when it was assumed that they were protecting their bodies. Chelsea said, "It's so awkward because my mom wouldn't even say the word. She would just give me the

eye and was like ‘you would tell me right?’ And I would just have to assume like ‘yes mom, yes’.”

“The eye” for a lot of women throughout the focus groups meant protection or a way for their mothers or other family members to ensure that they were protected without having to talk about private body parts. The topics of shame and respect were also prevalent throughout the focus groups when discussing learning about the body in relation to reproductive health. For many of the women participating, learning about reproductive health and the body correlated with learning about ways to develop respect for the family. Many of the women discussed learning about shame and respect as being directly related to womanhood and learning about reproductive health. In discussing making reproductive choices, Lee said,

I think a lot of it, yes is respect, but also like protecting your child and just like your image so and not to shame your family because there are much more worse things that can happen but I just thing it’s about protecting your image—not saying that you’re perfect but it’s so secretive that you don’t want everyone to know like how young you were or whatever—just protect yourself. I mean covering it up doesn’t make it better because I feel like that makes it worse when you don’t know, but I think part of it is just protecting your image and your family.

Shaming “your family” and having respect for the family’s image were points that many of the women talked about. Even though many of the women, like Lee, understood that not talking about the body in relation to reproductive health made learning about reproductive choices more difficult, it remained important to avoid feelings of shame and embarrassment. Processes of learning about reproductive choices and the body also meant facing difficult experiences and learning from what many of the women termed as “mistakes.” For Katerina, feeling the pressures of patriarchal expectations meant dealing with a difficult experience and turning to her mother for emotional support. Katerina said,

I know that um, when I lost my virginity, I didn’t use protection and it was just because of the situation. Like I felt forced and also the guy that I was dealing with—the guy that I

lost it to—he was not from over here [the United States]—he came— you know he had this different mentality, he was very aggressive. And at he time you know, I was, I must have had low self-esteem because I didn't want to get him upset. And I hated the feeling like, oh my god I'm gonna make him pissed off because I'm not you know, because I'm not giving him something. It sounds so stupid now, but at the time I was like I don't want to get him pissed off—I don't like that feeling of people getting upset with me. And we would get upset with me. So, and he hated to do it with a condom. I'll be like no lets do with a condom—“no, why? Why I gotta do that? I don't gotta do that” and you know he gave me every reason in the book even if the reason didn't make any sense about why he shouldn't use a condom.

So I feel like that in that sense and that whole—that was a really bad experience and I learned a lot from it--I feel like my mother —cause I got sick—he got me sick—So, it wasn't up until then that I felt like I was dying literally—I had to tell my mother. I had to—there was no other person. So I told my mother, and she had my back. She yelled the crap outta me, and she made me feel like crap too. She's like 'you're so stupid—all these years I've been teaching you this this and this, how do you go in the other direction?' I feel like I feel like I failed her. And and failed myself. And um, you know, but at the end of the day, she was the one who took me to the hospital, she was the one who was holding my hand when I was at the ER, and she was there when the doctor told me the news about what he [1st partner] gave me.

Although she felt that she had betrayed her mother's trust, Katerina also felt emotionally supported by her mother after a negative experience. For Katerina, there was no other person she could think of to confide in but her mother, despite feeling that she somehow lost her mother's respect. Like Katerina, many of the women learned about reproductive health choices after having both negative and positive experiences with their partners. Additionally, many of the women like Brianna, talked about the pressures of a patriarchal society to adhere to specific representations and constructions of womanhood.

Brianna said,

Even though I haven't had sex with anyone—it's very important to have that confidence. Like my body is mine and I don't have to give it away for like a guy to like me and I don't have to wear push up bras or push my boobs up for society to think I'm okay. And like at a young age my mom—not that she didn't teach me but like for awhile when I was like a teenager I would use my body as a sex symbol to get like a guy to like me or if I was in a relationship, I would use my body so that they would still like me. Because I wasn't giving them sex, so like I needed to give them something! [laughter]. But my

mom never taught me like oh you don't have to do that in order to like to be accepted like as long as long as you're comfortable in your own skin, you don't need that.

In talking about what her mom did or did not teach her about her body in relation to reproductive health choices and interacting with men, Brianna openly discussed having the confidence to understand her own body and make her own choices around patriarchal expectations and constructions of womanhood.

Body Politics

The third theme that emerged from participant responses is body politics because of how the women participating in this project learned to understand their bodies as Puerto Rican women. Specifically, the theme of body politics refers to the process of learning about the body in relation to reproductive health and making reproductive health choices. This major theme included the ways the women referred to how they learned about the changes occurring in their bodies, feeling insecure about their bodies, and how they were taught to treat their bodies as Puerto Rican women growing up in New York City.

When describing bodily changes and going through puberty, many of the women openly expressed moments when they felt confused about the changes occurring in their bodies and how they felt about it. For many of the women participating, understanding the body in relation to reproductive health meant learning from confusing experiences when transitioning from girlhood to womanhood. In describing learning about puberty and her menstrual cycle, Mislá said,

The first time I got my period I thought that from now on I wore a pad like all the time—I just thought you kept it on! Because when you get your period and you're gonna get it again at some point and you don't know when it's gonna happen! So I just thought you wore it all the time! And so it was after a few days and my mom was like oh you're done with your period? And I was like yeah I know but I still have to wear this pad! And my mom was like no, no baby girl you don't, it's okay you don't have to wear it anymore.

In reflecting on her experience, Mislá talked about the constant feeling of not understanding her body in relation to reproductive health and feeling confused about her bodily changes. Mislá said, “I feel like that proves the same point again—I have like no concept of anything. I’m just trying to figure it out. I’m thinking that I have to wear a pad for the rest of my life.” The feeling of still “trying to figure it out” was a common theme in many of the women’s responses regarding learning about their bodies and reproductive health choices. While many of the women expressed having the need to feel comfortable and confident about their own bodies, a lot of the women talked about still feeling confused about their own bodies. Katerina said,

I am a hot mess. Like I already made appointments—I have a gynecologist appointment. I made an appointment to get a physical done. I have pain in my boobs—like breast cancer runs in my family—so I’m really scared. Then like I’m scared with like—I get paranoid—I’m like oh my god what if I have another break out? What I have pain down there? Does that mean I’m gonna have another break out? I mean is it on is it off? Like, I go through all of these emotions and it’s so overwhelming. And I just feel like I wish I didn’t have to deal with these things.

Despite feeling confident about making reproductive health choices and taking the necessary steps towards learning more about her body, Katerina still felt overwhelmed about not knowing all that was going on with her body. Katerina continued, “And I’m so tired of like always having those questions. I feel like there’s never a moment where I’m like tranquilla [calm] about my body. I feel like I’m always worrying about something.” Many women also discussed learning about reproductive health choices and their bodies through the choices their mothers made. Sapphire said,

This is probably how I understood that you could have the choice of having a baby or not. Well my mother she—she went in for the surgery—she got her tubes tied. Cause after my brother she was like ‘nah, I’m not gonna have three plus children that’s insane. I’m not gonna keep doing this to myself.’ So I think it was then—I was like nine—so I was like I think I understood. When she told me that, when she told me that ‘I don’t want to have children anymore,’ I think that I understood that, I understood for the first time that you could have the choice to not have children if you were about to have—like that weird middle ground where you could have not but also could have the choice. So that was like

new information for me and I probably placed that in the back of my head—that I still have now—that I could still choose not to have a baby. So I guess the operation was like the main thing that I learned from my mother to stop [pregnancy].

Much of the conversations about understanding the body in relation to reproductive health revolved around taking care of the body and protecting it. Many of the women participating related having confidence about their bodies to taking the necessary steps to take care of their bodies. For many of the women, like Lee, learning about reproductive health directly related to knowing their bodies. Lee said,

So I think reproductive health for me is like really taking care of myself and knowing one, yes you can conceive but two, just really taking care of my body, of me and protecting what is given to me and what is mine. You know like taking the right precautions or even waiting— like there are different ways.

“Protecting what is given and what is mine” for a lot of the women, meant knowing their bodies through remembering how their mothers taught them about their bodies and reproductive health. Connecting to both gender expectations and constructions of womanhood, many of the women remembered being taught that their bodies were “temples” and that they should protect their bodies and keep them sacred. Chelsea said,

I remember when I used to have friends over and my mom would, I don’t know, come in to see how we were doing and she would tell me like ‘your body is a temple—don’t be running around with these boys’—blah blah blah.

Despite being taught to treat her body with respect and consider her body special, Chelsea felt confused and remembered feeling unsure of how to understand her body. Chelsea continued,

It was like this is what it is—treat it as so. I didn’t know how to treat it [body] as such, so um I didn’t know what to do with that information. So I was told your body is special. You don’t have to give it to boys. You don’t have to do anything you don’t want to do. But I didn’t really know what that looked like. I didn’t know how to put that into play.

The journey of truly understanding their bodies in relation to reproductive health and choices was a prevalent focus of the women participating in the focus groups. Many of the

women talked about taking the time and efforts to get to know their bodies. In reflecting on self-respect and how it applies to the body in relation to reproductive health, Sapphire described how important it was and currently is for her to know her body under her own terms. Sapphire said,

Like I've had a lot more partners and um, how should I say, a little bit of regret, like when I think back to my sexual history. Like I said a lot of things I didn't know. I didn't know that my body could be a temple. Like I didn't know that like, of course I could say no—that was one, but I didn't know that it [body] was something that was special—that it could be treated that way. I didn't get that at all. No temple-ness here [laughter]. Maybe now, maybe now that I'm older and I can understand—I have the capability to understand what that means, like self-respect. And you know, like what it means for you to respect yourself and men to respect you—as well as other women to respect you too. So now I get that, but it took me awhile unfortunately. It took me a really long time to understand that.

Similarly, Dee described how important it was for her to get to know herself in relation to reproductive health and how much knowing her body contributed to feeling truly comfortable with herself as a Puerto Rican woman. Dee said,

I personally, I feel super super comfortable with my body, as far as like reproductive wise and all of the lady stuff that goes on. Because I've taken time to get to know myself and I must say—the nuvaring birth control—it has helped—like a lot! [laughter]. So, my body and I—we are on the same page. So I rarely have any worries.

Transmission of Reproductive Healthcare Resources

The last theme that emerged from the data described how participants discussed reproductive healthcare resources and how these resources were accessed. Many of the participants talked about feeling unsure or “ignorant” about the resources or choices available or unavailable to them regarding reproductive health. Many of these feelings emerged after discussing what the participants learned about reproductive health and their own bodies via educational resources, health clinics, and through relationships with other women in their lives.

For many of the women participating, having access to adequate reproductive healthcare or information regarding reproductive healthcare often meant trusting healthcare practices or

doctors to relay information about reproductive choices back to them. Many of the women discussed turning to doctors to find more information about their bodies related to reproductive healthcare. For many of the women participating, experiences in the healthcare system often turned negative and useless. Chelsea said,

I remember when I was 15—and at the time I was sexually active and I went to the gynecologist and um she was like looking at me like ‘come back when you’re 21 when you need a pap smear’ and I’m like what do you mean?! And she’s like ‘what’s wrong?’ and I told her I’m sexually active and I want, you know, to get regular check ups and get acquainted with my gynecologist and she just looked at me like I was bizarre and I’m like really? But like taking initiative is really important because she obviously wasn’t going to call me—a 15 year old. Regardless of age I was trying to educate and get reproductive materials—that was just a weird situation.

In wanting to learn more about reproductive health choices and her own body, Chelsea had expected to find the support and help from her doctors and the healthcare system. Instead, Chelsea did not receive the encouragement and help from a medical professional that she needed to move forward in learning more about her body in relation to reproductive health. Similarly, when discussing how reproductive health was learned within their families, the conversation among the women also turned to experiences and decisions surrounding abortion. Many of the women discussed how healthcare clinics responded to their needs and situations. For Tish, the healthcare clinic she went to after having a miscarriage did not answer her questions or support her decisions. Responding to Tish’s experience, Mislá said,

It’s true. I feel like there was a lot you were figuring out in the moment that you wouldn’t have known beforehand and I guess there’s also an expectation that someone’s going to tell you some of this stuff—without even having to ask.

Throughout the focus groups, many of the women expressed feeling jaded and confused by the medical professionals and institutions that they trusted to give them adequate healthcare information. Like Mislá, many of the women relied on medical professionals to relay adequate information regarding their bodies in relation to reproductive healthcare. For many of the

women, having access to reproductive healthcare also meant feeling emotionally, socially, and culturally supported and respected by medical experts in their field. In responding to her experience, Tish said,

That's true and like being out of the clinic—they kind of knew the situation but the people who are like doing the sonogram they are thinking like alright you just want an abortion. I don't know if they knew the details about it. So regardless she [nurse at clinic] wouldn't have said oh you're good, you have fluids. She was like okay go. And that's it.

Many of the women expressed having to push further for answers and information from medical professionals, especially while trying to learn more about reproductive health choices and their own bodies. Katy said,

I think there's a lack of education on which birth control works best or which works better than most, because I think some people think or automatically assume that all birth controls have the same rate when it's just insane to think that, because there are high chances of getting pregnant on some birth controls, you know. So I think that your doctor will tell you one thing but I think you have to go deeper.

Like Katy, many of the women felt that the information or knowledge they received from their doctors was not enough to make informed decisions about their bodies in relation to reproductive health. “Going deeper” for many of the women, means taking different initiatives to learn more about reproductive health and their bodies on their own. Many of the women also expressed making the efforts to educate younger women on issues regarding female bodies and reproductive health. “Passing down” knowledge to their friends and family members was an important aspect of transmitting access to reproductive health for many of the women. Lee said,

You know like taking the right precautions or even waiting— like there are different ways, but I think a lot of it is just being aware and like being able to tell others who might not know so you can like save them from really hurting themselves. Like it may not seem like a big deal but to me it is [Chelsea: it is!]. Especially with teenagers, because if they don't know it could be really easy to fall into something and if their partner doesn't tell them and they find out from a doctor or a friend and not even from the person they're with. Trying to tell others who might not know what I know—but like the right information.

When discussing learning about reproductive health and reproductive health choices, the focus group conversations also addressed how knowledge on reproductive health was passed down from the women in their families. Many of the women were adamant in talking about how transmitting knowledge about reproductive health from one generation to the other is more nuanced and complicated than it might seem to the general public. Jen said,

Like when you have an older parent—like you [another participant] said, being raised in a single parent household—it's a lack of communication to your children by parents. And I'm like what if our parents didn't have the resources and knowledge? What if they weren't educated? How are they supposed to educate us? So I think that's a big part of it. And I think now and days—Puerto Rican women—there's really no excuse not to be educated about certain things. All you have to do is look for it you know and then you have it. So um hopefully, like generations will be wiser than we are—then our parents were.

Addressing the lack of access their parents had to reproductive health resources and knowledge was essential for the women to locate their own understandings of their bodies in relation to reproductive health.

CHAPTER FIVE: DISCUSSION

When we are loved we are afraid
love will vanish.
When we are alone we are afraid
love will never return
and when we speak we are afraid
our words will not be heard
nor welcomed
but when we are silent
we are still afraid.
So it is better to speak
remembering
we were never meant to survive.¹⁴³

In the findings chapter, four major themes and one overarching theme was presented. The overarching theme of learning how to be a Puerto Rican woman is central to understanding the experiences of the women featured in this study. For the purposes of this project and as an overarching theme, learning how to be a Puerto Rican woman in the context of New York City requires an analysis of gender, sexuality, and United States' based patriarchy for learning about topics of reproductive health in relation to understanding their bodies derived from having racialized experiences of womanhood.

For Puerto Rican women raised and living in the United States, specific constructions of womanhood play significant roles in learning about the body in relation to reproductive health. Similar to other women of color, constructions of womanhood for Puerto Rican women reflect racialized notions of gender, class, and culture. As part of a hierarchal stratification system, gender, as a social construction, positions women of color within dual and often multiple constructions of womanhood. Learning how to be a Puerto Rican woman within the context of

¹⁴³ Lorde, "A Litany for Survival," 31.

the United States is itself compounded by the effects of race, class, age, ethnicity, culture, and ability.

Puerto Rican womanhood is defined and understood in a multitude of ways. For the women in this project, womanhood was tied to understanding their bodies under tenets of multiple constructions of womanhood and the effects of living in a patriarchal society. Central to understanding Puerto Rican womanhood is the ability to connect Puerto Rican women's productive and reproductive work, both inside and outside the home, with how they learn about their bodies and reproductive health. Drawing from Souza's (2002) analysis on how Puerto Rican women in the United States are gendered and socialized to be "*en la casa*," much of what the women in this project discussed regarding their bodies and reproductive health stemmed from observing how the women in their families ensured household and community survival. For example, in describing how her family members feel towards having children at a young age and the importance of motherhood in Puerto Rican families, Dee said,

I find it so interesting that in our culture, and I see it in like friends—its just like—we come from—in our generation at least—we come from our parents saying “don't have kids and get an education and do this and do that!” but like, they are like the most supportive people ever. That baby is not going to be missing out on anything because of the whole family dynamics.

It is essential to note here that the productive and reproductive work of Puerto Rican women in the United States, and more notably in New York City, is not only necessary for household survival but also “critical for economic and social policy on both local and global levels.”¹⁴⁴

In continuing this discussion it is essential to frame the experiences of the women in this study in multiple and complex ways. For the women participating in this study, it remains obvious that reproductive health in relation to their bodies is understood in ways that cannot be

¹⁴⁴ Gina Perez, *The Near Northwest Side Story: Migration, Displacement, and Puerto Rican and Puerto Rican Families* (Los Angeles: University of California Press, 2004), 8.

simplified and reduced to simple answers. While it is clear that the women, whose voices are featured in this project, view their reproductive choices as necessary and empowering, it is also important to position their experiences within the larger context of reproductive health and the systems of control that limit their access to both understanding reproductive health and receiving quality reproductive healthcare. The following sections draw from participant responses to provide an analysis and discussion regarding the topics addressed directly from the women participating. These sections include, addressing patriarchy, understanding reproductive health, body politics, and transmission of reproductive healthcare. While these sections do not provide concrete solutions, they do provide a foundation for future research projects and understanding the ways that Puerto Rican women in New York City learn about their bodies in the context of reproductive health.

Addressing Patriarchy

While the role of patriarchy in Puerto Rican families influenced the ways many of the women participating in this project learned to understand their bodies, it is also important to view patriarchy in Puerto Rican communities in nuanced ways. During the great migration of Puerto Ricans to the United States, previous social scientists viewed the Puerto Rican family in New York City as “singular” and “homogenized” while simultaneously marking the Puerto Rican woman (singular) as deviant and ignoring successful strides made by Puerto Rican migrants in New York City.¹⁴⁵ Critiquing newly migrated Puerto Rican families as being overly authoritarian and patriarchal, many social scientists viewed Puerto Rican families as “marked by excessive patriarchy and matriarchy—victimized *and* dangerous women.”¹⁴⁶ To the white male

¹⁴⁵ Laura Briggs, *Reproducing Empire: Race, Sex, Science, and U.S. Imperialism in Puerto Rico* (Berkeley: University of California Press, 2002), 175.

¹⁴⁶ *Ibid.*, 176.

Anglo-Saxon social scientist, Puerto Rican families, and specifically Puerto Rican women, were at fault for their own conditions and “fundamentally unable to support healthy children or a healthy community.”¹⁴⁷

Historically, patriarchal values in Western societies have marked specific women of color as social deviants and “welfare queens” or overly matriarchal and unable to support their husbands and families. For Puerto Rican women in New York City, Western patriarchy has marked them both “over-protected and too independent.”¹⁴⁸ Western social scientists who spread United States-based patriarchal values on the lives of Puerto Rican women in New York City, have claimed that the sexuality and reproduction of Puerto Rican women were “overly guarded by husbands and fathers” but at the same time Puerto Rican women “often raised their children alone.”¹⁴⁹ Many social scientists in the United States tried to blame poverty on the cultural and patriarchal values of Puerto Rican women rather than looking into how the United States uses patriarchy to create systemic policies that makes it more difficult for Puerto Rican women to succeed economically, politically, and socially.

When addressing patriarchy in the context of these women’s experiences and responses it is important to contextualize how the role of patriarchy affected the ways many of the women learned about their bodies in relation to reproductive health. Many of the women expressed learning how to protect their bodies from men at early ages. Learning about their bodies in the context of patriarchy often meant that these women were taught “code words” to refer to their private body parts to ensure protection. By teaching them how to protect their bodies as young girls, the mothers of the women participating essentially tried to shield their daughters from

¹⁴⁷ Ibid.

¹⁴⁸ Ibid.,175.

¹⁴⁹ Ibid.

patriarchal violence. For many of the women, learning about protecting their bodies was indoctrination into Puerto Rican womanhood from a United States, Western, perspective.

What is most important to acknowledge are the ways the women in this project reacted to and resisted Western forms of patriarchy both in their families and in society. Expected to bare many children at an early age, many of the women expressed the need to make their own personal choices when considering reproductive health and motherhood. As Dee described,

The thing is—the pressure for me is not pressure to have kids. The pressure is like let's see if she's going to fail. Let's see if you're going to end up pregnant. You know? So it's kind of like I'm holding up this really big weight and prove it. And it's just not for that—for show—but that's just what I believe in. Like I don't want to do that. I want to have a career, I want to have my own place to live, I want to be comfortable before I have my family. You know? So, it's interesting.

Understanding Reproductive Health

Simply positioning the responses from the women who participated within the contexts of their own family socializations ignores and individualizes the larger impact of political, economical, and societal factors on the bodies of Puerto Rican women. The experiences of these women represent perhaps a glimpse into the lives and experiences of New York City Puerto Rican women in addressing reproductive health and their bodies. In discussing and providing an analysis on the experiences of the women presented in this project, it is necessary to place their experiences within the context of capitalism, colonization, and access to resources.

As Lopez (2008) argues, the reproductive lives of Puerto Rican women in New York City are not framed within the paradigm of agency vs. victimization.¹⁵⁰ Due to economic, social, cultural, and historical constraints and the effects of colonization and capitalism, Puerto Rican women in New York City do not have the reproductive freedom or agency to make voluntary

¹⁵⁰ Lopez, *Matters of Choice*, 142.

reproductive choices.¹⁵¹ Lopez notes that the lives of Puerto Rican women in New York City are constrained by the effects of poverty, social inequalities, and the lack of access to safe healthcare.¹⁵² Therefore, in analyzing how the women in this study respond to the questions of making reproductive “choices” it is important to avoid placing their stories within a constricting dichotomy of “agency vs. victimization.”¹⁵³ The women participating in this project view their “choices” as a combination of being necessary, limiting, and empowering. The responses made by the women in this project suggest that they are neither victim nor active agents in their reproductive lives.

In looking further into both Acuna-Lillo (1988) and Lopez’s studies on the increase in the percentage of Puerto Rican women who were permanently sterilized from 1988 to 1995, it is clear from participant responses that permanent sterilization or tubal ligation remains currently prevalent. Additionally, looking at how the women participating spoke about how they learned about sterilization within their families, suggests that the “unofficial sanctioning” of sterilization as a form of population and fertility control as Lopez (2008) discusses contributes to the use of slang words like “tubes tied” in their families. Referring to the process of sterilization through the use of slang also contributes to this notion that permanent sterilization for Puerto Rican women has become culturally accepted and embedded as a reliable form of birth control.

Additionally, as Lopez discusses within her ethnographic study of Puerto Rican women in New York City, the lack of funding for temporary methods of birth control and how Puerto Rican women in New York City are continuously constrained from fertility options impacts the ways Puerto Rican women view sterilization practices and why Puerto Rican women in New

¹⁵¹ Ibid., 143.

¹⁵² Ibid., 128.

¹⁵³ Ibid., 142.

York City continue to pursue it. Within the findings, this notion is evident in the way Sapphire acknowledges the lack of available and reliable birth control options for the women in her family by stating that, “they didn’t know all of the options.”

It is important to contextualize how Puerto Rican women in New York City view reproductive health within the historical background of reproductive health for Puerto Rican women in the United States. Part of centering Lopez’s positioning on Puerto Rican women being neither victims nor agents in their reproductive choices is also understanding that Puerto Rican women are not passive agents in attempting to acquire adequate reproductive health resources, services, and rights. Historically, Puerto Rican women in New York City have organized and fought for the rights to their own bodies. Tied to other political, societal, and cultural movements, Puerto Rican women in New York City have a historical relationship with reproductive rights and social justice activism. The most prominent example of this type of activism is prevalent in the Young Lords Party (YLP) stance on reproductive health and freedom.

The YLP, a Puerto Rican nationalist organization based in New York City during the 1970s, claimed that Puerto Rican women in New York City were targeted for genocide through population control policies and practices. Similar to Black Nationalists and the Black Panther Party, the Young Lords argued that the quality of healthcare in hospitals that catered to Puerto Rican women in New York City, created unsafe environments that fostered the context for population control methods. Puerto Rican women in New York City who were encouraged to seek abortions were subjugated to a lack of “pre-and postnatal care and run-down accommodations,” as well as, unsafe medical equipment and facilities.¹⁵⁴

¹⁵⁴ Nelson, *Women of Color*, 114.

While the YLP advocated for safer and adequate healthcare facilities, their politics also supported fertility control for Puerto Rican women, even if chosen voluntarily. In contrast to Black Nationalist organizations, the YLP were not completely opposed to reproductive control. The YLP, instead, advocated for community control of reproduction and fertility. The pro-reproductive rights and control stance of the YLP was initiated by the few women in the organization who demanded that “safe legal contraception, abortion, and other reproductive rights” become part of the YLP’s politics.¹⁵⁵

The YLP also initiated an inclusive reproductive rights agenda, which made a “feminist position central to their political ideology.”¹⁵⁶ Central to their political framework, the women in the YLP created a reproductive rights agenda that included both nationalist and feminist politics. Their politics emphasized the “right of poor people of color to have control over local institutions” and “a women’s right to control her own reproduction.”¹⁵⁷ Establishing community control over reproduction and community health facilities through a nationalist and feminist framework, also aimed to end mass-genocide and the poverty experienced by people of color. The YLP stance on reproduction and the creation of a “libratory reproductive politics” and agenda, declared the right of Puerto Rican women to have the number of children they wanted and the right to raise them in an economically, socially, and politically safe environments.¹⁵⁸

The women in the YLP developed a new and inclusive reproductive rights agenda. By redefining reproductive rights to include the reproductive freedom to have or not to have children in Puerto Rican communities, the women in the YLP also established an anti-sterilization position that highlighted pro-abortion. The YLP argued that if Puerto Rican women had access

¹⁵⁵ Ibid.

¹⁵⁶ Ibid.

¹⁵⁷ Ibid., 121.

¹⁵⁸ Ibid.

to safe and legal method of fertility control, then women would not have to choose sterilization as a form of birth control. Additionally, the YLP also maintained that the safest methods of birth control for Puerto Rican women should come from “publicly funded health facilities under community control.”¹⁵⁹

In result, the YLP declared control over hospitals and other healthcare facilities in their neighborhood and in other Puerto Rican neighborhoods. Advocating for collective control, the YLP believed that the only way Puerto Rican women would gain complete autonomy over their reproductive bodies was if Puerto Rican communities controlled healthcare institutions that provided care for Puerto Rican women. Puerto Rican women had the right to decide when to limit their fertility but the right to abortion “needed to be guaranteed by the politicized community” to protect the interests of the larger group.¹⁶⁰

For the YLP and Puerto Rican women in New York City, redefining reproductive rights and establishing community control over healthcare institutions meant complete reproductive freedom for Puerto Rican women. As one of the first organizations to demand an end to sterilization practices while arguing for a right to abortion and contraception, the YLP redefined reproductive rights and transformed it into an inclusive reproductive right agenda. The YLP stance on establishing reproductive freedom influenced how Puerto Rican women in New York City would come to view their reproductive freedom and their choices. The importance of the YLP’s positioning on the reproductive bodies of Puerto Rican women is two-fold. The positioning of the YLP on reproductive health provides Puerto Rican communities ways to alternatively view reproductive rights, access to healthcare, and eventual reproductive freedom. Despite the fact the YLP’s success in achieving community control over healthcare institutions

¹⁵⁹ Ibid.

¹⁶⁰ Ibid.

was short-lived, the YLP's stance on reproductive justice and healthcare is important for Puerto Rican women to know about and understand in the contexts of their own lives.

While the YLP's history is not readily known among the women who participated in this project, remnants of the YLP's legacy is prevalent in how the women who participated in this project engaged in community welfare, politics, organizing, and education. For many of the women in this project, it was not worth discussing reproductive health without considering the ways they wanted to pass down knowledge to the younger generations in their communities. As Carol Hardy-Fanta (1993) argues, the notion of politics for Latinas in the United States "is an interactive process, embedded in their daily lives and culture."¹⁶¹ In discussing the ways they learned about their bodies in the context of reproductive health, many of the women brought up notions that resembled the connectedness, collectivity, and communal of Latina politics. For most of the women in this project, it was important to pass along knowledge on reproductive health to their siblings, friends, and community members.

Body Politics

As a major theme, body politics, acknowledged how the aspect of "not knowing" in the context of Puerto Rican women in New York City, translates into an intergenerational cycle of knowing or "not knowing" and passing down information. The cyclical nature of information or ways of knowing is exemplified in the ways the women participating in this study addressed how the women in their families discussed the body and how they had come to know their bodies. Similar to what Flores, et al (1990) argue in their study, Puerto Rican women can achieve empowerment and knowledge through understanding the ways their bodies have been used since

¹⁶¹ Carol Hardy-Fanta, *Latina Politics, Latino Politics: Gender, Culture, and Political Participation in Boston* (Philadelphia: Temple University Press, 1993), 3.

“the most important site of Puertorriquena struggle is the female body.”¹⁶² This notion is evident in the ways many of the women remembered feeling “ashamed” about the changes occurring in their bodies and stating that, “I didn’t really know my body.” Flores, et al argue that in the United States, Puerto Rican women gain empowerment through having a “heightened” sense and knowledge of their own bodies, especially in relation reproduction and sexuality.¹⁶³ For many of the women participating, not having a “heightened” understanding of their own bodies, made it difficult to feel “comfortable with bodies” and ownership or agency over their bodies.

Transmission of Reproductive Healthcare

The women participating in this study expressed a lack of support and care from the medical professionals; they sought out for answers, regarding their bodies in relation to reproductive health. Many of the women did not receive adequate information or knowledge from their healthcare professionals, and as a result, many of the women expressed feeling betrayed by the doctors and healthcare institutions they turned to. While many of the women discussed knowing about their bodies and reproductive health because of medical professionals, many of the women also talked about having to “go deeper” to access the information they wanted to know or needed to make reproductive health choices.

Therefore, a comprehensive and critical understanding of how the larger Latina population in the United States experience healthcare is necessary to contextualize the ways Puerto Rican women in the United States access knowledge on reproductive health. In understanding the complexities surrounding how Latinas in the United States access information or knowledge on reproductive health, it is important to discuss the economic, social, political,

¹⁶² Flores, et al, “La Mujer Puertorriquena,” 224.

¹⁶³ Ibid., 128.

and cultural factors that affect the ways Latinas gain access to healthcare, access information on reproductive health issues, and therefore make reproductive health choices.

In framing Latina reproductive health in the United States public sphere, it is necessary to understand how the United States positions and categorizes Latino groups residing in the United States. According to the United States Census Bureau population estimates as of July 2013, persons of Latino or Hispanic origin in the United States represent approximately 17% of the United States total population.¹⁶⁴ For the purposes of providing population demographics, the Office of Budget and Management (OMB) of the United States White House defines and views Hispanic and Latino as “a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race” and uses Hispanic and Latino interchangeably despite political or cultural implications.¹⁶⁵ As the second largest group of Hispanic or Latino origin within the United States, Puerto Ricans comprised 9% of the total Hispanic or Latino population in the United States according to the 2010 United States Census.¹⁶⁶ Population statistics demonstrates how Puerto Ricans are positioned within the larger context of healthcare in the United States, providing a sense of how healthcare resources are disproportionately distributed. For example, although Latinos comprise 17% of the total population of the United States, 29.9% of the Latino population has no health insurance as compared to 11.1% of the non-Latino or non-Hispanic white population.¹⁶⁷ These statistics are

¹⁶⁴ Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States and States: April 1, 2010 to July 1, 2013. Source: U.S. Census Bureau, Population Division. Release Date: June 2014.

¹⁶⁵ The 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, issued by OMB, is available at www.whitehouse.gov/omb/fedreg/1997standards.html.

¹⁶⁶ United States Census Bureau, 2010 Census Summary File 1.

¹⁶⁷ See *Income, Poverty, and Health Insurance Coverage in the United States (2012)*, 22, retrieved October 20, 2014, <http://www.census.gov/prod/2013pubs/p60-245.pdf>.

especially important considering Puerto Ricans comprise 9% of the total population and are more likely to have public insurance rather than private insurance.¹⁶⁸

The following section provides an overview of how Latina reproductive health is framed in the United States public and how Puerto Rican Latinas fit within the larger discussion of Latina healthcare in the United States. For the greater purpose of this project, the terms *healthcare*, *healthcare services*, and *quality of care* are defined according to the Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care as part of a study conducted by the Institute of Medicine of the National Academies (2003). *Healthcare*, according to the study committee, refers to the range of services by “traditional” healthcare providers—including providers in “public and private clinics, hospitals, community health centers, nursing homes, and other healthcare facilities—as well as home-based care.”¹⁶⁹ *Healthcare services* refer to the allocation of “preventative, diagnostic, rehabilitative and/or therapeutic medical of health services” to individuals, communities, or populations. The term *quality of care*, according to the study committee, refers to the “degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”¹⁷⁰

To frame Latina health, and specifically reproductive health, in the public discourse, the terms *healthcare*, *healthcare services*, and *quality of care* are used to assess the disparities and variations of the process, structure, and outcomes of healthcare that Latinas experience in the United States. For the purpose of this analysis, the term *disparities* is defined as “racial or ethnic

¹⁶⁸ Ibid.

¹⁶⁹ Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, eds. Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson (Washington D.C.: The National Academies Press, 2003), 31.

¹⁷⁰ Ibid.

differences in the quality of healthcare” that may or may not be determined by access-related factors, preferences, and clinical needs.¹⁷¹ Addressing racial and ethnic disparities in healthcare are important in establishing the implications for healthcare providers, administrators, policymakers, and healthcare patients. Disparities in the quality of healthcare for racial and ethnic populations greatly affect access to employment prospects and hinder opportunities to advance both economically and professionally.¹⁷² From a social justice perspective, racial and ethnic healthcare disparities “raise concerns about the overall quality of care in the United States” and therefore affect the *quality of care*.¹⁷³

Healthcare disparities in the United States greatly affect Latinas, and specifically Puerto Rican women, who are marginalized within the healthcare systems and services. From a public health standpoint, disparities, specifically racial and ethnic disparities, in healthcare systems “threaten to hamper efforts to improve the nation’s health” and thus links individual and community health to the larger society.¹⁷⁴ Aspects of healthcare systems refer to “the ways in which systems are organized and financed, and the ‘ease’ of accessing services.”¹⁷⁵ Issues with accessing healthcare systems also have different effects on how marginalized patients receive healthcare services.

Many of the Puerto Rican women participating in this study relied on public clinics to access healthcare, especially reproductive healthcare, services. For many of the participants, like Tish, public healthcare clinics did not provide her with the information necessary for her to make

¹⁷¹ Ibid., 32.

¹⁷² Ibid., 36.

¹⁷³ Ibid., 37.

¹⁷⁴ Ibid., 36.

¹⁷⁵ Ibid., 140.

an informed decision about her miscarriage and abortion. Explaining the lack of adequate information she received from the clinic, Tish said,

But then when I went [to the OBGYN], I found out that it had broken [her water]. But um, that's what I learned—that I need to take it easy maybe—like don't stretch that much. But also, I should have asked more questions at that time. Because when I went back—they have to give you a sonogram before you get an abortion—I started feeling it [the baby] move after. Because when I found out I couldn't have it [the baby] um, she [the doctor] was like 'oh did you feel it [the baby] move?' Because apparently you'll feel it [the baby] move because of the water—because whatever, it's swimming around. I started feeling it move after like literally Christmas day—was the first time I felt it which was ironic—and I was like that's weird. And then it [the baby] started swimming and you could even see it! So I feel like when I went to get it [abortion] I should have asked because there's a possibility that it would have—like the amniotic fluid would have come back and maybe it did. Obviously my life would be like completely different so I'm not like whatever about it, but yeah but that was definitely a learning experience. Like that's what I learned.

Expressing the lack of care and services she received, Tish learned that it was necessary for her to seek out the answers to important questions that she would not have received otherwise. Having important reproductive health and other medical needs ignored by medical professionals and public clinics prompted many of the women participating, like Tish, to seek out their own answers to questions on sexual and reproductive health concerns. Looking forward, it is vital for public health clinics and services to expand their perspectives on how to better serve Latina, and especially Puerto Rican, communities in New York City.

According to the National Latina Institute for Reproductive Health (NLIRH), “20% of Latinas receive reproductive health care services from Title X clinics and family planning programs and 28% of Title X clinic clients are Latino.”¹⁷⁶ As part of the Public Health Service Act, the Title X program is designed to provide contraceptive services and information regarding reproductive health to anyone who might request them. The Title X program is “the only federal

¹⁷⁶ National Latina Institute for Reproductive Health, *Cervical Cancer & Latin@s: The Fight for Prevention & Health Equity* (January 2014), 8, retrieved December 6, 2014, <http://latinainstitute.org/sites/default/files/Latinas-and-Cervical-Cancer-Fact-Sheet-Jan-2014.pdf>.

program dedicated solely to the provision of family planning and related to preventative health care.”¹⁷⁷ Agencies, healthcare institutions, and organizations that are funded through the Title X program provide low-income communities with information and resources on reproductive health services that are often completely voluntary and confidential.¹⁷⁸ While the expansion of healthcare clinics that are funded through the Title X program is beneficial for Latina communities, Title X funds are not allowed to be used in clinics or programs “where abortion is a method of family planning,” significantly impacting and reducing the reproductive healthcare services that Puerto Rican women might receive in New York City.

Latinas in the United States also remain affected by a lack of culturally and linguistically competent healthcare providers and systems. As one of the fastest growing demographics in the United States, Latinas are consistently underrepresented in the medical profession. According to the NLIRH, in 2011, Latinas in the United States only represented 3.8% of medical-school graduates.¹⁷⁹ Due to lack of representation in the medical field, Latinas also experience a lower quality in healthcare and overall health. As reported by Robin M. Weinick et al (2004) in “Hispanic Healthcare Disparities: Challenging the Myth of a Monolithic Hispanic Population,” Latinas “have poorer health status and a higher incidence of illnesses such as diabetes, human immunodeficiency infection, and cervical cancer compared with non-Hispanic whites,” but despite these reports, Latinas are also more likely to use “fewer healthcare services.”¹⁸⁰ As

¹⁷⁷ C.I. Fowler, J. Gable, J. Wang, and E. McClure, *Family Planning Annual Report: 2012 National Summary*. Research (Triangle Park, NC: RTI International, 2013), 1.

¹⁷⁸ Ibid.

¹⁷⁹ National Latina Institute for Reproductive Health, *Cervical Cancer & Latin@s*, 3.

¹⁸⁰ Robin M. Weinick, Elizabeth A. Jacobs, Lisa Cacari Stone, Alexander N. Ortega and Helen Burstin, “Hispanic Healthcare Disparities: Challenging the Myth of a Monolithic Hispanic Population,” *Medical Care* 42, no. 4 (2004): 313.

evident from the experiences shared from the women participating in this study, many of the women described feeling betrayed by the medical professionals they received services from.

Throughout the focus groups, the women participating talked about the systems that limit their access to quality reproductive healthcare services. As well as relying on public health clinics for reproductive health, many of the women also discussed the lack of access to both private and public insurance. Addressing healthcare policies relating to reproductive health and the body brought up questions and conversations about the affordability of adequate reproductive healthcare during the focus groups. Many of the women participating were frustrated at the lack of affordable reproductive health services in the face of public versus private insurance policies. Feeling frustrated at birth control policies and the lack of concern for making birth control easily accessible for young Puerto Rican women, Sapphire said,

And they [political representatives] complain about population control and they don't even give it [birth control] to us for free? But you know what I mean? But they don't even give us the freaking birth control for free—god dammit. Like so many kids [do not have access to affordable birth control options].

For reporting purposes of the Current Population Survey Annual Social and Economic Supplement (CPS ASEC), health insurance is classified as both private and governmental coverage. Private coverage includes plans that are provided through an employer, union, or “purchased by an individual through a private company” while governmental health coverage includes federal programs such as Medicaid and Medicare.¹⁸¹ According to the CPS ASEC, people are considered “insured” if “they were covered by any type of health insurance for part or

¹⁸¹ Income, Poverty, and Health Insurance Coverage in the United States (2012), 22. Retrieved from <http://www.census.gov/prod/2013pubs/p60-245.pdf>.

all” of the previous year. People are considered “uninsured” if “they were not covered by any type of health insurance” for the whole year.¹⁸²

According to recent statistics from the Census Bureau and the Office of Minority Health, Hispanic or Latino populations have the “highest uninsured rates of any racial or ethnic group” within the United States. As compared to non-Hispanic white populations in the United States, Hispanic American or Latinos have a 29.1 percent of being uninsured while non-Hispanic white populations have an 11.1 percent of being uninsured.¹⁸³ While Puerto Rican women are the least likely to be “uninsured” in comparison to other Latino groups, they are more likely to have public insurance only, rather than private insurance, throughout the year compared to other Latino groups.¹⁸⁴ Medicaid and other public forms of health insurance are essential and vital programs for young Puerto Rican women in the United States. As indicated by the NLIRH, education on sexual and reproductive health alone is not sufficient enough to ensure that Latinas are receiving adequate reproductive healthcare information and services.¹⁸⁵ Having access to adequate healthcare services in the form of public insurance and community-based health clinics is essential to ensure that Puerto Rican women in New York City are not only receiving reproductive and sexual education, but also reproductive and sexual healthcare services.

Conclusion

Limitations

¹⁸² Ibid.

¹⁸³ Ibid., 23. See also, “Unequal Treatment,” 83.

¹⁸⁴ Weinick et al, “Hispanic Healthcare Disparities,” 316.

¹⁸⁵ L. Fuentes, V. Bayetti Flores, and J. Gonzalez-Rojas, *Removing Stigma: Towards a Complete Understanding of Young Latinas’ Sexual Health*, New York: National Latina Institute for Reproductive Health, 2010.

I encountered many limitations throughout this project. Although I self-identify as a Puerto Rican woman born and raised in New York City, I also faced the dilemma of negotiating my identity between both an insider and outsider within my community. As argued by Zavella (1996), I could not assume automatic commonalities with the women participating in this project. While engaging in critical and decolonial feminist research, I could not overlook definite differences between me and the women I worked with due to stepping back into my community as an academic scholar. Negotiating my identity as a Puerto Rican woman and as an academic scholar proved difficult while hosting focus groups and because of this I consistently evaluated power dynamics, my position in academia, and my position in my own community.

Throughout the research process, I was constantly aware of how I represented the voices of the women who participated. It was a struggle for me to ensure that, although I could identify with the women culturally, that I would represent their voices legitimately and accurately to the best of my ability. It was of the utmost importance for me to honor the voices of the women who participated in this project. Therefore, as a new researcher, one of the limitations that I faced was learning how to appropriately host focus groups, present the findings that emerged from the women themselves, and to critically discuss participant responses.

Additionally, due to time and resource constraints, I could not include as many participants as would have been necessary to provide a more in depth research study. Grounded theory in particular involves continuous data collection.¹⁸⁶ For the sake of time and resources, only two focus group responses and eleven participants were evaluated for data collection and analysis. Therefore, the data presented in this study is not generalizable data.

Future Implications

¹⁸⁶ Charmaz, *Constructing Grounded Theory*, 57.

I think I wish I would have learned like the true meaning of your body—like what that really means...But I wish I really understood like how—I guess like how special, important, and personal your body is to you.

The women participating in this project expressed a need for greater resources and education for young Puerto Rican women. These women were adamant about discussing how their generation of Puerto Rican women could aide in educating future generations of young Puerto Rican women. The women felt that it was important for older generations of Puerto Rican women in New York City to mentor younger generations because they felt that reproductive healthcare agencies, medical professionals, and healthcare institutions were neglecting to provide appropriate and quality services. To address these poor or neglected services, many of the women participating mentioned the use of peer-to-peer education workshops as possible avenues for reproductive health mentorships. Jen stated,

Like what you guys did [referring to other participants], you said you went to like a teen workshop [peer-to-peer]. Maybe like more available resources for young women and teenagers should be available. Because you know there are teenagers that get pregnant and they don't know what to do, they don't know where to go—we see it on the news—so I think that's something else that can be done.

Additionally, many of the women expressed the need for more avenues for young Puerto Rican women to gain access to accurate knowledge in regards to reproductive health and the body. Chelsea also shared,

Definitely take the initiative and make sure you get the right information. That's one thing I learned in the program—the program that we keep referring to trained us to become peer educators so we were taught all of that information and we taught mini seminars in our school and would have events like that.

Much of what the women discussed as future steps for achieving greater access to reproductive health knowledge in Puerto Rican communities involved implementing peer-to-peer education workshops. It is important to note here that peer-to-peer education workshops derive from community-based healthcare models. It is necessary for Puerto Rican women in

communities in New York City to feel culturally, socially, and politically connected to the healthcare institutions that cater to their needs. In alignment with the opinions and suggestions from the women in this project, it is necessary for future research projects to evaluate what community-based healthcare models look like in Puerto Rican communities, how they cater to healthcare needs, and how they specifically address the Puerto Rican female body in relation to reproductive health.

A prime example of community-based healthcare in Latino communities is the use of *Promotoras de Salud* healthcare models to distribute knowledge and resources on reproductive health to young women. *Promotoras de Salud* are community health workers that cater to the communities that they are connected to culturally, socially, economically, and politically. *Promotoras de Salud* in Latino communities play vital roles in ensuring that healthcare information and services are distributed in culturally competent ways. According to the NLRH, studies show “community health workers to be effective in increasing vaccinations, breastfeeding, breast cancer screening and other chronic disease screening among Latinas and in other communities.”¹⁸⁷ Therefore, it is essential that programs that fund *Promotoras de Salud* be expanded and implemented across Latina communities in the United States if the health needs of Latinas are to be effectively addressed. Similar to the YLP’s stance on community control over healthcare institutions, expanding programs that use the *Promotoras de Salud* model provides resources on reproductive health that are community-based for young Puerto Rican women in New York City.

Reflection

It’s very important to have that confidence that my body is mine.
Brianna

¹⁸⁷ Fuentes, Bayetti Flores, and Gonzalez-Rojas, “Removing Stigma,” 8.

When I started this project, I was interested in discovering how Puerto Rican women in New York City, like myself, learned to understand their bodies, how they talked about their bodies, and the ways they viewed their bodies in relation to reproductive health. I was not expecting this project to transform the ways I personally understood access to healthcare and the ways my body is personally, socially, and structurally connected to the larger ways reproductive health is made accessible to Puerto Rican women in New York City.

There were many moments throughout this research process that I questioned the purposes, outcomes, and implications of this project. I questioned the project's importance and contribution to existing literature. There were many moments that I considered changing the focus and goals of this project because I felt too emotionally and mentally connected to its context. However, by continuing the research process, I realized that the importance and validity of this project resided in the experiences and voices of the participants. To honor the women in this project, I chose to highlight their stories and experiences throughout the data collection and analysis processes. The experiences of the women featured in this project are legitimate, true, and valid. The themes presented in the findings represent their voices, experiences, and journeys towards understanding their own bodies.

Throughout the focus groups, a majority of the women expressed excitement over possibly continuing future conversations regarding reproductive health. These themes are truly a reflection of how liberatory dialogue can transform the ways knowledge is learned and received. While this project cannot offer concrete solutions or answers, I hope that the experiences of the women who participated will illuminate the current literature regarding reproductive health and the Puerto Rican body. The significance of this project stems from how the women expressed their stories, what they felt was important to share, and their responses to how we, as second and

third generation Puerto Rican women in New York City, can create dialogue and move forward, because as in the words of Audre Lorde, “we were never meant to survive.”¹⁸⁸

¹⁸⁸ Lorde, “A Litany for Survival,” 31.

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APPENDIX A: FOCUS GROUP QUESTIONS

Semi-Structured Focus Group Questions

1. Tell me about who talked to you about reproductive health. (prompt for clinics, school, family [mother, aunts, etc.], media observations).
2. Can you tell me about what you learned about your body and reproductive health? (prompt for decisions on contraception in family history, family and communication, birth control practices, sterilization, sexuality, and personal observations).
3. Are there any stories that you have heard from your family/community about reproductive health (prompt for historical events in Puerto Rico, prompt for Puerto Rican cultural, and family understandings about the body)
4. Is there something I should have asked but did not or anything else you would like to add?