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Nidhi Chawla
nidhi.chawla@uconn.edu

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Intersectionality, Access, and Women's Health:
Engaging and Enacting a Feminist Model of Health Care

Nidhi Chawla

BS: Physiology and Neurobiology
BA: Women's Gender and Sexuality Studies

Advisor: Cathy Schlund-Vials
University of Connecticut, Storrs, CT 06029
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Abstract

"Intersectionality, Access, and Women's Health: Engaging and Enacting a Feminist Model of Health Care" takes seriously the potential role feminist theory can play in the making of a more accessible and effective model of medical care. In terms of theory and methodology, this thesis draws upon Kimberlė Crenshaw's influential notion of "intersectionality" as a means of mapping multiple identities and subjectivities; as an additional lens, the thesis accesses Audre Lorde's insistence that one cannot rely on established systems as the basis for progressive politics. Consistent with the reflexive dynamics of intersectional feminism, and guided by the notion that the personal is indeed political, this thesis likewise utilizes the author's personal experiences and familial history to establish a distinct academic and professional trajectory. This trajectory presages an intersectional analysis of women's health and contextualizes the author's use of feminist practice in a medical setting.

Introduction/Overview

Women's Studies is a distinct interdiscipline that uses as a first premise the ways in which gender is both socially constructed and culturally embedded; such understandings are inextricably tied to long-standing histories of oppression and ongoing practices of power which impact to varying degrees and divergent ends the experiences of those who identify as cis-gender men, cis-gender women, gender non-binary/non-conforming, genderqueer, trans men, and trans women. Born in large part from the Civil Rights and liberation movements of the 1960s and 1970s which advocated for equal participation, equitable treatment, and nonbiased representation, Women's Studies (as learned discipline) functions as the academic counterpoint of a larger gender-based, rights-oriented movement. Such a movement is by no means limited to individual gain nor is it necessarily fixed to one group. As Gloria Steinem provocatively summarizes in a 2008 *Los Angeles Times* op-ed, feminism and the women's movement "had never been about getting a job for one woman. It's about making life more fair for women everywhere. It's not about a piece of the existing pie…It's about baking a new pie."[1] This revolutionary cooking metaphor productively encapsulates the interdisciplinary registers of

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[1] Steinem, Gloria. "Wrong Woman, Wrong Message" (op-ed). *Los Angeles* Times. 4 September 2008. <articles.latimes.com>. Accessed 5 May 2020.

Women's Studies (known more capaciously as gender/sexuality studies), which draws upon numerous disciplines within the humanities and social sciences, including history, literature, psychology, cultural studies, anthropology, and sociology (among others).

In addition to these traditional disciplines, Women's Studies has expanded its intellectual purview to include more nuanced considerations of gender (specifically with regard to transgender subjectivity) and sexuality; however, despite the liberatory politics which brought the field "into being," the interdiscipline (along with the multiple waves that comprise the larger feminist movement) has been consistently and rightly critiqued according to its limitations with regard to race, ethnicity, and class. It is these other subjectivities – specifically as they involve the experiences of women of color – that serve as the basis for this thesis project, which on one level focuses its critical attention on the integral role intersectionality plays in the making of more accessible, equitable, and ethical medical environment. Originally coined by critical race theorist Kimberlė Crenshaw, "intersectionality" involves the simultaneous evaluation of multiple subjectivities and different identities (particularly with regard to race, ethnicity, class, gender, and sexuality).[2] Accessing 19th-century activist Anna Julia Cooper's famous feminist assertion that "Only the Black Woman can say, when and where I enter…then and there the whole Negro race enters with me," Crenshaw considers her own location (alongside other African American women) as both *raced* and *gendered* subject."[3] It is this reality of inhabiting "both" that foregrounds Crenshaw's notion of "intersectionality," which involves a multifaceted and complex consideration of connected identity politics and entangled identity-based polemics.

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[2] Crenshaw, Kiberle. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist, Theory and Anti-Racist Politics." *The University of Chicago Legal Forum*, 1989: pp. 139 -166.

[3] Quoted in "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist, Theory and Anti-Racist Politics." *The University of Chicago Legal Forum*, 1989: pp. 140.

As Crenshaw compelling maintains, to see an individual or a group as singularly “raced” without a concurrent accommodation for gender, class, ethnicity, and sexuality contributes to a profound dismissal of what she subsequently characterizes as groups who are “multiply burdened” (140). Focused on the problematic ways in which antiracist politics, feminist movements, and sex discrimination cases involving African American women privilege *either* race *or* gender, Crenshaw offers a corrective against such “single-axis analys[es]” via the more inclusive evaluation of *both* race *and* gender (138). It is this inclusivity with regard to identity—intersectionality—which serves as an overall theoretical frame for this thesis. As I later maintain, such “single-axis analyses” are by no means limited to the legal realm. Expressly, this narrowed thinking persists in medical spaces that are specifically intended to serve women and are focused on women’s health.

While this thesis engages an intersectional analysis to promote a more holistic approach to women’s health, it is important to note that its focus is very much connected to past/present gender politics; this work is likewise framed by the larger interdiscipline of gender/sexuality studies and emblematic of my own location as a woman of color and feminist thinker. Correspondingly, I utilize a reflexive, intersectional methodology—comprised of autobiographical reflection, familial history, and on-site ethnography—to explore the role race, class, and gender play in a contemporary medical clinic in which I recently interned. To further contextualize a “new way of seeing” multiple identities and underscore why such seeing matters, the first section of the thesis opens with Audre Lorde’s feminist manifesto, “The Master’s Tools Will Never Dismantle the Master’s House” (1984), which implicitly and illustratively utilizes an intersectional analysis as the justification for paradigmatic shift. Such feminist pronouncements serve as a frame through which to establish my own location as a student, scholar, woman of

color, and aspirant medical practitioner. I then move to my recent internship at a women's health clinic and consider how my experiences "on-site" cohere with and diverge from extant scholarship about race and women's health. While I acknowledge from the outset that such on-site experience is particularly configured and not necessarily emblematic of medicine as a multidisciplinary, multifaceted, and multivalent field, I nevertheless maintain that my firsthand accounts as a woman of color (along with my grandmother's previous experiences as a woman of color and doctor) matter because they underscore the limitations of a contemporary women's health practice.

In particular, such limitations are apparent in the systemic failure to take seriously and centrally historically-embedded power dynamics and more recent racial formations to ensure greater inclusivity. These omissions are further highlighted in the paucity of scholarship focused on women of color and their experiences with doctors and other healthcare practitioners (particularly as these experiences involve outreach, preventative care, and sexual health). As a possible way forward, by way of conclusion, I consider alternative interactions between medical professional and patient which utilize an intersectional dynamic that enhances, expands, and strengthens outreach to heterogeneous communities of women. Such considerations are not merely theoretical; rather, these intersectional medications serve as significant foundations for a project I pursued during my internship. Expressly, as the attached appendix illustrates, I attempted to incorporate a feminist practice in the development, implementation, and distribution of informational brochures. In so doing, this thesis (and the accompanying appendix) reflects my particular trajectory through feminist critique and potently builds on Crenshaw's influential assertion (with slight revision) that "any analysis that does not take intersectionality into account

sufficiently address the particular manner in which Black women [and other women of color] are subordinated" (140).

Towards a Feminist Critique: Academic Reflections and Personal Connections

Many feminist theorists have touched upon and emphasized the importance of feminist perspectives and intersectional inclusion in the workspace and society. Among the best known is Audre Lorde (1934-1992), a self-designated "black, lesbian, mother, warrior, poet" whose creative work and scholarly *oeuvre* were consistently intersectional, politically-engaged, feminist-focused, and provocatively revolutionary. These characteristics are very much at the forefront of Lorde's aforementioned and oft-cited essay, "The Master's Tools Will Never Dismantle the Master's House," which was written in response to a conference that took place at New York University; as indicated in the introduction, Lorde was invited to offer comments concerning "the role of difference in the lives of American women: difference of race, sexuality, class, and age" (110). Indicative of intersectionality, this multifaceted approach to "difference" was, according to Lorde, an integral part of any viable feminist critique. As Lorde maintained, "The absence of these considerations weakens any feminist discussion of the personal and the political" (110).

Notwithstanding her presence at the conference, and despite these intersectional contentions, Lorde was struck by such "absences," as is clear in the following characterization: "It is a particular academic arrogance to assume any discussion of feminist theory without examining our many differences, and without a significant input from poor women, Black and Third World women" (110). In stressing "input from poor women, Black and Third World Women," Lorde on the one hand underlines the importance of perspective and consideration of

intersectionality within a specific professional site (e.g., the U.S. academy). On the other hand, Lorde's critique of scholarly discourse and practice lays bare the past/present limitations of academia as a space of progressive, inclusive, and intersectional politics Consistent with Lorde's experiences at the conference and consonant with her criticisms of exclusionary scholarship, my experiences *with*, research *in*, and negotiation *of* Women's Studies has likewise highlighted the paucity of literature and scholarship focused on women of color, particularly with regard to health and health disparities. To wit, there is very limited data presented regarding many conditions that are highly prevalent in these communities.

Such absences are by no means limited to theoretical discussions and disconnected scholarly inquiries. Instead, as this thesis maintains and as my experiences further confirm, the absence of data and analysis carry profound real-life and real-time impacts on at-risk communities, and communities who already lack access to health care and education. It is therefore imperative to rethink and expand our understandings of women's health in ways that include those previously "left out" and "left behind." Such reconceptualization's depend on a dismantling of single-axis analyses and the building of intersectional evaluations which simultaneously consider race, class, gender, ethnicity, and sexuality. At the same time, we must move beyond a beyond a binary which assumes the primary issue involves cis-gender men and cis-gender women. As Lorde evocatively reminds at the conclusion of her manifesto, "Women of today are still being called upon to stretch across the gap of male ignorance and to educate men as to our existence and our needs. This is an old and primary tool of all oppressors to keep the oppressed occupied with the master's concerns" (114).

It is admittedly Lorde's sense of "destructive" rebuilding that has most characterized my recent academic trajectory as Women's, Gender, and Sexuality Studies (WGSS) double major at

the University of Connecticut. As per the WGSS website, the current mission of both its research profile and teaching program includes the following intents and goals:

1. [transformation of] scholarship in existing academic disciplines by incorporating the study, contributions, and feminist analysis of gender and sexuality;
2. [creation of] a new body of interdisciplinary feminist research and teaching that concentrates on women, gender, sexuality; and
3. [the building of] supportive and critical scholarly community that advances our understanding of the construction, reproduction, and resistance to inequality. (https://wgss.uconn.edu/our-mission/)

In addition to these objectives, the WGSS Program also involves the following aims, including:

1. [the institutionalization of] the generation of feminist and queer knowledge about women, gender, and sexuality within and across disciplines and other interdisciplinary sites; and
2. [the development of] understanding and opportunities for political activism that advances social justice; and
3. [providing] individuals with the means to integrate feminist and queer theory into their scholarship, professional work, and everyday lives. (https://wgss.uconn.edu/our-mission/)

These learning goals and pedagogical aims, which resonate both with Crenshaw's intersectional schema and Lorde's "dismantling" feminism, have had profound impacts on my thinking and influenced greatly the ways I see gender as not only socially constructed but—in terms of medical practice—institutionally embedded.

To further elaborate and clarify, the WGSS Program has pushed me to think more critically about the ways in gender is not only antithetically fashioned (e.g., as a binary male/female dyad). Instead, I have consistently been pushed to consider—through multiple disciplinary lenses and intersectional approaches—how one's view of the world must actively accommodate complexity and multiplicity. The experiences and epiphanies I have had in the many courses completed and literature read are very much integral to my current thinking and values. Perhaps even more significant, my academic engagements with feminist critique has clarified my career aspirations in terms of medicine and the medical profession.

By way of example, and in the interest of making concrete the relationship between theory and practice, I turn to feminist philosopher Sara Ahmed, whose work involves the intersection of feminist theory, lesbian feminism, queer theory, critical race theory, and postcolonial studies. In her 2017 monograph, *Living a Feminist Life*, Ahmed articulates the activist and affective stakes of feminist-oriented labor; according to Ahmed, such work "is often about timing; sometimes we are too fragile to do this work; we cannot risk being shattered because we are not ready to put ourselves back together again" (27). In linking political project to individualized personhood, and in connecting opportune time to self-care, Ahmed on one level emphases the significance of reflexivity via feminist critique. In particular, while certain moments, events, and histories make the project of dismantling oppressive regimes of power timely, the success of such labor relies on an individual's ability to maintain agency. On another level, Ahmed's focus on "fragility" underscores the enormity of doing politically-relevant, progressive feminist work. While movements involving equality and equity are aspirational and future-oriented, those involved "on the ground" must contend with present-day pressures, concerns, realities, and disappointments.

It is the acknowledgement and implied acceptance of the "disappointing realities" of the present, along with a simultaneous belief in future possibility and "just out of reach" progress, that has profoundly shaped my current relationship with coursework, my most recent experiences as an intern in a medical clinic, and my future aspirations as a medical practitioner. With regard to coursework, I realize that intellectual explorations involving difficult subjects such as racism, sexism, xenophobia, homophobia, and transphobia carry a considerable emotional toll. Nevertheless, I have learned to balance these costs knowing that this struggle is fundamental to change. In terms of my internship, I recognized that institutional shifts require a paradoxical

understanding of individual need and larger-scale comprehension of institutional history and systemic biases. Finally, as I near the relative end of my undergraduate career and prepare for a different and more intensive experience with medicine, I know that fragility is not something that must be avoided but is instead an outcome to manage.

Modeling a "Feminist Life": The Story of My Grandmother

While much of the thesis has focused on theoretical and scholarly engagements with feminist thought and intersectionality, I want to return to Lorde's invocation that the "personal" is inherently "political." Such linkages foreground this section's focus on my grandmother, whose experiences as a woman of color in a traditionally male-dominated field are both instructional and inspirational.

Ever since I was a young girl, I have always looked up to my maternal grandmother. For thirty years, my grandmother was an anesthesiologist at Tata Memorial Hospital in Mumbai, which was and remains India's top-ranked hospital. Though it was told to me previously, it has only become even clearer to me now (due to my work in WGSS and my own experiences as a medical intern) that pursuing a medical degree as a woman of color was at the time difficult and largely unprecedented. The fact my grandmother did her postgraduate work and training in the United Kingdom made her career trajectory even more remarkable in light of ongoing racialization (as a direct consequence of British colonial rule), wide-ranging racism, and pervasive sexism. While my grandmother's foray into medicine was exceptional, it was by no means decontextualized. Instead, this particular journey was born out of my grandmother's firsthand witnessing of revolutionary change and political shift. When India gained its independence from Britain in 1947, my grandmother was a seven-year-old child. While she did

not initially nor fully comprehend the gravity of independence, she nevertheless was inspired by her father and uncle, two committed anticolonial activists who were on the front lines of the nation's freedom movement. It was there activist example in the face of seemingly unchangeable and impossible odds that shaped my grandmother's considerable sense of determination. This is evident in the stories she often narrated to me during my childhood, which repeatedly stressed her desire to pursue a medical career. However, she also revealed that though her family supported this path, they were nevertheless cautious given prevailing gendered norms (particularly around marriage) and in light of past colonial exclusions (specifically for people of color).

Consequently, during her adolescence, her immediate family and more distant relatives urged her to marry and not pursue what they deemed an unreachable goal. These expectations were amplified by my grandmother's positions as an only daughter. Despite the pressure "to do otherwise" via career, it was my great-grandfather – my grandmother's father—who would, in the end, encourage my grandmother to apply to a top medical program. Armed with financial support, and shaped by the experiences of her activist relatives, my grandmother made her way to Wales. While my grandmother certainly struggled with gendered expectations "at home" in India, she faced different yet connected challenges abroad as a woman of color in a predominantly white nation. Moreover, despite the passage of almost two decades since Indian independence, there remained a lingering characterization of inferiority that was part and parcel of British colonization and subjugation. Last, but certainly not least, my grandmother had to negotiate race *and* gender during her medical school training. This marginalized "double-ness," the end product of systemic sexism and racism, further illustrates the validity of Crenshaw's intersectional argument. Notwithstanding the very high score she received on her board exams,

my grandmother was nevertheless limited in her ultimate career options. While she initially dreamed of becoming a surgeon, these positions were "just out of reach" and limited to her white male colleagues. Faced with few options yet still dedicated to pursuing a medical career, my grandmother chose to pursue a more inclusive field (as an anesthesiologist).

In reflecting upon my grandmother's experience, and in considering her professional "life story," it was admittedly surprising to learn that being an anesthesiologist was not my grandmother's first choice; it was likewise illuminating to know that this career trajectory was directly connected to systemic and institutionalized racism, sexism, and xenophobia. Prior to these familial revelations, I was under the impression that my grandmother had not only achieved so much; I assumed she had achieved exactly what she had envisioned. This impression reflects my own location as an Indian American woman living in the United States. Within the U.S., anesthesiology is considered an aspirational, high paid position; an integral part of any surgical operation, an anesthesiologist occupies an esteemed place in the medical profession hierarchy. By contrast, my grandmother confessed that she felt marginalized insofar as her labor required validation from a surgeon and was not particularly valued. In articulating this sense of marginalization, my grandmother made me see how this mode of medical work was, in relative terms, was denigrated and feminized. She also stated that despite her professional success, her ultimate value was linked to her ability to assume a more typical, socially-acceptable role as wife and/or mother.

As a young girl, my grandmother's stories made me think only about immense possibility. Now, as I near the end of my undergraduate career, as a direct consequence of my WGSS major and my concomitant explorations into feminist theory, thought, and critique, I now have both a renewed sense of respect for my grandmother's achievements and a profound

understanding of the activist work "still to be done," particularly as this labor is linked to the medical profession I intend to enter. My current commitments and interests in medicine stem from, an informed desire to make meaningful strides in the lives of my patients. To do that work requires a distinctly intersectional approach to diagnosis, treatment, and care which takes seriously overlapping histories of systemic oppression. And, as my grandmother's example makes clear, to do this requires an equally important acknowledgement of how one's subject position—along with where that position fits into a larger sociopolitical spectrum—is a necessary and integral component of effective care. To further highlight why an intersectional, feminist approach to medical care matters, I take a more traditionally "academic" approach in the next section, which considers the current state of women's health via difference and disparity.

A Feminist Crisis: Women's Health in the U.S.

TABLE2
AGE-ADJUSTED DEATH RATE (PER 100,000 POPULATION) AND RATES FOR THE LEADING CAUSES OF DEATH BY GENDER AND RACE: UNITED STATES, 1992

CAUSES	*WHITE MEN*	*WHITE WOMEN*	*BLACK MEN*	*BLACK WOMEN*
Heart disease	190.3	98.1	264.1	162.2
Malignant neoplasms	157.3	110.3	238.1	136.6
Cerebrovascular disease	26.3	22.5	52.0	39.9
Chronic obstructive pulmonary disease	26.8	16.1	24.8	11.2
Motor vehicle crashes	22.2	9.6	25.0	8.7
Pneumonia and influenza	15.8	9.7	25.0	12.2
Human immunodeficiency virus	18.1	1.6	61.8	14.3
Diabetes mellitus	11.6	9.6	24.2	25.8
Suicide	19.5	4.6	12.4	2.1
Homicide and legal intervention	9.3	2.8	68.1	13.0
Chronic liver disease and cirrhosis	11.1	4.6	17.2	6.9
Alcohol-induced causes	9.9	2.6	22.3	6.3
Drug-induced causes	5.5	2.7	10.6	3.6
All causes	620.9	359.9	1,026.9	568.4

Source: Data from Fauci et al. (1998, 16).[4]

[4]

There is a major current crisis in medical care in our society as it pertains to accessibility to health care. As the above-placed table included in *Journal of Health Care for the Poor and Underserved* (2002) makes clear, African American men and African American women are, with few exceptions, more likely than their white counterparts to suffer fatal consequences due to medical illness, accidental catastrophe, and substance abuse. Indeed, the percentages connected to fatality outcomes is significantly higher for African American men and women in nearly all categories with the notable exception of suicide. To more starkly illustrated, there are 1,026.9 deaths amongst black men per 100,000 versus 620.9 in white men, which represents an almost 50% difference between the two groups. Even more alarming is the data concerning the category, "homicide and legal intervention," wherein 68.1 deaths involving African American men were reported compared to a mere 9.3 deaths involving white males. While this information is drawn from a 1992 data set, more recent media reports involving Covid-19 fatalities repeatedly stress disproportionate fatality rates for African American and Latinx populations, underscoring the ongoingness of racially-inflected disparities. Continuing with this contagion-based analysis, the aforementioned data concerning deaths related to "human immunodeficiency virus" vary dramatically along racial lines: fatalities involving African American men (61.8) and African American women (14.3) outnumber those connected to white men (18.1) and white women (1.6).

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[4] 1. Rodney, Patricia, Zania Kanini Rodney, Seseni Nu, and Judy E. Hemans-Richards. "Cervical Cancer and Black Women: An Analysis of Disparity in Prevalence of Cervical Cancer." *Journal of Health Care for the Poor and Underserved*, Volume 13, Number 1: February 2002. Pp. 24-37.

While there are numerous factors involved in assessing the reasons behind and the causes of health disparities in the United States, what becomes quite clear is that access to health education and health care *matter*. According to a 2004 report issued by the National Research Council, racial and ethnic minorities (inclusive of African American, Latinx, and Southeast Asian Americans) face "challenges in having access to medical care in the United States" due to a lack of health insurance. When those who fall into these categories receive care, such care "may not be equivalent to that for other groups" due to disproportionate premiums, coverage scope, and inability to access preventative care.[5] In addition to these issues, differences involving "ability to pay and provider behavior," along with "patient preferences, differential treatment by providers, and geographical variability" further impact access and qualitatively influence (in)effective care and treatment.[6]

While there is considerable variability and significant complexity vis-à-vis medical care, I focus on "access" because it is this aspect of care that is frequently invoked in scholarly discussions involving preventative treatment and women's health. This particular connection between "access" and women's health is most evident when one considers the prevalence of breast cancer and cervical cancer. According to the American Cancer society, breast cancer is—with the exception of skin cancer—the most common cancer among American women.[7] Although cervical cancer rates have decreased dramatically in the last four decades due to increased screening and annual exams, it was—according to the Centers for Disease Control and

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[5] National Research Council (US). "Panel on Race, Ethnicity, and Health in Later Life" (edited b RA Bulatao and NB Anderson). Washington, DC: National Academies Press, 2004.
[6] IBID.
[7] American Cancer Society. "Breast Cancer." <https://www.cancer.org/cancer/breast-cancer/about/how-common-is-breast-cancer.html> Accessed 20 April 2020.

Prevention—previously the leading cause of cancer death for women.[8] Ovarian cancer now occupies the top position as the leading cause of gynecologic cancer-driven death, uterine cancer is presently the most common gynecologic cancer diagnosis, while vaginal and vulvar cancers remain rare.[9]

This brief overview of women's health through cancer rates and diagnoses underscores the importance of preventative health and consistent screening as the primary mechanism for early diagnosis and effective treatment. Even so, women continue to face serious complications and impediments regarding much-needed preventative care, even at the most minimal levels. Socioeconomic status, and its ubiquitous connection to ethnic background and racial category, functions as a considerable hurdle to health care access. Such impediments are not limited to cancer diagnoses; they also impact other aspects of women's health, including pregnancy. Notwithstanding its standing as a leading GDP nation, the United States ranks last among similarly wealthy countries in maternal morbidity rates; according to a 2020 Centers for Disease Control and Prevention report, the overall maternal mortality rate in the United States was 17.4 deaths per 100,000 live births. While seemingly low, this number is considered high in comparison with other nations; to wit, the United States (as per statistics put forth by the World Health Organization) ranks 55th in the world.[10]

When one considers the issue of maternal morbidity using an intersectional framework, what becomes clear is the disproportionate number of deaths involving African American mothers. As Ana Langer (Harvard T.H. Chan School of Public Health) recently averred, such impediments to access represent "a public health and human rights emergency" because a

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[8] Centers for Disease Control and Prevention. "Cervical Cancer." <https://www.cdc.gov/cancer/cervical/statistics/index.htm> Accessed 1 May 2020.
[9] IBID.
[10] IBID.

significant portion of maternal fatalities involving African American women were attributable to nonaccess to consistent prenatal care. The determining factor involving such access involves socioeconomic status; illustratively, poverty rates among adult women in the Unites States vary considerably along racial and ethnic lines: Native American women have the highest poverty rate (28.1 percent); 25.7 percent of African American women and 24 percent of Latina women have the second and third highest poverty rates.[11] By contrast, white women have the lowest poverty rate and the overall women's poverty rate is higher than that of their male counterparts.[12]

Shifting from poverty rate to health insurance coverage, as of 2013, white and Asian/Pacific Islander populations have the highest rate of coverage (82.8 percent), whereas Latinx and Native American women have the lowest rates (64 percent and 67.7 percent respectively).[13] However, for all racial and ethnic groups, women had higher coverage rates than men, though such coverage—as the percentages illustrate—vary greatly among different populations. As these statistics highlight, considerations of health disparity are intimately connected to racially-inflected, ethnically-specific, gendered, and classed subjectivities; such positions have direct impacts on medical care access and preventative treatment. When one considers cervical and breast cancer diagnosis rates and prognostic outcomes, "women of color have benefitted less from the prevention, early diagnosis, and treatment of the disease" ("Cervical Cancer and Black Women"). It is therefore imperative to develop a path to care that facilitates greater access while attending to the specific realities that circumscribe that access for particularly vulnerable populations.

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[11] "Women and Poverty." <https://statusofwomendata.org/women-of-color/> Accessed 12 March 2020.
[12] IBID.
[13] IBID.

Enacting a Feminist Model of Care: Experiences On-Site

This past year (2019-2020), as part of my WGSS major, I interned at St. Francis Hospital and Medical Center in Hartford, CT. Given the last section's focus on disparity, it is perhaps appropriate that the internship occurred in Hartford, which in 2012 had the second highest poverty rate gap in the United States.[14] My internship placement involved a low-income OB-GYN clinic intended for local women; the clinic's primary agenda involved connecting women to preventative and prenatal health services. Located in the center of Hartford (on Woodland Street), the hospital and its affiliate clinic were in a relatively poor area of the city; many patients travel to the facility on foot. The main entrance is a stop on a well-used public transportation route, allowing others to access it by bus. Whereas St. Francis—due to its location—serves a number of poor and uninsured residents, UConn's John Dempsey Hospital (affiliated with UConn Health) is located in Farmington, a relatively affluent nearby town (though the hospital does have a "Charity Care" service for uninsured patients). While the Hartford clinic served a diverse population, inclusive of a wide range of ages, the majority of those served were African American and Latinx. Like John Dempsey Hospital, St. Francis has a professional connection to the University of Connecticut; it is also a teaching hospital that annually hosts a number of medical students and residents. Though St. Francis is not the largest hospital in Connecticut, it is the largest Catholic hospital in New England; with 617 acute care beds, St. Francis is classified as a Level 1 trauma center (the highest level afforded to trauma care facilities).

The clinic in which I interned offered a range of services, and its programs varied from those intended for teenagers to those in their sixties. Admittedly, my placement at the clinic was

[14] "Poverty Rate Gap Second Highest in Nation." *NBC News.* <https://www.nbcconnecticut.com/news/local/poverty-rate-gap-second-highest-in-nation/2065795/> Accessed 1 May 2020.

quite accidental. In spring 2019, I was not sure as to what I would do the ensuing summer; however, given my dual interest in gender/sexuality studies and medicine, I knew that I wanted to volunteer in a place that would bring these two investments together. I had previously spent three summers at St. Francis as a volunteer (during high school); it was due to this past experience that I reached out to the volunteer coordinator who subsequently connected me with a RN at the clinic. It was through this second contact that I was matched with the Breastfeeding Heritage Program coordinator, who introduced me to the Hispanic Health Council and placed me with Dr. Trymbulak.

My main role this summer was to create a resource guide for incoming patients; the guide would be distributed prior to the initial care provider contact. Prior to my internship, the clinic did not provide such materials, which created communication issues between medical provider and patient, particularly as they involved relevant programs. To make these programs more visible, I created a guide which outlined in brief detail programs such as the BHP initiative, focused on breastfeeding. The guide also contained information about breast pumps, which were distributed to women at no charge following an application process. In addition, the resource guide contained non-clinic resources such as Hartford WIC and connected initiatives such as the CT Breast and Cervical Detection Program which offered free of charge annual screenings (please refer to appendix for guide documents).

Once I finished writing the resource guides and after they had been approved by the hospital's marketing department, I was charged with their distribution. At the beginning of shift, I would do my morning rounds and scan patient charts to anticipate which programs would be most relevant. And, as the internship progressed, I became much more adept at ascertaining particular needs. For example, teenage mothers often shied away from breastfeeding due to

concerns that such activity would negatively impact their appearance; in response, I brought information that was focused on the nutritional benefits of the practice (for babies) and its positive hormonal impacts (on mothers). While the resource guides offered one mode of information, they also functioned as a way of doing on-site teaching, particularly with regard to breast pumps and latching techniques. Because I was the sole distributor of the resource guides at the clinic, I was not able to visit with every patient given the sheer volume of its clientele. Faced with limited patient time, I was forced to make visitation decisions based not on individual need but instead on an incomplete group evaluation (e.g., new mothers, patients who had missed appointments, and/or patients who were first-time visitors to the clinic). Such decision making with regard to information distribution was far from ideal and very much inconsistent with the original purpose of the resource guide creation.

As important, such selectivity with regard to patient information does not afford a holistic mode of care; as I continued the internship, what became clear was that there was a direct correlation between time spent with a patient and that patient's willingness to fully participate in a treatment plan or program. The clinic was, for many clients, an alien and alienating place; for those who had previously little access to such care, the clinic was viewed as an emergency or triage site rather than as an accessible and relevant space. Despite its communal vision as an open health space, the clinic was at times disconnected from those it served. Such disconnectedness was in some instances due to anxieties about diagnoses and prognoses.

However, in other cases, the barrier to open access and clear communication between medical professional and patient was much more nuanced. Expressly, there was a stark difference between care providers and patients. The clinic's primary medical staff (specifically doctors and nurses) was entirely comprised of white men and women who, with few exceptions,

were not bilingual and only spoke English. By contrast, the few people of color who worked at the clinic served as medical assistants or receptionists. As an intern who had one-on-one contact with patients, I was initially struck by the positive reactions I received from patients, which I originally attributed to a non-specific kindness. Nevertheless, as my internship progressed and I thought more critically about my own subject position (as a woman of color), I realized that such reactions were linked to a misreading of my position by patients as a primary caregiver. It was therefore out of an assumed solidarity that such exchanges were immediately more open.

CONCLUSION

Such senses of solidarity—predicated on a shared experience or common history—is reminiscent of the aspirational politics of gender/sexuality studies, an interdiscipline which endeavors to build coalitions through shared visions of an equitable future. Even so, I must acknowledge that – despite my status as a woman of color – I do enjoy a degree of privilege. As someone who is able to pursue an internship and attend university, I occupy a privileged class position; as an Asian American, I am the recipient of a model minority status connected to stereotypes of socioeconomic success; and, as my grandmother's descendent, I know that a medical career is something that is most certainly within reach. Acknowledging these positions does not devalue my interactions at the clinic; however, such reflexivity productively pushes me to see—through an intersectional, feminist framework—the degree to which women like those who used the clinic inhabit complex lives that deserve consideration and accommodation. As I move from coursework to medical school applications, I realize that being a doctor is not just about proficiency; it is instead a profession that requires its practitioners to consider in more holistic fashion the histories, politics, and dynamics that are embodied by their patients.

In making medicine "feminist," and in pushing medical practitioners towards "intersectionality," I am reminded that this work is not fixed to a specific cis-gender agenda; instead, it is the basis of human rights and ethical medical practice. By way of conclusion, I return to my internship and the clinic. While on-site, I had an illuminating conversation with one of the doctors. When I asked a question about the clinic's clientele and the difficulties with outreach, I expected a distanced response as a white doctor. After a brief pause, he stressed that it was important to remember that some patients were recent immigrants from South America and the Caribbean. In their respective countries of origins, hospitals were considered "last options" and places where relatives perished. And though the notion of preventative care is highly visible in the United States, it is either non-existent or limited to the most privileged in other nations. In articulating these circumstances, the doctor unintentionally yet evocatively accessed a feminist way of seeing his patients. In so doing, he offered me a much-needed sense of hope that what may seem marginal via intersectional methodology is actually quite mainstream.

APPENDIX (RESOURCE GUIDES)

Breastfeeding Heritage and Pride Program

- ❑ **Program Goals:** to improve rates of breastfeeding initiation, duration and exclusivity among low-income women of all racial and ethnic women
- ❑ Community health worker program that is established, delivered, and replicated by the Hispanic Health Council
- ❑ **Services provided:**
    - ❑ Free of charge
    - ❑ Confidential
    - ❑ Bilingual and culturally appropriate
    - ❑ Printed materials provided
    - ❑ Offered in clinical and community settings through breastfeeding education and basic support
- ❑ **Eligibility requirements:**
    - ❑ Pregnant patient at the clinic
- ❑ **Contact:**
    - ❑ Bethany Salguero (860) 527-0856

Hartford WIC Program

- ❑ **Program Goals:** to educate women on the nutritional needs and diet their infants or children require and provide food to supplement
- ❑ **Services provided:**
    - ❑ Free of charge
    - ❑ Information on breastfeeding
    - ❑ Education on feeding your baby and child through healthy eating habits and utilization of WIC food
- ❑ **Eligibility requirements:**
    - ❑ Low income, automatically qualify if enrolled in Medicaid
- ❑ **Contact:**
    - ❑ Rossana Spriggs (860) 714-????

Family Wellness Healthy Start Program

- ❑ **Program Goals:** to include the father in plans to engage the entire family and not just mother and baby, develop care plans, personal goals, and advocate/connect families with community resources
- ❑ Care coordinator provides services to women before, during and after pregnancy including till the child is 18 months of age

- **Services provided**:
    - Free of charge
    - Health education
    - Maternity preparation and parenting education including milestone development
- **Eligibility Requirements**:
    - Women must be from either Hartford or New Britain
    - Pregnant or the mother of a baby less than 18 months of age
    - Enrolled in Medicaid or unable to enroll in Medicaid
- **Contact:**
    - Yesenia Acosta (860) 714-7520

The Connecticut Breast and Cervical Cancer Early Detection Program (CBCCEDP)

- **Program Goals:** to increase the number of medically underserved women women who receive breast and cervical screening, diagnostic treatment and referral services
- **Services provided:**
    - Free of charge
    - Breast and cervical screening and diagnostic treatment
- **Eligibility requirements:**
    - 40 to 64 years of age for a mammogram
    - 21 to 64 years of age for a clinical breast exam and pap test
    - 35 to 39 years of age with symptoms and/or specific risk factors for breast cancer
    - Limited income or no health insurance
    - Health insurance that excludes routine pap tests and/or mammograms
    - Have an insurance deductible of $1,000 or more or have no Medicare Part B
- **Contact:**
    - Renee Richard (860) 714-7151

The Connecticut WiseWoman Program

**Nearly twice as many women in the US die of heart disease, stroke, and other cardiovascular diseases as from all forms of cancer including breast cancer*
**High blood pressure, high blood cholesterol, overweight, physical inactivity and diabetes*

- **Program Goals:** to provide women who are found at risk for heart disease, a chance to participate in nutrition and physical activity interventions which will help decrease their risk of heart disease
- **Services provided:**
    - Free of charge

- ❑ Encouragement and support on a healthier lifestyle through diet, exercise, and heart health education

❑ **Eligibility requirements:**
- ❑ Enrolled in the CBCCEDP
- ❑ 40 to 64 years of age
- ❑ Have limited income or no health insurance
- ❑ Insurance does not cover routine blood pressure and cholesterol screenings

❑ **Contact:**
- ❑ Gillian Walcott (860) 714-7262