BLACK QUEER BEING/KNOWING/FEELING AS DISCURSIVE TERRAIN FOR REIMAGINING REPRODUCTION

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ABSTRACT

This dissertation, “Black Queer Being/Knowing/Feeling as Discursive Terrain for Reimagining Reproduction” centers and conceptualizes Black Queer folks' (cisgendered and non-cisgendered) lived experiences with gestation through storytelling. I put into dialog a study of in-depth interviews with Black queer gestational parents and discourse analysis of the only popular television representation of a Black Queer main character’s gestational journey utilizing assisted reproductive technology in Netflix’s Masters of None's "Moments in Love." By blending analysis of fictional storytelling and people’s lived experiences, I highlight continuities and ruptures in reproduction discourses and raise possibilities for reimagining reproduction (e.g., reproductive health services, care, politics, and information) through a justice-oriented Black Queer lens.

I dedicate this dissertation to my chosen family!

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PREFACE

As a Black feminist in health communication, I am concerned with the field's viability. Specifically, the field's ability to effectively document, evaluate, produce, and disseminate health-related research that informs and empowers individuals, populations, and communities to make health decisions that ensure their well-being. As a transdisciplinary scholar whose research expands across multiple disciplines, epistemological and ontological perspectives, I recognize, like other scholars in this field, that a positivist paradigm dominates health communication—leaving little room for the lived experiences of society's most vulnerable groups. Both academic and journalistic investigations have shown that enrollment in participants in health research studies has continuously perpetuated exclusionary research practices that build upon research systems designed to comfort white people and prioritize white people's participation in research studies (Rabelais & Walker, 2021; Tam, 2021). The imbalance in "ways of knowing" in the health communication field has caused an overproduction of research that addresses health phenomena that largely exclude the concerns of non-white, sexual, and gender-diverse populations and utilizes tools that reinforce white supremacist ideals (Rabelais & Walker, 2021; Roberts, 1999; Tam, 2021). The field's past failure to recognize and call out how the pervasiveness of anti-blackness has plagued health communication research is one of the many reasons contributing to the recent national recognition of racism as a serious public health threat (Walensky, 2021).

I argue that racism, particularly anti-blackness, is also a serious public threat to the effective health communication research generation. Racism, anti-blackness, and intersecting biases like heteronormativity, patriarchy, transphobia, xenophobia, classism, and ableism, among other societal oppressive forces, keep Black people from health research and the claims it can

make. My scholarship addresses the implications of shifting epistemes of health from a positivist paradigm to a Black feminist paradigm, where ways of knowing to resist how dominant approaches to health research reproduce anti-blackness. Additionally, I argue for the dire need for health communication to thoughtfully consider Black feminism as a life-saving praxis for studying health. As health communications scholars, we must reckon with the history of anti-blackness and its connection to the field and concede to the lived experiences of Black people (non-binary and binary, regardless of assignment at birth) as experts of their lives and bodies. By taking this approach, I utilize Black people's individual perspectives and collective experiences to produce health-related interventions that address their unique health concerns via an anti-racist approach to the study of health. Through this concession, it is necessary to revisit the fields' current dominant uses of methods, theories, research designs, data collection practices, participant pools, and other aspects of the research process. This commitment approaches the systematic silencing of Black people's experiences, the lack of understanding of their societal position, and many intersecting social identities that place them in an inescapable matrix of power that exposes them to many forms of oppression.

Throughout this dissertation, you will discover my attempts to engage with reproduction as a health phenomenon using Black feminism as a traditionally trained health communication scholar to develop and integrate anti-racist research practices to study reproductive health. Thus, this dissertation provides a conceptual and methodological roadmap for addressing health-related topics intentionally from an anti-racist approach in hopes of moving the field forward in providing health research to the public that empowers most people, if not all, to make choices that secure their ability to live healthy lives.

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INTRODUCTION

Health-related research on reproduction has largely failed to attend to the needs of Black birthing peoples' lived experiences with gestation. For example, Black birthing people in the U.S. who experience gestation have a pregnancy mortality rate that is 5.2 times higher than their white counterparts (Artiga, Hill, & Ranji, 2022). Furthermore, there is a continuous uneven distribution of access to assisted reproductive technology (ART) (i.e., fertility treatments like in vitro fertilization (IVF) and gamete intrafallopian transfer (GIFT) across intersecting social statuses of race, gender, sexuality, and class (Tam, 2021). Thus, those living with multiple societal-based deviant human differences like Black Queer folks (e.g., Black Lesbian, Gay, Bisexual, Transgender, Queer, 2-spirited, and Intersex) experience compounding forms of oppression (e.g., racism, sexism, heterosexism, homophobia, transphobia, and many more) when interacting with the health care system (Tam, 2021). Previous research and journalistic investigations acknowledge the violence enacted by the healthcare system on Black people. However, few health-related studies have included Black birthing people's storytelling about their health-related experiences (Leath et al., 2022) within research. There is an abundance of reproductive-based storytelling present in literature (oral narratives, poems, and artmaking like *She Doesn't Deserve To Be Treated Like This: Prisons as Sites for Reproductive Justice*, *Reproductive Justice: Keisha's Story*, and *Bendolph in Gee's Bend: A Reproductive Justice Quilt Story from the South* in Ross et al., 2017) from Black birthing people, but it is wholly missing in health research. I argue that identifying and integrating these missing narratives into the study of reproduction can enable the exploration of customary and unconventional health logic that can aid in understanding reproductive disparities.

“The summer of 2022 felt like the blues

The people screamed songs of despair

as the bigfoot bigot

found its way stomping up their doorsteps

crushing every(body) home" (Adams, 2023)

Like most, on the afternoon of June 24, 2022, I was glued to my social media feeds as the world reacted to the judicial ruling on Dobbs versus Jackson (2022). This news came after a month of ruminating over Justice Alito's statement in a leaked majority opinion draft: "We hold that Roe and Casey must be overruled" (Gerstein & Ward, 2022, para 3). Soon after the drafted judgment was released, Justice Roberts bellowed out his disappointment that the disclosure undermined the "integrity" of the U.S. Supreme Court's judicial process (Forgey, 2022, para 2). The Court then insisted that the leaked draft was not final. However, many of us knew then that the government would fail to protect our rights and access to abortion care. Still, I sat in disbelief as chaos ensued on my Twitter timeline. Until I came across Loretta Ross, a "Godmother to the Reproductive Justice movement's" series of tweets, which stated:

"In response to the #roeoverturned, we will continue to do what we always have done: Center the most vulnerable people in our lives to ensure that they have access to the services and information that they need" Lorretta Ross [@LorettaJRoss]. (2022, June 24).

"Whether that be paying for abortions through our abortion funds, providing safe transport, or creating a pill black market, we're going to do whatever is necessary to save women's lives" Lorretta Ross [@LorettaJRoss]. (2022, June 24)"

"We will rely on others to participate in the struggle with us – or, at least, get the hell out the way so we can do what we need to" Lorretta Ross [@LorettaJRoss]. (2022, June 24)

By then, I had already conceived my dissertation topic, been in the field of the reproductive justice movement, and sat at the feet of Loretta Ross almost a decade ago; the moment I read her series of tweets, this work became more personal than ever. The "personal is political" (Combahee River Collective, 1977; Lorde, 1984; Taylor, 2021). In this society, my existence as a Black, darker-skinned tone, physically curvaceous, underpaid, masculine-presenting lesbian placed me in an inescapable matrix of power that prioritizes the wellness of men, whiteness, wealth, and heterosexuality, among other statuses, that I would never be. These politics that position my many intersecting identities in this grid, or, as described by Audre Lorde (1980), societal "deviant" human differences, are in the same systems of power which determine the order of societal beliefs that inform the governing of protection for access to abortion care (such as the legislative decision-making). The U.S. Supreme Court's recent decision to deny the federal protection of access to abortion was because abortion legislation did not exist in the late 1800s during the ratification of the Due Process Clause (*Dobbs v. Jackson*, 2022). Thus, they argued that abortion is not a substantial right deeply rooted in the country's history. However, the Court's dispute denies genealogical evidence of abortion care and services in the U.S., particularly the archival data of all birthing people, especially those from Indigenous and Black populations (Schindler, Jackson, and Asetoyer, 2002; LaPier & Beck, 2022; Acevedo, 1979; Roberts, 1999).

To mitigate the impact of the dismantling of federal protection of access to abortion care, Ross, like many other activist scholars, propose centering Black, Indigenous, Hispanic/Latine,

and Asian individuals' narratives of their reproductive experiences– the most vulnerable birthing populations – and their access to healthcare. This centering happens through practice and theory utilizing a reproductive justice framework (RJ) that prioritizes and documents the storytelling of birthing people. RJ's crux as a frame is the historical genealogy of Black birthing people and feminists' resistance against oppressive reproductive legal discourse and their refusal to have their experiences disregarded by lawmakers (Ross et al., 2017). As Ross states (Whaley, 2019, para 10):

> "We, black women, who have been very active in reproductive politics for a long time felt like we were leaders without a constituency."

Thus, highlighting collective experiences is essential when understanding reproduction as a journey and human right – shifting the conversation of reproductive health not as an individual concern but as a collective right and the issue as a collective responsibility.

Within communal spaces, birthing people can see relations between themselves and the commonalities between past and present conversations about reproductive cruelties encountered because of their intersecting sociopolitical identities (Ross et al., 2017). Thus, by examining lived experiences with reproduction, we move beyond observable encounters to understanding more about Black birthing people's ability to make decisions about reproduction and their capacity to access care as influenced by their past and current social positionings within "Blackness," "Queerness," "income/class," and many more positions. In addition, by amplifying the storytelling of Black life, we can understand how these experiences connect to more significant sociopolitical issues that highlight the ongoing historical inequitable practices influenced by white supremacy that are the source of reproductive health disparities (Tam, 2021).

Following this imperative, RJ utilizes an intersectional approach that emphasizes the importance of pulling birthing people of color's storytelling out of the margins to the center of reproductive discourse; my dissertation "Black Queer Being/Knowing/Feeling as Discursive Terrain for Reimagining Reproduction" commits to focusing on Black Queer folks' (binary and nonbinary, regardless of sex assigned at birth) lived experiences with gestation. Through practices of community exchange and exploration (or conversations between research partners (or participants), Black feminist thoughts, and the Black Queer people's storytelling), I put into dialog a study of in-depth interviews with Black queer gestational parents and discourse analysis of the only popular television representation of a Black Queer main character's gestational reproduction: Master of None's "Moments in Love." Moreover, by triangulating analysis of fictional storytelling and people's lived experiences, I work with Black Queer folks in this study to highlight the continuities and ruptures in reproduction discourses and raise possibilities for reimagining reproduction (e.g., reproductive health services and care) through a community-based examination. This dissertation's commitment to community learning through storytelling and artmaking (e.g., the poetics, visual imagery, literature, and other forms of cultural production) of Black birthing people's lived experiences and use of bidirectional communication (between me and Black Queer thoughts) as a form of data analysis provides new sensitivities, practices, and synthesis for health communication moving forward that powerfully blend reproductive justice and Black feminism.

The connecting and furthering of Black feminist studies across the multiple fields mentioned in this dissertation provide a nuanced and complex theorizing of how discourses and institutional agendas complicate and limit the reproductive healthcare journey for Black birthing people. Together, through the sacred offering and veneration of Black Queer

being/knowing/feeling gifted in this dissertation, we demonstrate how our journeys often disrupt "common sense" about reproduction found in dominant reproductive discourses (e.g., law-making and popular media) and reveal the possibilities of birthing a world that ensures the reproductive well-being of all.

CHAPTER 1: LITERATURE REVIEW

Reproductive Justice Theoretical Framework

> "**The reproductive justice framework provided a radically different way to place reproductive health and rights in the context of the experiences of women of color** and the struggle for equality, social justice, and human rights." (Roberts, in "Radical Reproductive Justice: Foundation, Theory, Practice, Critique", 2017 pg.10) (emphasized)
>
> "[**We are] participating in the creation of yet another culture, a new story to explain the world and our participation in it**, a new value system with images and symbols that connect us to each other and to the planet." (Anzaldúa, in "Radical Reproductive Justice: Foundation, Theory, Practice, Critique", 2017 pg.63) (emphasized)

The Reproductive Justice (RJ) framework defines *reproductive justice* as "the human right to maintain "personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (Ross et al., 2017, p. 63). Theoretically, the framework includes many perspectives, such as Critical Race Theory (CRT) which is concerned with the ways that racism is inherent within societal structures and practices, Critical Feminist Theory (CFT) which identifies how race, class, gender, ability, and other social positionings are intersecting and contribute to white patriarchal systems of oppression, and Black Feminist Thought which centers Black women's self-definitions of their lives as a resistant site to oppressive structures beliefs and for ending injustices. RJ shares six major assumptions as the theoretical perspectives mentioned that influence the framework (Ross et al., 2017, p. 210), such as:

1. Relies on storytelling as primary form of communication.
2. Views racism and sexism as normal part of domination not aberrant.
3. Recognizes how elites use racism and sexism to serve them.
4. Views gender and race as social constructs, not immutable biological categories.
5. Understands how racial and gender stereotypes change over time.
6. Incorporates intersecting identities.

Black Women's Lived Experiences and Reproductive Justice

In Gee's Bend: A Reproductive Justice Quilt Story from the South, Mary Lee Bendolph, an artist, quiltmaker, and Alabama born descendent of enslaved people and Jim Crow sharecroppers, shared her experience with gestation as a 14-year-old girl during the 1940s. Bendolph and other quiltmakers of Gee Bend utilized scraps of old clothing to create quilts that not only kept them warm in their unheated slave plantation cabins but created a visual language to describe their experiences of being secluded in the rural south from society by white supremacist systems (e.g., Jim Crow, Ku Klux Klan, and many more).

> **"One day, I got ready to go to school and Mama wouldn't let me go.** I ask her why I couldn't go. She say, "You don't want to go." I kept asking her why I don't go. She say, "You big." That meant I was with a baby. I cried and prayed all day for the Lord to take it away from me, but he didn't. Nothing but made me big and fat. The first time I had sex my period came along. The next time I had sex, I got pregnant. I learnt the hard way. I got to the sixth grade. When I got pregnant I had to quit. Mama knew the school wouldn't take you when you pregnant. **They made you quit, and after you had the baby you couldn't go back to school. Soon as the school see you pregnant, you had to go home and stay. They say it**

> **was against the law for a lady to go to school and be pregnant, 'cause that influence the other children to get pregnant.** Soon as you have a baby, you couldn't never go to the school again" (Bendolph in *Gee's Bend: A Reproductive Justice Quilt Story from the South* in Ross et al., 2017). **(emphasized)**

She states, "They say it was against the law for a lady to go to school and be pregnant." Bendolph's storytelling highlights her experience with institutional-based oppression or state-sanctioned violence where the government, through legal policy, forced Bendolph out of the education system during her pregnancy due to her being a Black child and living in the Jim Crow South. In this specific example of her story, we can identify more about the legal discourse that existed during the 1940s to keep Black girls experiencing gestation outside of societal institutions, whether that be education or forced exclusion from structures via government policies. Additionally, by closely reading and exploring Bendolph's storytelling, we discover what societal beliefs or "truths" existed in discourse about reproduction relating to Black girls who experience gestation. Bendolph notes in her story that Black girls experiencing gestation in the South were restricted from returning to school based on the absurd assumption (or societal belief) that having a Black girl who is experiencing or has experienced gestation would cause other girls to become pregnant. Like many other Black girls experiencing gestation, Bendolph was considered a threat to the educational system, and the government and educational system wanted to remove them from this structure permanently.

Moreover, when we connect Bendolph's story to other Black folks' experiences in literature (e.g., *She Doesn't Deserve To Be Treated Like This: Prisons as Sites for Reproductive Justice*, *Reproductive Justice: Keisha's Story*, etc.) with gestation, we find a long history of institutional and state-sanctioned violence (via enactment of legal policies) against Black

birthing people. Similarly, scholars like Jackson (2018), in their work, discuss the ways Black birthing people (or "Black female figure/Black materal") and their experiences with gestation are historically being used as discursive sites for building societal truths about the appropriateness of womanhood and relating concepts like motherhood and sexuality. While simultaneously developing discourses (e.g., legal policies) about these issues that harm Black birthing people by excluding them from important institutions and practices of society (e.g., learning, liberty, and bodily autonomy). By utilizing the RJ framework to guide a close reading of Bendolph's storytelling of gestation as a child while living in the Jim Crow South or through other narratives like *She Doesn't Deserve To Be Treated Like This: Prisons as Sites for Reproductive Justice* and *The Autobiograhy of Assata Shakur* (in Ross et al., 2017; Shakur, 1987) we can identify how Black birthing people's experiences connect to more significant sociopolitical issues (e.g., legal policies criminalizing Black birthing people and state-sanctioned violence through the denial of reproductive care within prison systems). Additionally, I argue that connecting their stories to other Black birthing people's narratives in society can improve our understanding of the genealogy of reproduction and reproductive health disparities in the U.S.

Racism and Sexism as a Dominant and Reinforced Norms in Society

> **My suggestion is that slavery, as an experimental mode, sought to define and explore the possibilities and limits of sex, "gender, and reproduction [and to this end, all social conceptualizations]** on the plantation and beyond in a manner distinct from but relational to the assumed proper subject of "civilization," and, in fact, enabled hegemonic notions of sex/gender and reproduction such as "woman," "mother," and "female body. "I demonstrate that racial slavery as well as early modern proto-racializing conceptions of "monstrous" races and births are

> integral to ideas of sex/gender, reproduction, and indeed what it means to possess a body such that receding and emergent ideal(s) of mutability and optimization provide cover for **historical and ongoing discursive-material modes of domination that precede and surround its idealized and retroactively constructed white(ened) subject and from which historical and current biomedical and philosophical discourses** (Jackson, 2020, pg. 11) (emphasized)

As posited by theories within Black feminism and Queer studies that inform the RJ framework, racism and sexism are not deviances but a normal part of society due to the ongoing history of colonialization as seen through white supremacist global domination practices like The Atlantic Slave Trade, Jim Crow, and more historical moments of anti-black violence. Previous findings suggest that these many forms of white supremacy have caused long-term effects on our current ways of being and knowing in the U.S. For example, the effects of The Atlantic Slave Trade include:

- ongoing ethnic fractionalization (or the discouragement of the formation of larger communities and ethnic identities),
- the deterioration of legal institutions, and
- the constant placement of contemporary Black people being subject to state-sanctioned violence.

For example, during President Nixon's "War on Drugs" campaign, Black Americans were imprisoned at a rate of five times more than South Africans during the apartheid (American Civil Liberties Union, 2001, para 3), cyclical disproportionate incidents of police brutality against Black Americans (such as Mike Brown, Breonna Taylor, Latasha Harlins, and many more Black murdered by the hands of law enforcement) (Brown, 2020), and discriminatory health practices

(e.g., utilizing Black people's bodies for the development of health knowledge and health-related technologies like Henrietta Lacks) (Lacks, 2020; Owens, 2017).

Additionally, the profits of slavery and related practices have helped fund and build many modern-day institutions such as the U.S. higher education system, the U.S. presidency and dwelling, the banking industry (JP Morgan Chase), health care system (like the health insurance industry), U.S. currency, and many more influential societal structures that we interact with daily (Helligar, 2022) Those with power (e.g., elite social institutions) will use racism and sexism to serve them (Ross et al., 2017; Jackson, 2018; Spillers, 1987) to uphold white supremacy and reinforce anti-blackness by distributing many discourses that communicate their racist beliefs. For example, in the U.S., Black people have the highest student loan debt (Perry, Steinbaum, & Romer, 2021) and are least likely to receive business and housing loans from banks compared to their white counterparts (Enwemeak, Ma, & Datar, 2022; Thielman, 2015), there are increased pay gaps between Black people and their white counterparts (U.S. Bureau of Labor Statistics, 2017) and worsening health disparities in the Black community in the U.S. compared to any other racial/ethnic groups (American Public Health Association, 2021).

We do not live in a post-racial society. Incidents of racism and sexism are not the result of an individual level of deviance. They are the direct manifestations of racism and sexism already inherent in society's institutions and ways of being and knowing. Thus, RJ as a framework and its' related theoretical perspectives seek to interrogate the role of racism and sexism that is omnipresent within society and its structures. This interrogative process happens via the critique of societal and institutional practices and their promotion of anti-blackness and by examining the experience of Black birthing people to understand more about how they interact with these institutions and their agendas. Since these institutions in society, like the health care system,

media, and the government, are given the power to define and shape common sense about reproduction through their many forms of discourse, it is essential that we carefully examine how these institutions choose to discuss this conversation and whether it upholds anti-blackness ideologies.

Race, Gender, and Sexuality as Social Constructions and Sites for Interpretive Struggle

> "**Given the structural inequalities that have historically been associated with race, gender, and sexuality** for this [Black] population, my subjects cannot entirely stop thinking about or escape from categories. Therefore, I pay attention to—and sometimes (but not always) reconcile—the fractured, problematic aspects of identity. **Identity is represented in this work not as a settled status but as a lived, continuous project.** – (Moore, 2011, pg.4) (emphasized)

When Moore writes, "identity is represented in this work not as a settled status but as a lived continuous project," she speaks to the idea that one's identity and ability to name and know what one knows about their identity is forever evolving. This understanding of identity formation is particularly true for Black Queer birthing people, whose identities related to race, sexuality, gender, and motherhood are under constant discursive formation and reformation by those who can produce what we know about these concepts (e.g., dominant societal institutions through their main discourses). Previous scholars (Foucault, 1970; 1998; Moore, 2011; Jackson, 2020 Snorton, 2017) discuss the relations of power that are intrinsically entangled in knowledge or "ways of knowing" about social constructs, particularly identity within society.

For example, Foucault argues that the construction of knowledge depends on what is happening at a given historical point in society (e.g., society's social ordering), and

power is knowledge (Foucault, 1970; Foucault, 1998). Additionally, Foucault notes that power can be found everywhere and exercised over people through supreme acts of domination. Thus, dominant institutions in society (like the health care system, government, media, and other prominent structures) possess power through their mass production and circulation of many discourses that communicate their truths (on gender, race, and sex), which then become dominantly enforced on society's understandings of these topics (Foucault, in Rainbow 1991; Foucault, 1998). Jackson (2020), in conversation with Foucault, seeks to build on this theorization of the importance of history and its relationship to knowledge and the sovereign acts of domination by social structures like research as a dominant system for knowledge production on the discursive formations of sexuality, motherhood, gender, and Blackness (or Black people) by centering on Foucault's discussions of "historical a priori." Foucault states that historical a priori:

> **Concerns a fundamental arrangement of knowledge, which orders the knowledge of beings so as to make it possible to represent them in a system of names** […] This a priori is what, in a given period, delimits in the totality of experience a field of knowledge, defines the mode of being of the objects that appear in that field, **provides man's everyday perception with theoretical powers, and defines the conditions in which he can sustain a discourse about things that is recognized to be true** (Foucault, [1966], 1994, pg.157-158) (emphasized)

When Foucault says, "This a priori is what, in a given period, delimits in the totality of experience a field of knowledge" and "provides man's everyday perception with theoretical

powers, and defines the conditions in which he can sustain a discourse about things that are recognized to be true." He speaks to the importance of time as a historical juncture for which one can track and identify our understanding of what is accurate about topics and, as a result, how these beliefs inform the way we choose to live. How we choose to live is based on our belief which is influenced based on what was happening at that moment, and who has the power to define what is true and the order of those truths in our lives.

While Foucault (1998) and Jackson (2020) note that there will always be power found everywhere in society, including at sites of resistance, even in the presence of dominant ways of being, the concern I bring attention to which is similar to Jackson (2020) is whose power is widely seen and centered on when producing how things ought to be in society at large. For example, Jackson (2020) extrapolates Foucault's historical priori theory to situate the discussion on how do we know what we know about Black birthing people or the "Black materal/Black female figure" in society's current dominant beliefs and what are the historical moments that contributed to the formation of what we know about these types of people. As discussed, there are truths perpetuated by society's dominant institutions' practices throughout history that Black people are undeserving of equitable treatment with access to housing, access to quality healthcare, access to education, and freedom from state-sanctioned violence, especially Black birthing people (as seen through Bendolph's story or Breonna Taylor, and many more). To understand the importance of history and its influence on the modern Western conceptualizations of Blackness, motherhood, and sexuality, she digs into the archives of some of the most influential and early philosophical texts that help conceive current dominant understandings of these issues. To argue that gender and sex in its' creation were developed with an interest in making race a "visualizable fact," thus Blackness as a racialized category is historically

intertwined with the politics of sexual difference (Jackson, 2020, p. 6). Additionally, our current understandings of concepts related to sexuality and race are predicated on a social ordering created by earlier philosophers that made Black birthing people deviant in society due to their race and gender (Jackson, 2020).

For example, Jackson illustrates this idea further by revisiting Kant's (1757), and Burke's (1756) work with the "Sublime" or their attempt to define "the quality of greatness, whether physical, moral, intellectual, metaphysical, aesthetic, spiritual, or artistic" in society (2018). Specifically, in this work, Kant (1757) and Burke (1756) create a social ordering by defining humanism (what it means to be human), the attributes of being human (by explicating the gender binary and its relationship to ideas of morality), and its' relationship to racialized markers (such as "black" and "white"). Through interpretation of their work, Jackson discovers a connection between how in the 18th century, Black birthing people were used as a building site for the creation of normativization (or what in society is considered non-deviant), as the fundamental arrangement and rearrangement of knowledge related to sex and gender in Western globalization. For example, when seeking to differentiate the sublime from beauty by providing laws of taste in society (so what is tasteful for how a human should act and be in the world), Burke participated in both racialized and gender constructions of the two (Armstrong, 1996, p. 215).

Burke saw beauty as the equivalent of feminine and light and the sublime as masculine and dark. However, Burke, in his work, also noted that the "negro woman" could not be feminine but rather dark and masculine. Which Burke noted spoke to the "terribleness" of Blackness (Burke, [1757]). He determined his categorization of Black birthing people and their societal ordering after hearing a story about a white blind boy getting temporary sight and seeing a "negro woman" accidentally and instantly being horrified. Burke's theorization of the feminine

and masculine led to his explications of the sublime, which led to his interpretations of what people in society are aesthetically appealing. Burke's understanding of what was aesthetically appealing informed his definition of how people are and ought to be, which led to the creation of gendered and racial implications of societal normalizations relating to beauty and morality. Through his societal-based ordering of knowledge on aesthetics, sexuality, and race, his ideologies on society's ordering placed the "negro woman" outside the coding (or creation of defining normalcy) of these concepts by making Black birthing people the template for societal deviancy. Kant's (1757) and Burke's (1756) work on the sublime subsequently became one of the most prominent earlier accounts of iconographies of sexuality, and despite the absurdities of their racist thinking, are considered some of the most prolific philosophers in history. As a health communication scholar, I call attention to these historical moments and their impact on contemporary understandings of Black sexual and gender-diverse people. I am also interested in its relationship to how institutions like their health care system or health research have utilized these archaic and racist ideas of Blackness and how it has led to the unfair treatment of Black people in these systems.

The influence and significance of these historical junctions and their relationship to Black people build from Jackson’s work (2020). For example, her exploration of the earlier 18th century is a mere yet important example for understanding the importance of history in understanding how we come to know what we know about Black birthing people and how they are conceptualized in dominant societal beliefs. Also, she points to those who possess the most influence on knowledge about Black birthing people, such as white cis heterosexual men (e.g., Kant (1757) and Burke (1756), or white colonizers) through their affiliations to dominant institutions who help spread their anti-black ideologies (e.g., academia the circulation of their

works or legal colonization through the establishment of government-based protected practices like slavery). Historically, these institutions maintained white supremacist knowledge about race, gender, and humanism, particularly their understanding of Black birthing people. It is important to note that The Enlightenment Period (of Kant and Burke) or the Atlantic Slave Trade is not the only historical junctures where we see white men or white people with white supremacist ideologies being supported by societal structures and allowed to define and widely distributed truths about Black birthing people. We also see this ongoing issue of uneven distribution of power seen during the 1877-1960's Jim Crow and the government's support of acts of violence against Black communities by white mobs, the 1980 's War on Drugs which led to the mass incarceration of Black people, or the 1990's Welfare to Work Bill that led to the implementation for stricter work requirements to receive government assistance which systemically and unfairly impacted Black low-income families (Carten, 2016).

In Moore's (2011) book and longitudinal study of Black women, gay identities, and motherhood, she builds power with Black Queer birthing people by resisting the dominant knowledge offered by societal structures and centers on the narratives of Black Queer mothers by giving them space to self-define their many identities throughout their life. For example, in her book, she explores how Black lesbians have changed how they identify with their sexuality and gender-based expression depending on where they were at particular points in their lives as Black women (2011). This exploration calls attention to how Black women may experience non-linear paths in their constructions of sexual and gender-based identities, are self-aware of these changes in their many identities, and should be affirmed in their self-description (by including them in her work as the experts).

> “There’s no ifs, ands or buts about it. And I’ve know it since I was about—since seven.” [Moore] asked her what it was in her experiences with women and men that prompted her to reply in this way, she answered: **“I’ve just always known. I didn’t experience, have any [sexual] experience with men until I was almost eighteen. And that was only because I didn’thave any references to acknowledge how I was feeling**. I didn’t have**— I was the only gay person around me. I was the only gay person that I knew of in my family**. I mean, I had uncles who were kind of feminine, but they never were openly gay**. So I kinda kept how I felt in the background. And then I got to college and said, ‘To heck with it”** (Moore, 2011, pg. 25 (emphasized)

When this Black woman states, "**I've just always known.** I didn't experience, have any [sexual] experience with men until I was almost eighteen. And that was because **I didn't have any references to acknowledge my feelings.**" The excerpt above highlights how identity constructions of sexuality for Black Queer women are nonlinear and influenced by what could be understood at a particular historic moment in their lived experience. For this Black lesbian's experience, the construction of her sexuality as a "feeling" (e.g., her same-sex attraction) was not dependent on her sexual behaviors (whether she was having sex with a man or woman), but rather her inability to have the vocabulary to describe what she was feeling. The lack of "naming" her same-sex attraction as "gay" or "lesbian" was due to her scarcity of connectivity related to knowledge productions around queerness that she could relate to (e.g., having people in her life who were gay or lesbian). It is essential to acknowledge how knowledge productions related to queerness for Black people have evolved within history and its influence on how Black Queer individuals construct their own racial and sexual identities (Snorton, 2017; Spiller, 1987).

By centering on the experience of Black sexual and gender-diverse people and relying on their definitions of self, it provides us clarity within the health field to understand and develop culturally specific health information that addresses their unique health concerns.

This text makes me think about questions like this, "What if Black Queer birthing people were able to look at their life moments and define their own identities?" Second, "Are Black Queer birthing people able to self-define and have their definitions represented in societal institutions?" Third, "What are the current truths distributed about Black Queer birthing people in societal institutions, and do they align with Black Queer birthing people's experiences?" Lastly, "What are the potential dangers for Black Queer people when dominant societal institutions do not give them the power to have their feelings and emotions about themselves included in societal structures' truths about them?"

Incorporating Intersectional Identities as a Research Practice for this Dissertation

The last assumption of RJ is the importance of including intersectional experiences in the study of reproduction and reproductive politics (Ross et al., 2017). As mentioned, through the explication of the other five assumptions of RJ, Black Queer birthing experiences are scarcely included in conversations related to reproduction and discourse in general about sexuality, race, and gender. Thus, this dissertation seeks to engross future studies in Chapter 2, Chapter 3, and Chapter 4 in the perspectives (e.g., lived experiences, theoretical lens, and self) of Black Queer individuals within a reproductive justice framework. Meaning, how Black Queer birthing people desire to have children, not have children, have control over their bodies, and how they desire to raise their children to serve as the authoritative voice for the study of reproduction.

Lastly, I recognize my intersectionality as a Black lesbian scholar producing research relating to reproductive health. This understanding acknowledges how I contribute to knowledge

production about Black Queerness and reproductive health via research such as this dissertation. I am not a researcher who claims objectivity; I am critical of "truths" offered by social structures and people who do not center the experiences of Black Queer birthing people. I recognize that there is always resistance to the presence of dominant discourses distributed in society that rely on anti-blackness and heteronormative restrictions to define Black Queer birthing people's experiences with identity and reproduction. My job as an activist-based scholar is to center on that resistance by employing perspectives via storytelling from Black Queer birthing people and research from Black scholars within a justice-oriented framework like RJ that centers on Black birthing people's wellness throughout this dissertation. With this approach, I build power with Black people (regardless of assignment at birth) as experts in their lives and conversations about reproduction, as a lifesaving praxis for reimagining reproductive politics, healthcare, and services.

RJ's Influence on the Dissertation's Study on Black Queer Reproduction

This Dissertation, moving forwards, includes a Black feminist media-based analysis of a popular television show's depiction of a main character's assisted reproductive technology (ART) journey as a Black Queer woman (Chapter 2), a study of in-depth interviews with Black Queer birthing people about their experiences with gestation (Chapter 3), and essay about the future of reproduction health, services, and politics as reimagined via Black Queer justice-oriented lens (Chapter 4). Chapter 2 addresses several of the tenets offered by the reproductive justice framework by conducting a discourse analysis of the only television show to include the ART experiences of a Black Queer couple to explore how an institutional structure like the media distributes and creates discourse about Black Queerness and Black Queer reproduction. The

overarching research question that guides Chapter 2's analysis of the television show Master of None's "Moments in Love" is:

RQ1: What dominant and disruptive discourses are illuminated in the storytelling of Master of None's Moments in Love, the only media depiction of Black lesbian reproduction on popular television?

By addressing this research question, I explore the ways that the show reinforces dominant societal understandings of Black Queerness that rely on heterosexism and anti-blackness while also highlighting how the show offers disruptive discourses on reproduction by centering the ART experiences of Black women-loving-women in their television narrative. Additionally, through my analysis, I demonstrate how media can be utilized as a pertinent site for the tracking of dominant discourses about Black Queer reproduction that is circulating within society and offer insights on how television can be used more effectively as a disruptive platform by offering discourse that overthrows beliefs about Black Queer reproduction that can be contradictory to these individuals lived experiences.

RJ, as a framework, posits storytelling as the primary method for understanding the reproductive experiences of Black birthing people. Thus, Chapter 3 of this Dissertation reengages and intentionally centers the lived experiences of Black birthing people in society to build power and affirm their lived experiences with gestation via storytelling. Therefore, the overarching research question for Chapter 3 is:

RQ2: What are Black Queer people's experiences with gestation?

Additionally, through in-depth interviews, I explore with the partners (Black birthing people) how their many intersecting identities, such as race/ethnicity, gender, gender expression, sexuality, financial stability, and ability, among other factors, influence their gestational

experiences within healthcare settings. By exploring these partners' social statuses, I demonstrate the importance of looking at reproduction from an intersectional lens, as noted by the RJ framework. Additionally, through their storytelling, I explore their interactions with several societal institutions with the partners as they navigate their gestational journeys. Additionally, I expand health research on Black Queer reproduction and the use of the RJ as a framework by primarily focusing on the lived experiences of Black Queer birthing people via a justice-oriented approach – a research perspective and population not commonly employed in health communication research.

As a Black feminist in health communication, I was interested in merging the skillsets of my training as a health communication scholar (e.g., analytical coding practices) to understandings coming from several Black Queer gestational experiences. I am taking this approach because I recognize that Black feminism as a perspective has no specific methodological approach but instead provides sensitivities to the study of Blackness. Black feminism is concerned with how we center as scholars on Black women's (regardless of sex assigned at birth) storytelling to help understand their experiences in society. Similarly, RJ helps you identify what type of data you want when studying reproductive justice and shapes your understanding of what a justice-oriented approach looks like examining reproduction. Thus, for Chapter 3, RJ and Black feminism was utilized to justify the centering of Black birthing people's storytelling of their gestational experiences for our understanding of Black Queer reproduction and reproduction rights and health from a justice-oriented approach.

Lastly, to further center the lived experiences of Black Queer birthing people as lifesaving praxis for reimagining reproduction, I explore via series of poems and art-makings the future of reproduction utilizing insights of Black Queer folks from chapter 3, in the world,

literature, RJ leaders, and myself. Thus, the last overarching research question for this Dissertation is:

RQ3: How can we reimagine reproduction when utilizing Black Queer being/knowing/feeling as Discursive Terrain?

By addressing this research question in Chapter 4, I discuss the importance of reimagining a world prioritizing the reproductive needs and desires of society's most vulnerable populations – Black Queer birthing people. This reimagining includes insights on addressing equitable reproductive health care treatment and access to health services within the health care system by discussing issues like anti-blackness, transphobia, fatphobia, homophobia, and many more inequities. Additionally, I discuss reproductive politics, such as critical law-making policies and bills needed to attain reproductive justice. Also, I address the conditions and desires needed for people to raise their children and live safely, such as addressing environments ridden with state-sanctioned violence.

Lastly, I address the future of health communication via a radical Black feminism lens via the original creation of health material that includes Black Queer reproductive experiences perspectives from Chapter 3. Thus, Chapter 4 sought to wholly and freely unbreak the study of Black Queer reproduction from dominant research practices commonly utilized in health research by employing the oppositional knowledge of the research partners and me in this study by centering on our expertise as Black Queer people. Through this approach, I reimagine health research practices and our understanding of reproductive health care, information, and access.

Essential Concepts and Language utilized in this Dissertation as informed by RJ

Before diving into the Dissertation, it is necessary to address the essential concepts and language utilized within this study to address Blackness, Queerness, and reproduction. RJ, as a

framework, stresses the importance of including intersectional perspectives to discuss reproduction. It is pertinent for this study to use language that includes all sexual and gender-related experiences of people in society while also relaying this information in a way that allows the reader to easily follow along with the discussion of sexual and gender diversity. Thus, when you see Black Queer/Queerness in this study, I am referring to the Black-identified people who identify with sexualities or gender/gender expressions that fall outside the norms of heterosexuality. The norms of heterosexuality in this paper are defined as an everyday mode of being human that assumes that sexuality is binary or tied to ("male" or "female"), that gender relies on biological determinants, and that one's sexual or romantic relations are tied being partnered or with someone of the opposite sex. Therefore, in this Dissertation, when I reference Black birthing people, I am referring to Black identified people who can biologically reproduce (regardless of assignment at birth). When I reference Black Queer birthing people, I am speaking about Black birthing people who uniquely have sexual orientations outside of heterosexuality. Additionally, "Black" in this study refers to individuals who encompass the African or Black diaspora, such as but not limited to African/Black Americans, Afro-Caribbeans, Afro-Latin Americans, and Black Canadians. Lastly, it is essential to note that this language will vary when describing Blackness and Queerness in Chapter 3 (in-depth interviews) as partners are encouraged to self-describe their identities to build power and affirm their understandings of their identities.

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CHAPTER 2: MOMENTS IN LOVE: REDEFINING "BABY-MAKING"

BACKGROUND

During the summer of 2022, the highest federal court in the U.S. judicial system ruled that abortion-related care and services were not an essential nor protected right for the American public (Mangan & Breuninger, 2022). Following the Supreme Court's decision, there was an outpouring of criticism from historians, parents, activists, foreign leaders, and birthing people who condemned the ruling of Dobbs vs. Jackson Women's Health Organization that overturned Roe vs. Wade (Center for Reproductive Rights, 2022). Many also questioned how the overturning of abortion access would impact other federally protected rights. For example, the judicial precedent that recognized access to abortion was also the bedrock for protecting many rights, such as interracial marriage (Loving v. Virginia), same-sex marriage (Windsor v. United States and Obergefell v. Hodges), and contraception (Groswold v. Connecticut) (Shutt, 2022). During these unprecedented times, it is now more important than ever to understand the U.S. public's discourse about reproduction. More specifically, how people's experiences, feelings, and thoughts about reproduction coincide with the changes in legal discourse about access to reproductive health care and services in the U.S. Television is a major part of society's cultural production of topics related to reproduction and sexuality.

As scholars have previously discussed (Hall, 1973; McRobbie, 2013; & Rottenberg, 2017; hooks, 2006), television is one way that culture talks to itself. Over the years, it has been pertinent to understanding reproduction discourse (Luna, 2019; Edge, 2014). Scholars suggest that television has offered a "back door" reality to people's real-life experience with family-forming. However, as seen through literature, traditional television discourse about reproduction has been dominated by a heteronormative lens that commonly depicts the family-forming

journeys of heterosexual, cisgender people —leaving little room for an understanding of the reproductive experiences of sexual and gender-diverse people. Thus, hook (2006) suggest this patriarchal culture perspective dominated by popular media like television makes it an important site for critique to understand how this problematic aspect of mass media is normalized.

Thus, this current study utilizes a Black feminist lens alongside a reproductive justice framework (RJ) (hooks, 2006; Crenshaw 1989; Collins, 2000; Ross, 2006) to justify the centering and critical interpreting of one television show's (*Master of None's* "Moments in Love") unique role in shaping and circulating dominant and disruptive reproductive discourses about Black Lesbian, Gay, Bisexual, Transgender, Queer + (Queer*) individuals to its audience. *Master of None's* "Moments in Love" is the first televised scripted series to present the assisted reproductive technology (ART) journey of two Black "women loving women." Thus, this show becomes a rare yet pertinent artifact for the exploring and tracking of discursivity related to reproduction. Through interpretations of the television show, the current study explores the intersection of identities such as race, gender, sexuality, and ability, among others, and the societal-based cultural power relations connected to them to interpret how these social statuses influence access to reproduction for its main characters. Furthermore, the exploration of the show's discourse about reproduction for Black sexual and gender-diverse women leads to a discussion about the consequential nature of television in its ability to develop and distribute an understanding to a mass audience about Black Queer women and ART. Lastly, I discuss how television recycles traditional beliefs about reproduction and how it can counter society's dominant family-forming ideologies by presenting alternative content for the audience's active interpretation.

LITERATURE REVIEW

Television as a Site for Reproductive Discourse, Heteronormativity, and Family-Forming

Television is a consequential site for producing normative frames for its' mass audience and introducing the audience to varying ideas about society's culture (hooks, 2006; McRobbie, 2013; Rottenberg, 2017; Hall, 1973). Traditionally, heteronormativity has been the dominant normative framework utilized to produce television discourse. For example, according to the Gay and Lesbian Alliance Against Defamation (GLAAD) 2021 report, only 9.1% of series regular characters that appeared on U.S.-based scripted primetime television represent the Queer community (Lasky, 2021), making heteronormativity and its' norms pervasive throughout character representation and story narratives.

Consequently, the majority of television about reproduction (e.g., family-forming journey) is primarily dominated by the storytelling of heterosexual, cisgender couples (e.g., "mother" – woman and "father" – man) creating children through sex or assistant reproductive technology (ART). For example, critically acclaimed series like *Sex in the City* and *Grey's Anatomy* have reached a significant physical reach and a large cultural television audience and introduced their viewers to an assortment of ideas about reproduction. Two significant ideas presented in those series' conversations are the types of people who experience gestation and how people conceive a child. In each of these shows' narratives, the characters' identities play an important role in their access to reproduction. For example, both shows depict reproduction via various episodes of their main characters through the lens of heterosexuality, cisgenderism, and overwhelming level of financial stability. Despite shows like *Sex in the City's* recent strides in depicting the reproductive stories of Queer individuals, the storytelling is reserved for characters with dominant statuses in race and gender (e.g., white cisgender women). Once again, leaving

little room for the representational family forming experiences of individuals who live outside society's dominant ways of being (e.g., Black Queer individuals). Heteronormativity is not only reserved for conversations about gender and sexuality; it intersects with depictions of race, class, and ability. This intersection reveals the "complex matrix of power" that underpins heteronormativity where even white women's stories about reproduction are privileged (McIntosh, 2017) over Black birthing people's experiences.

Black Queer Individuals' Access to Reproductive Health Care and Services

As shown in health research, television's usual depictions of who primarily gets access to reproductive health care and services sometimes aligns with what is happening in the real world (Ross, 2006). Previous scholars within Black feminism and health have documented how reproductive health care access is granted based on person living with dominant statuses within race, gender, sexuality, class, etc. (Luna, 2019; Ross, 2006; Tam, 2021). Heteronormativity is present within the health care system and prevents birthing people, especially those who are gender and sexually diverse, from getting quality health care (Mamo, 2013; Mamo & Alston-Stepnitz, 2014; Roberts, 2009; Roberts, 1999; Hartnett, Lindley, & Walsemann, 2016; Kates et al., 2018; NLGBT Health Education Center, 2019). Current government-informed policies that regulate reproductive health care advancements in assisted reproductive technology (ART) position this technology as a cure for infertility or low fertility (Tam, 2021). These heteronormative regulatory practices assume that those who access family-forming technology are dealing with difficulties with conception due to fertility issues. However, individuals like Black "women loving women" are not inherently infertile, nor do they always have fertility issues; they are *queer*.

Whether it be through racial stereotyping or sexual and gender-based discrimination, Black Queer individuals experience significant difficulty when navigating the health care system, even when compared to white Queer individuals (Mosley, Abreu, Crowell, 2017; NLGBT Health Education, 2019). These barriers encountered when accessing health services, care, and information, ultimately inhibit people who are Black and Queer from making sound personal health decisions about their bodies in traditional health care settings. Thus, scholars interested in reproductive health care should examine how power relations become evident through individual statuses in sociopolitical identities along their family-forming journeys when accessing the health care system.

Intersectionality, Reproductive Justice, and Television

When describing identity, whether collective or self, Black feminist understand identity as not fixed but fluid and under constant negotiation of what can be understood historically, politically, or culturally at that time (Collins, 2000). Crenshaw highlights the influence on identity-related politics and discusses how the intersection of identities serves as a lens in where we can see where power collides (Crenshaw, 1989). Identity-related markers are present in a television show's discourse, like visualizations of the characters and through character dialogue (Hall, 1973). Thus, television becomes a critical media site for understanding the representation of identity. Following this imperative, hooks (2006) notes that it's important that we not only acknowledge media as a pertinent site for representation but critique mass media and the culture it presents that may be deemed as unproblematic but actually undermines the truth of one's many identities in real-life. Previous scholars like Osborne-Thompson (2014) and Edge (2014) in their works discuss television's role in presenting information about the relationship between access to ART and individuals' sociopolitical identities, specifically among wealthy heterosexual

(cisgender) celebrities of various racial/ethnic backgrounds. Their studies call attention to the importance of television as a site for tracking discursivities (or understandings) about reproduction and then presenting these varying ideas to their audiences. However, the scholars' conversations are limited to the experiences of primarily white women utilizing ART.

In recent developments about the relationship between television discourse and reproduction, Luna's (2019) seminal research seeks to disrupt normative discussions about reproduction through her discussion of Black heterosexual (cisgender) women celebrities and non-celebrities' storytelling of accessing ART on television talk shows. Through her interpretations of the talk shows, guided by reproductive justice, she discusses how Black women resist and affirm the reproductive health norms established by heteronormativity. Luna argues that through this targeted analysis of Black women's narratives, commonly excluded from reproductive health discourses, these stories provide the viewers with the space to redefine and expand or "Queer" their traditional normative beliefs about reproduction. For example, in Luna's study, television talk shows' narratives perpetuated falsehoods about Black cisgender heterosexual women and fertility issues (e.g., Black cisgender heterosexual women are highly fertile). Alternatively, the television narratives also resisted stereotypes about Black women (e.g., Black cisgender heterosexual women must conceive at a certain age). Luna's exploration demonstrates the consequential nature of television discourse about family forming by showing how the issue presented can either resist or accept the societal ideals of Black women and their gestational experiences.

Luna (2019) pushes the needle further compared to Osborne-Thompson (2014) and Edge (2014) by highlighting how the intersection of these Black women's social statuses in race/ethnicity, gender, and wealth identities and the power relations connected to these identities

becomes evident along these women's journey with ART. An analysis is needed for these women's journeys as disparities in family-forming technology outcomes have been continuous for Black women for decades (Davis, 2020). However, this research is again limited to the television storytelling of individuals' experiences in dominant normative categories of gender and sexuality.

My current study seeks to add to the minimal literature on television storytelling of Black sexual and gender-diverse people's experiences with family forming. Like, Luna (2019), I utilize a reproductive justice framework alongside Black feminism to discuss what can be understood about society's beliefs about Black sexualities and access to reproductive health care, services, and discourse when interpreting a television series about Black Queer reproduction.

CURRENT STUDY

Specifically, this study centers on the narrative-based experiences of Black Queer people by analyzing the television series *Master of None's* "Moments in Love." This Netflix series highlights the experiences of two Black "women loving women" characters and their reproductive health care journey utilizing ART. I use a Black feminist perspective (hooks, 2006; Crenshaw 1989; Collins, 2000; Ross, 2006), and an RJ approach to justifiably center and interpret how "Moments in Love" explores the identities of its main characters to discuss the societal-based cultural power relations connected to them and their influence on their reproductive health journey. Thus, the two questions that guide this exploration are:

RQ1: How does "Moments in Love" depict the intersectional identities of its characters during their reproductive health care journey?

RQ2: What does the show's narrative tell us about cultural power relations through its depiction of these characters' reproductive health care journey?

By addressing these research questions, I discuss “Moments in Love’s” role in reaching a mass audience and introducing its audience to varying ideas about reproduction and Black Queer women by interpreting the show's visual representations and character dialogue. Lastly, I demonstrate how the show's depiction of Black Queer women and their baby-making journey disrupts and upholds the heteronormative norms usually associated with society's traditional beliefs about reproduction ordinarily presented on television. Even though these characters are fictional, the show gives insight into the reproductive discourse distributed widely to television audiences about Black Queer women – potentially offering a backdoor view to society's many beliefs about family forming.

METHOD

Materials

The Netflix series *Master of None* is a Primetime Emmy and Golden Globe award-winning television show, created and directed by Aziz Ansari and co-written by Lena Waithe. Waithe and Ansari were awarded the 2017 Primetime Emmy Award for Outstanding Writing for a Comedy Series for Season 2's *Master of None's* "Thanksgiving" episode. The episode details the experience of the show's character, Denise, played by Waithe, and is inspired by her real coming out story as a lesbian to her family (Butler, 2017).

As a continuation of Denise's coming out story and inspired by Waithe's real-life marriage, Season 3 of *Master of None* ("Moments in Love") follows Denise and her wife, Alicia's family forming journey via ART. In a five-episode season, the viewers follow the emotional, mental, and physical process of the couple's family-forming journey and its impact on their marital relationship along their ART journey due to the emotional strain caused by an unexpected miscarriage, bouts of infidelity, the couple divorces. The show then depicts the ART

journey for Alicia, a single, Black Queer woman, and the challenges she encounters in getting pregnant. Since *Master of None's* “Moments in Love” is the only season that focuses on the reproductive health journey of Black Queer women, I focus the qualitative analysis solely on this season. Moreover, only the first four episodes (~188 minutes) of this season detail the ART journey of the main characters. Thus, I did not include episode 5 in my interpretations of the show's discourse. I selected *Master of None's* "Moments in Love" because it is the only scripted popular television show to date that details the experience of Black Queer women utilizing assisted reproductive technology.

Approach

To help with my interpretation of how *Master of None's* "Moments in Love" explores the multiple, intersectional identities of its characters along their reproductive health journey, I utilized the varying transdisciplinary perspectives from the reproductive justice framework (e.g., Black feminist theory, intersectionality, queer theory, and critical race) (hooks, 2006; Crenshaw 1989; Collins, 2000; Ross, 2006) to make meaning of the show's text. Specifically, I was interested in not only the representation of the main characters’ multiple, intersectional identities on the show, but the performance of these identities, and the presence of power through the lens of intersectionality. I viewed the show several times between its release on Netflix in Summer 2021 to Summer 2022. All episodes were available to stream to the 18 million platform subscribers.

Analyzing the Materials

The first full watch provided a contextual overview; the second provided an analytical frame and theoretical constructs of interest to map. The third was a complete analysis, field notes, and qualitative coding. I identified the dominant plot points, characters, technologies, and

institutions during the first analysis stage. Additionally, I identified how the show depicted the reproductive health care journey of the main characters via the character's visual representations (e.g., skin color, clothing, hairstyles, etc.) and any dialogue along their reproduction health journey. The second watch provided the basis for identifying broader themes (Luna, 2019) about the reproductive journey of the characters in dialogue and visual representations identified within the show. The final viewing was performed through field notes, transcriptions, including visual cues and observances related to the broader identified themes about the reproductive health journey of the main characters pinpointed in the previous stages.

Following that, using a Black feminist lens and the RJ framework, I triangulated my multiple data points (e.g., transcriptions of audio-based dialogue, visual cues, observances, and broader themes) (Patton, 1999) to interpret the show's discourse. My close reading of the show's content and qualitative analysis of my identified data points helped me understand: 1) how the show explored the multiple, intersectional identities of the characters; (2) what the show's storytelling depicts about cultural power relations through its showing of the characters' reproductive health care journey; and (3) what possibilities about reproduction and Black Queer women the show introduces to its audience.

FINDINGS

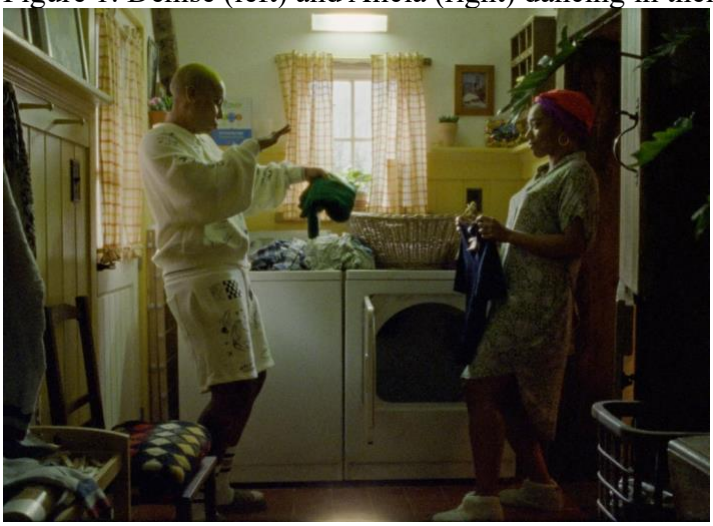
Master of None's Moments in Love Exploration of Intersectional Identities

Master of None's "Moments in Love" presents a diversity of ideas about reproduction and Black Queerness via creating and distributing a narrative that follows two main characters, Denise and Alicia. The main characters embody multiple intersecting dominant and non-dominant sociopolitical identities that are not normally shown on television for those embarking on the family-forming journey (Lasky, 2021). Specifically, through this discussion, I unpack

ideologies presented by the show to its audience about Black Lesbian love, Black Lesbian community-based norms about gender and gender expression, Black Indigeneity, and Black Queer individuals and socioeconomic mobility.

Black Lesbian Love and Community-based Norms about Gender and Gender-based expression

Figure 1: Denise (left) and Alicia (right) dancing in their laundry room



In this scene (Figure 1), we find Denise and Alicia dancing and folding laundry together in their cottage. The two characters exchange flirtatious smiles, giggles, and warm embraces, and the audience is immediately met with images of two Black "women loving women." The ideas of romantic-based Queerness and Lesbianism are visually depicted through the characters' many layers of emotional and physical affection exchanged among one another throughout the series. In another scene, we see Denise almost nose to nose with Alicia, holding her tenderly and expressing to her wife, "This brown-on-brown love is going to work." In both these scenes and many of the show's moments, the audience is introduced to what romantic chemistry and partnership could look like when two Black women love one another. These moments are a rare as the characters break through the glass ceiling of the traditional heteronormative depictions of

love usually offered by television and show new possibilities of what intimacy is and what types of people experience intimacy with one another.

The viewers are also introduced to two Black women through Denise and Alicia's physical attributes (e.g., clothing, hairstyles, skin color, bodies). However, the depiction of what womanhood can look like through the two characters' expressions of gender is different from one another. For example, in Figure 1, Denise wears a two-piece, baggy sweater and short set, shorts slightly sagging off Denise's body, Yeezy sandals, and a colored natural "fade" haircut that is shortly tapered on the side. Alicia wears a “house” dress, and low-cut slipper, a headscarf, and gold hoop earrings. The show offers its' viewers varying and novel possibilities of what gender expression via clothing and personal grooming can look like for Black women. Once again, a unique perspective not commonly seen on television as Black girls and women are normally shown via the physical attributes of "European standards of beauty" and are more likely to be shown in revealing clothing than white women (Geena Davis Institute on Gender in Media, 2019). Additionally, Black women are less likely to be shown on television in a romantic partnership compared to white women and other women color (Geena Davis Institute on Gender in Media, 2019).

While the expression of the main character's gender is a non-dominant depiction of Black women on television, it is also a dominant depiction of the gender identity-related norms that are seen in the different types of expressions of womanhood within Black Lesbian communities (Reed et al., 2011; Lane-Steele, 2011; Moore, 2011; Wilson, 2009; McMickens, 2020). These primary dominant gender expressions within the Black Lesbian community include:

1. A "stud" (signifying a Black woman who is masculine in the presentation of self).
2. A "femme" (signifying a Black woman who is feminine in the presentation of self).

3. "Stemme" (signifying a woman who is fluid in femininity and masculinity in the presentation of self).

Within *Master of None*, Denise is visually representative of a stud and Alicia as a femme. Previous literature suggests that stud and femme are the dominant dating dynamics norms within the Black lesbian community (Wilson, 2009). Thus, the show's representations of Denise and Alicia's romantic partnership, gender and gender-based expressions, and sexual orientation subvert the heteronormative norms commonly depicted about two Black women on television. While also reaffirming the dominant Black lesbian community norms of how two Black women express gender in an intimate relationship. Though the show's depictions of varying gender expressions open a window of opportunity to its' audience of how Black Queer women can look on television, it still, at the same time, promotes a dominant viewpoint of Black Queer love.

Black Indigeneity

Despite Denise and Alicia's shared race via Blackness in physicality (e.g., skin tone), their positioning in this social status is different. Throughout the show, the audience is presented with varying accents between Denise and Alicia via their audible dialogue. For example, Denise speaks with a deep Chicago (American) drawl and Alicia with a British accent. Through the characters' speeches, the show introduces the audience to the expansiveness of the African diaspora and the true complexity of Blackness that can be primarily attributed to the Transatlantic Slave Trade (Brazelton, 2021). Television is identified as a critical informational source of America's racial education (Leonard & Robbins, 2021). Unfortunately, past research shows that television has distributed narrow representations of Black people for decades, mainly via colorblind casting (Leonard & Robbins, 2021). Colorblind casting in television means characters are chosen for a show without critical or real consideration of people's experiences or

identities. “Moments in Love’s” representation of Blackness introduces the television audiences to a non-dominant perspective of Black characters where Blackness is not monolithic regarding indigeneity.

Black Queerness and Socioeconomic Mobility

Figure 2: Denise and Alicia’s 150-year cottage’s living room

"Moments in Love," through character dialogue and visual representations of Denise and Alicia's lifestyle (via clothing and living arrangements), introduces the audience to the socioeconomic mobility of Black women that is commonly seen on television, but which also conflicts with what is understood about Black Queer women in real life. For example, in Figure 2, we see Alicia and Denise's living room in their 150-year-old cottage in upstate New York. The house has vibrant snake plants, antique furniture pieces, and rare artworks from artists, such as mid-20-century photographer Carrie Mae Weems, whose pieces auctioned off for upwards of $300,000. From these visual representations shown in the series, the audience is introduced to a Black lesbian couple that is financially more than "well off." For example, in one of the show's scenes, the audience discovers that Denise is a New York Times best-selling author, and Alicia is a buyer and seller at a rare antique shop in New York City.

While depicting wealthy Black women is not new to television viewers (Nicholas, 2022), the existence of Black Queer people having wealth in the real world is nearly non-existent. For example, Black Queer people in the U.S. experience significantly higher poverty rates than their white and Black, heterosexual, cisgender counterparts (Badgett, Choi, & Wilson, 2019). Additionally, 39% of Black Queer individuals live below the poverty line, making as little or below $24,000 annually, leaving almost 40% of Black Queer individuals food insecure within the last year (Choi, Wilson, & Mallory, 2021). While "Moments in Love" introduces the audience to the possibilities of what a wealthy Black Queer couple's lifestyle could look like, it is a mere fantasy compared to the real lives of these individuals. This show's non-dominant perspective is the storytelling of a world where Black Queer people are not gatekept from the luxuries that wealth can provide. However, it is an imaginative viewpoint that even the top financial Black Queer earners within the U.S. cannot access. This depiction leaves the unanswered question of what type of representation of Black Queer people is best suited for television storytelling – is it actual or fictitious representation?

Cultural Power Relations through the Character's Sociopolitical Identities & ART Journey

Previous discussions of *Master of None's* "Moments in Love" depictions of the main characters' sociopolitical identities highlight the show's role in introducing its audience to non-dominant and dominant ideologies about Black Queer women. Next, through my interpretations of the show's discourse, I discuss how societal-based cultural informed power relations become evident through the main characters' positions in their many sociopolitical identities along their family-forming journey. Broadly, throughout "Moments in Love," power relations come into play via Denise and Alicia interpersonally with one another and their interactions with institutions (e.g., the health care system) along their baby-making journey.

Interpersonal Cultural Power Relations

Figure 3: Denise and Alicia's conversation about baby-making

The scene, in Figure 3, in "Moments in Love" depicts Denise and Alicia having a conversation about starting the baby-making process. Alicia comes to Denise, letting her know she is ready to have a child and waiting for Denise's approval as her partner. Alicia states:

> "I don't want you to say that. I know you're gonna say you…let's wait, let's wait another year."
>
> **Denise:** "That's not what I was gonna say; let's wait until the dust settles."
>
> **Alicia:** Audible laughs, "Oh my gosh."
>
> **Alicia:** "You know what? All I'm saying is I don't wanna be 52 and pregnant. I'm 34 years old. My ovaries there are starting to get stale."

This segment of the conversation between Alicia and Denise highlights the cultural informed power relations between couples within society on a family-forming journey. Specifically, Denise, in this scene, is exercising reproductive decision-making power over Alicia.

While Alicia could reproduce autonomously without Denise, she still seeks her partner's emotional support and approval to make the final decision. Denise's decision-making power over Alicia's reproductive experience is seen similarly in research about Black lesbian community norms and the family-forming journey. For example, research suggests that among Black Lesbian couples, the decision-making power to have children or not is normally held by studs in the relationship. Black women identifying as studs in the Black Lesbian community, like Denise, are equated with having dominance in their romantic partnerships, where studs determine whether the family-forming journey can happen in a relationship with their femme partners (Reed et al., 2011).

In their study (Reed et al., 2011), scholars detail how the studs' decision-making power in their romantic partnerships is connected to Black Lesbian community standards of appropriateness. These standards of what is appropriate for studs versus femmes influence the reproductive health process for Black lesbians. For example, Black women who identified as studs discuss not experiencing gestation as the pregnancy process is seen as journey for only femme-identified Black women. Additionally, the studs mention that if they get pregnant, they risk losing their dominance in the Black Lesbian community and their relational experience with their femme partner. These examples of interpersonal relations of power happening between Black lesbians in romantic partnerships along the reproductive journey are influenced by the heteronormative patriarchy. The heteronormative patriarchy is a sociopolitical system where those possessing attributes associated with masculinity are given authority over those with attributes that are associated with femininity (Arvin, Tuck, & Morrill, 2013). In the case of “Moments in Love,” Denise's proximity to masculinity via her identification as a masculine-presenting woman afford her the highest cultural power compared to her femme presenting

partner, Alicia. Denise's cultural power becomes evident by exercising the decision-making of whether Alicia begins her baby-making journey. In this example, the show introduces the audience to non-dominant discourse about who can reproduce not usually seen on television by detailing the family-forming experiences of Black Queer women. While also reaffirming normative beliefs offered by the heteropatriarchy about the roles of the masculine and the feminine along the family forming journey.

As the show progresses, Alicia experiences a reclamation of decision-making power and autonomy over her reproductive experience upon the couple's divorce. The show then introduces a cultural informed power relation in the interpersonal relationship between Alicia and Denise when Alicia decides to continue her journey with baby-making via ART as a single Black Queer woman. The show's depiction of Alicia's baby-making journey is unique for television discourse and real life. As discussed, heteronormativity is the dominant frame for depicting pregnancy on television, where achieving pregnancy is reserved mainly for couples. Additionally, the norms associated with the Black lesbian community suggest that femme partners need a stud or a masculine figure to start the family-forming journey. “Moments in Love” shows an alternative perspective to family forming by introducing the audience to the non-dominant idea that single Black Queer women can utilize ART without an intimate partner's emotional, physical, or financial support.

Institutional Cultural Power Relations

As a couple and individually, Alicia and Denise experience multiple interactions with the health care system along their baby-making journey, where societal-based cultural power relations become evident due to the characters' sociopolitical identities. For example, in one

scene, Denise and Alicia experience at-home insemination, where they work together to have a baby.

Denise: "Okay, legs up."

Alicia: “Make sure you ain't got no air bubbles in there."

Denise: “I got it. There’s no air bubbles in it. And…Oh Jesus this is gross. Here we go."

Alicia: “You good. You good”

Denise: “Okay, yeah, that’s all of it.”

In this scene, detailed above, Alicia lies on the couple's bed with both legs in the air as Denise inseminates the sperm. Within this scene, cultural power relations exist with the couple as Black Queer women and their ability to completely subvert the health care system by undergoing the insemination process on their own. “Moments in Love’s” depiction of the at-home insemination process is a non-dominant perspective on family-forming not commonly seen on television. However, the idea that Queer people subvert the health care system in this way is shared frequently among the Queer community. For example, in the U.S., the most common fertility treatment among LGBTQ+ couples is at-home insemination, also known as the "turkey baster" method. For Queer couples, it is often more straightforward and less expensive than utilizing ART services offered by fertility clinics ("Extend Fertility," 2020).

Previous literature documents that white Lesbian couples utilizing ART via fertility clinics to conceive found it to be a "stressful journey through the heteronormative world." These findings highlight the negative emotional consequences lesbians encounter when accessing the health care system (Engström et al., 2018), which is more than likely magnified for Black sexually diverse women (Tam. 2021; Luna, 2019; Davis, 2020). The show's depiction of the

characters' at-home insemination introduces its viewers to an inside view of what Black Queer couples may experience along their reproductive journeys and how these couples may reclaim their reproductive power over institutions like the health care system along this journey.

Later, due to Alicia's miscarriage and, subsequently the couple's split, Alicia decides to continue her journey with family forming via In Vitro Fertilization (IVF). Throughout the series, Alicia, as a single Black Queer woman, encounters many challenges from the medical insurance company along her IVF journey. For example, in one scene with Alicia and her fertility doctor, the doctor states (text bolded is my own):

> "One thing we need to factor in is cost. **Your insurance company does cover IVF, but it's complicated**. We have to prove that you are infertile and that you have been trying to **conceive with a partner for six months."**
>
> **Alicia**: "What does that mean in regards to me and **my sexuality?"**
>
> **Doctor**: "The insurance company needs a diagnosis code in order to confer benefit**. The majority of American insurance companies do not have a code for "gay and desires pregnancy" or "single and desires pregnancy**." They have a code being attacked by an orca, and they have a code being sucked into a jet engine but not for "**gay and desires pregnancy**."
>
> **Alicia:** "What about the fact that my friend is a donor? Doesn't that make it cheaper?"
>
> **Doctor:** "No, **it makes it more expensive** because we would have to test and screen his sperm."

Alicia: "Okay, so, if I'm straight and I have sex with my partner, they don't have to get their sperm tested."

Doctor: "No, because you've already been having intercourse and, therefore, assumed the risk of, uh, transmitting an infectious disease.

Alicia: "That's mad. **That's so unfair.** It's mad"

Alicia's identity as a single Black Queer woman influences her access to assisted reproductive technology care as regulated by the medical insurance company. In this instance, the medical insurance company utilizes its institutional-based power over Alicia and her desire for pregnancy by making her access to ART services more difficult. For example, compared to her coupled and heterosexual counterparts, she receives far less financial assistance from the insurance company when utilizing ART services. The show's depiction of Alicia's difficulty accessing ART services due to her sociopolitical identity is a common understanding among Black Queer people in the real world. Previous research documents that an individual's social status determines the distribution of reproductive health care services (Ross, 2006; Luna, 2019). Those in dominant positions in race/ethnicity, marital status, gender, and sexual orientation receive more access than others. The show's discourse in this scene mirrors the concerns of Black Queer people seeking family-forming services in the U.S. By detailing this experience, the show also distributes experiences about Black Queer gestation not commonly shown on television, opening its audiences up to knowledge about disparities within reproduction that are historically not amplified.

Despite the institutional barriers Alicia encounters, she continues the family-forming journey, gets from her mom and decides to hold off owning an antique shop to pay for ART

services. In these examples, Alicia decides to reclaim her power back from the health care system by finding ways to subvert their institutional power over her reproductive health journey. As seen in previous literature, this narrative offered by “Moments in Love” to their audience is similar to the reclamation of reproductive power and autonomy by Black women in the real world (Luna, 2019; Ross et al., 2017). Black women in their studies continue to fight for their right to reproduce under the conditions they want despite the heteronormative restrictions that block their access to family-forming services.

While the show eventually depicts Alicia successfully getting pregnant via ART and introduces the audience to the reproductive experiences of a Black Queer woman that are not commonly seen on television, it also perpetuates the dominant ideology of the "Superstrong Black Mother" (Collins, 2002; Burns, 2013; Elliot & Reid, 2016). The show ends with Alicia crying tears of joy after finding out she is pregnant (in Figure 4) but this comes after the show's storytelling of Alicia's arduous ART journey, which includes: two rounds of IVF, one failed conception attempt, a miscarriage, and a divorce. These experiences of difficulty shown to the audience about a Black Queer woman's journey to motherhood maintain what is commonly distributed in media about Black mothers. There is a stereotype that exists that the Black mother is resilient, and to be a good Black mother is to endure the exorbitant amount of harm, pain, and sacrifice not generally placed on others (like white mothers) (Collins, 2002; Burns, 2013; Elliot & Reid, 2016).

Figure 4: Alicia crying tears of joy

CONCLUSION

Master of None's “Moments in Love” representation of Black Queerness and assistant reproductive technology is consequential to understanding contemporary beliefs about accessing reproductive health care and services. The series is a unique and rare cultural artifact that presents its television audiences with not commonly shown ideas about ART, motherhood, sexuality, gender, socioeconomic mobility, gender and gender-based expressions, and race/ethnicity. Through a Black feminist lens and reproductive justice framework (hooks, 2006; Crenshaw 1989; Collins, 2000; Ross, 2006), I center and interpret the show's storytelling of Black Queer reproduction. I tease apart the show's exploration of the main characters' sociopolitical identities that offers television viewers varying beliefs about Black lesbian love, Black lesbian community-based gender norms, Black indigeneity, and Black Queer individuals' socioeconomic mobility that resist and reaffirm common stereotypes about Black Queer people in society.

More significantly, I highlight how the show includes cultural power relations that are evident via the sociopolitical identities of the main characters and their interactions interpersonally and with institutions along their baby-making journey. These findings reveal how

the show introduces the audience to the complex matrix of power that Black Queer individuals encounter along their ART journey throughout the show's discourse. The ideologies about the main characters and the ART journey presented within the series either counter or maintain society's dominant understanding of the family-forming process for Black Queer people.

Overall, this paper speaks to the importance of television shows like “Moments in Love” in understanding how television produces normative frames about reproduction. Understanding television and its role in shaping and circulating discourse about reproduction have become more critical than ever as reproductive laws protecting family-forming rights have become more unstable with recent legislative changes. By examining television discourse as a medium for offering a rare view of many individuals' experiences with ART (Edge, 2014), it can reveal how culture talks to itself about the subject. With hopes of understanding how television discourse can aid in disrupting current "common sense" about reproduction that often relies on the absurdities offered by anti-blackness and heteropatriarchal restrictions that may negate people's experience in society (hooks, 2006).

Lastly, this study addresses the pertinent tenets of the reproductive justice framework by bringing attention to the importance of examining reproduction from an intersectional perspective and highlighting the ways that institutions like media participate in the reinforcement of racism and sexism via their television storytelling. Throughout this paper, I discuss the unique challenges that Black Queer people encounter within society as seen through health research, and how their experiences either aligns or misaligns with the narrative provided by Master of None. While the show presents disruptive representations of the assisted reproductive technology journey not commonly seen within television narratives of Black people’s identities within desires for children and family forming, sexuality, gender, and gender expression, it also

highlights a performance of these identities, and many more (such as experiences with wealth) that undermine the challenges of the Black Queer gestational experience that real-life people encounter (hooks, 2006).

Thus, the results of this study highlight the importance of why we should center on the reproductive experiences of Black Queer people in society versus the ideologies about them via the many discourse that are developed and distributed via dominant institutions like the media. Thus, the next chapter seeks to address the next overarching question of this Dissertation:

RQ2: What are Black Queer people's experiences with gestation?

By addressing this question, Chapter 3 builds power with Black Queer gestational parents by making them the experts of Black Queer reproduction through the amplification of their personal storytelling. By centering on their lived experience within Blackness, Queerness, financial stability, and their many other intersecting identities, to identify it's influence on their reproductive journeys and relationship the health care system as an institution**.**

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CHAPTER 3: BLACK QUEER BEING/KNOWING/FEELING: STORYTELLING OF BARRIES TO REPRODUCTIVE HEALTHCARE

BACKGROUND

"Racism Is Rampant in the U.S. Reproductive Health Care" system, as noted by The Human Rights organization (Daniel, 2022), and Black birthing people have the highest infant and maternal mortality rate compared to their white counterparts (Artiga, Hill, & Rani, 2022). The United States (U.S.) healthcare system continues to enact violence against Black birthing people. These many acts of violence are demonstrated through the healthcare system's implementation and performance of exclusionary practices (e.g., limited health insurance coverage, increased wait times when seeking health services, and racial, sexual, and gender-based discrimination by healthcare providers) (Payne & Erbenius, 2018; Kyweluk et al., 2019; Wingo et al., 2018; Thomas et al., 2018). While reproductive-based health disparities research details the barriers to treatment that white Queer birthing people encounter within healthcare settings through medical provider-to-patient communication (Tam, 2021; Mamo, 2013) little to no studies within the fields of health communication or public health explore the experiences of Black Queer people and reproduction. Thus, this current interview study explores Black Queer reproduction through these individuals' storytelling of their experiences with gestation (e.g., miscarriage, pregnancy, conception, stillbirth, abortion, etc.). To understand more about distinct reproductive health barriers that Black Queer birthing people encounter along their gestational journeys within the healthcare system and how their many intersecting social identities within race, gender, sexual orientation, and ability, among other statuses, influence the reproductive health care and services they receive. Lastly, through Black Queer birthing people's storytelling of gestation, this study highlights how acknowledging this population's reproductive needs and desires addresses most,

if not all of the reproductive health care needs of everyone (regardless of one's social positioning).

LITERATURE REVIEW

Intersectional Approach to Reproductive Health Research

Access to reproductive healthcare knowledge and services in the U.S. is distributed based on people's dominant statuses within race/ethnicity, gender, socioeconomic status, and ability, among other demographic factors (Ross et al., 2017; Luna, 2019). Thus, those who are white, heterosexual, and wealthy receive access to the most quality reproductive healthcare services, while Black Queer individuals continue to receive inadequate care (Luna, 2019). This inequity in health care received by Black Queer birthing people is due to anti-blackness and the heteronormative restrictions that inform institutional practices within the healthcare system.

For example, the majority of the U.S. insurance healthcare companies do not fully cover family-forming technology services for Queer people because most policies that regulate these coverages are on the basis that the person is infertile and has attempted to conceive with their opposite-sex partner for at least six months (Long et al., 2020; Centers for Disease Control and Prevention [CDC], n.d.). However, not everyone who chooses to family form is partnered, and individuals who are sexual or gender-diverse are queer and not inherently infertile. Thus, the healthcare system's use of policies that assume one's status in partnership, sexual orientation, and gender for accessing reproductive health services fall under the guise of heteronormativity. There is little to no research within health communication or public health on birthing people's reproductive-based experiences who are Black and Queer. What is known racially is that Black birthing people are five times more likely to die while giving birth than their white counterparts (Artiga, Hill, & Ranji, 2022). Also, the number of maternal death rates of Black birthing people

has increased since the COVID-19 pandemic (Long et al., 2020). Due to these startling reproductive facts, in 2022, The White House proclaimed April 11-17 as Black Maternal Health Week to call attention to the disparities within Black birthing communities (White House, 2022).

Despite this national attention, most research in reproduction still largely ignores Black birthing people's experiences, especially those who encounter compounding forms of oppression due to their social positions within queerness (Tam, 2021). Thus, it is time for reproductive research to address this gap in reproductive-based literature by including Black Queer birthing people's experiences with reproduction as a life-saving avenue to improving both Black maternal mortality and these individuals' access to family-forming technology. To approach these health calamities, we must identify how Black birthing people's race/ethnicity, gender, sexuality, and socioeconomic status, among other statuses, influence their access and experiences to reproductive health care and services, particularly within healthcare settings.

The Importance of Storytelling and Reproduction

Reproductive Justice is a critical feminist framework established in 1994 by 12 Black women to respond to the U.S. political system's reproductive politics and the exclusion of Black birthing people's rights from healthcare-related policies (Ross et al., 2017). Since then, it has been used as a theoretical framework that relies on storytelling as the primary method of communication for understanding the reproductive needs (Ross et al., 2017; Luna, 2019) of people who do and do not desire children and the unique barriers they encounter along their reproductive journeys when interacting with society's many institutions (e.g., government, health care system, etc.). There is an abundance of reproductive-based storytelling present in literature and sociology (e.g., oral narratives, archival data poems, artmaking, etc.) from Black birthing people (Bendolph in Gee's Bend: A Reproductive Justice Quilt Story from the South in Ross et

al., 2017; Roberts, 1999; Bridges, 2011; Moore, 2011) but the majority of these perspectives are wholly missing or underdeveloped within health-based research.

Most studies within health discipline, particularly within public health and the field of health communication, rely on research dominated by a positivist paradigm or "individual and behavioral-centered data" (Khan, 2019). This research lacks the exploration of how power and institutions influence people's health-related experiences and health decision-making power (Khan, 2019). Thus, within reproductive-based health research, there is not only a shortage of Black Queer birthing people present, but there is an overall lack of understanding of Black Queer birthing peoples' interactions with societal structures along their reproductive journeys and the ways power becomes evident through these individuals' social positionings when seeking care. Thus, there is a need to explore Black Queer birthing peoples' storytelling to identify this population's reproductive-related material and lived needs and add their much-needed gestational experiences to reproductive health research.

Storytelling of Black Queer Gestation and Family-Forming

In her groundbreaking book, *Invisible Families: Gay Identities, Relationships, and Motherhood among Black Women*, Mignon Moore (2011) shines a light on the missing narratives of Black women loving women and issues related to their many intersecting identities and the influence of their social positions on their journey to motherhood and family forming. Moore's book not only highlights the ways that Black Queer motherhood and family forming are distinct from those who are heterosexual and or white due to their sexual and gender diversity but the importance of storytelling as a research method for understanding how Black Queer identities influence their interaction with social structures (e.g., employment, the government, the church, etc.) and the family forming process (e.g., methods for conceiving a child). Moore's book was

published over a decade ago, and much has changed in the political landscape since the conduction of her studies (e.g., the overturning of Roe vs. Wade, Same-Sex marriage legalization, and increased fight for health rights related to gender-affirming care). Unfortunately, since her book, no other study has explored the social positionings of Blackness and Queerness and their positioning's influence on their journey to family forming through storytelling as a research method.

This current study centers and conceptualizes Black Queer peoples' (regardless of assignment at birth) lived experiences with gestation through storytelling to add to the current literature on Black Queer family forming. Thus, the overarching research question that guides this chapter is:

RQ: What are Black Queer people's experiences with gestation?

By highlighting these experiences, this study seeks to understand Black Queer birthing people's experience with gestation to build health-related knowledge on this population's current reproductive needs and desires (e.g., addressing health disparities). Lastly, this interview study aims to demonstrate how a rich understanding of Black Queer people's experiences with reproduction can be utilized as a life-saving praxis to reimagine reproductive health care and services for ***all.***

METHOD

Population

This semi-structured, in-depth, online interview study included 10 Black Queer birthing people who had experienced at least one form of gestation. The average age of the research partners in this study was 31 years old. Relating to self-identified sexuality, two research partners are lesbian, one is queer lesbian, one is women loving women queer, one is queer and fluid, one

is pansexual, one is pansexual bisexual, one is demisexual, one is bisexual, and another is "just [research partner's name]" (please see Appendix A for a full explication of concepts). Additionally, regarding gender identity, five research partners are female, one androgynous, one gender fluid, one spiritual being, one non-binary, and one non-binary/woman-presenting person participated in this study (please see Appendix A for a full explication of concepts). All research partners self-identified as Black or with diasporic-related language and or communities. These ethnicities or Black community-related identities included self-identifications like "African American," "Black," "Black Black," "Cameroonian," and "a Nigga Nigga" (please see Appendix B for a full explication of concepts). When explicating the demographic-related concepts (e.g., gender and gender expression, sexuality, and race), I defined these terms based on a combination of the research partners' explanation of their identities and my own understanding of these concepts. This process was done to further decenter whiteness and its' contribution to current understandings of identity, recenter Black Queer being/knowing/feeling as described in the previous chapters and demonstrate the ways Black Queer being/knowing/feeling can used as discursive terrain for reimagining concepts related to sexuality, gender, race, and many other ideas.

The study's research partners were recruited through a snowball sample from my community networks, such as Black-centered reproductive justice and LGBTQ collectives, social media-based, Black-centered Twitter and Instagram accounts, and my personal Twitter, Facebook, and Instagram account followers. The initial recruitment strategy elicited over 40 Black birthing people interested in participating in this study. However, since explicit LGBTQ+ language was not used in the recruitment flyer (see Appendix C), but rather LGBTQ+ symbols (e.g., rainbow flags and pictures of gender-neutral birthing people), most of these people did not

qualify for the study because they did not self-identify as non-heterosexual during the screening survey. The screening survey yielded ten eligible research partners, and the ongoing recruitment of research partners and data collection lasted between May-August 2022. The interviews took place online because I wanted to ensure the comfort and privacy of the research partners. The types of gestational stories mentioned by research partners in this study included experiences with pregnancy and ectopic pregnancy, stillbirth, birthing, abortion, miscarriage, and assisted reproductive technology (in-vitro fertilization (IVF) and intrauterine insemination (IUI)).

Procedure

The University's Institutional Review Board approved all procedures. I provided informed consents to the research partners post the pre-screening survey. Each research partner had to reply with "I would like to proceed to the interview" before I invited them to schedule a Zoom interview via Calendly. Once the research partner scheduled a time, I emailed the research partners a brief overview of the questions that would be asked during the interview, as well as the information about the research partner's right to mention beforehand if there were any questions, they felt uncomfortable answering or did not want to be asked during the interview. None of the research partners mentioned any interview restrictions before the interview.

On the interview day, research partners were sent a reminder email of their interview time and a link to Zoom. Once the partner logged in, I introduced myself to the partner and reread the informed consent. Then, I re-requested permission to audio and video record the interview. Once consent was established, I proceeded with the interview and asked the research partners questions from the semi-structured interview protocol (please see a full list of questions in Appendix D). Questions included topics related to identity, gestational experience, and their experiences interacting with institutions like media, the government, and the health care system.

The questions were selected and created based on the dearth of previous social science research related to Black and LGBTQ+ reproduction and family forming (Moore, 2011; Mamo, 2013). Additionally, to affirm the experiences shared by the Black Queer birthing people, no saturation markers were utilized when gathering the gestational-based stories in this study. Previous studies suggest that most research designs within dominant research and specifically health research reinforce anti-blackness through strict limit-based procedures within their research designs like setting specific time limits for interviews, pre-selecting a specific number of participants before the conduction of the study and utilizing fully structured interview protocols. These preset procedures disaffirm the experiences of Black participants by assuming that people's experiences are not already enough (Jackson, 2020; Rabelais & Walker, 2021). The interviews in this study lasted anywhere between 45 minutes to 120 minutes. Per the flyer, the research partners received a $75 VISA or Amazon gift card and a short "Thank you" digital card once the interview was complete.

Analysis

Analysis from the interviews happened both during the interviews with the research partners and after completion of all interviews with the researcher triangulating information collected from the transcriptions of the interviews, previous research from Reproductive Justice (RJ), Black feminism, Queer studies, and Health, and the research partners' conversations with leaders and people in the reproductive justice movement (online and in person). These encounters with people in the reproduction justice movement were not a part of the official data collection process but rather personal practices of self-care that I engaged in to keep me grounded as an activist within the RJ movement as I spent most of my days working on this dissertation.

Specifically, during the analysis stage, I took breaks from my dissertation by volunteering and being in communities with other people and organizations that prioritized self-care via their offering of Black LGBTQ+ affirming communal spaces. These moments of self-care are critical to the research process because they reminded me that I am not my job as a researcher but a human that deserves time to be more than a researcher. In the following sections, I intentionally highlight these safe spaces that made me feel at home as offering to others who are advocates in the reproductive justice health space who want to learn more about this work while also feeling like they are not at work but instead in ***community*.**

Field site(s):

Afiya Center

The Afiya Center (TAC) was a significant in-person and online community that I was involved with during the Dissertation, and even now. My experiences include attending the center's rallies and protests, training, and interacting with the center's leadership and online content to help understand more about the ongoing Black birthing people's reproductive health challenges and how I could be of service to my community outside of research. The Afiya Center is the oldest, and only Black women-founded and led reproductive justice center in north Texas. Since joining the organization, I feel at home because they offered me a justice-oriented community where all my needs are met. It is not very often that we, as Black Queer people, can find those spaces that make us feel safe, and I am lucky enough to find that with TAC.

During this study, my service experiences with TAC included participation in the center's 2023 Advocacy Week, where I attended reproductive justice training, city-level community forums, and a visit with Texas legislators at the Capitol with 30 other Black people. During the Capitol visit, I spoke with legislators about important reproductive justice-based legislation such

as bills on Medicaid Expansion (HB1144; HB12), Doula Reimbursement (HB 465; HB1958), HIV testing (HB2235; HB526; HB1403), and Maternal Mortality and Morbidity (HB852; HB663; HB460). During this experience, I also had the chance to listen to Black birthing people's experiences with gestation. In addition, I spoke with leading regional and national justice-based groups like Texas Organizing Project and Foundation Health Partners, who are reproductive justice warriors and offer safe community spaces for Black Queer people. Lastly, I shared my reproductive health desires as a Black Queer person at the State Capitol steps.

Plan C

Plan C was a crucial online network and community I joined during the formulation of this study because I wanted to use my voice to advocate for access to reproductive justice services, especially as a Texas resident, where we are constantly fighting against restrictive policies against access to reproductive care. In the Summer of 2022, I became an official Plan C Ambassador after attending their required training. Plan C is a creative campaign and organization of veteran public health officials, digital strategists, social justice activists, and researchers whose primary mission is to transform access to abortion. Plan C provides financial and physical access to abortion pills and information on safely self-administering abortions at home. I engaged with Plan C to learn more about the abortion pill market and join the community with people willing to abet in abortion procedures by any means necessary.

All Your Pleasure Podcast

The Pleasure's All Yours (TPAY), hosted by Courtney and Lex, is a sex-positive podcast that opens conversations around pleasure in Black and Queer communities. Historically, the language around sex & pleasure comes from a very white, heteronormative lens. TPAY aims to bring nuance and transparency to these topics while encouraging their listeners to try new things,

think in new ways, and challenge the hetero/white-normative standards for how marginalized communities can show up for themselves and prioritize their pleasure. I actively listen to the podcast and interact with their digital audio content to learn more about sex and pleasure in Black Queer spaces and its' relationship with reproduction. More recently, I was invited to speak on their podcast about Black Queer health, reproductive justice, and the importance of experiencing self-related sexual pleasure via masturbation.

Vagina Rehab Doctor

The Vagina Rehab Doctor is a digital health information platform hosted through Instagram (~176,000 followers) by Dr. Janelle Howell, DPT, WCS, a pelvic floor dysfunction expert who teaches birthing people about vaginal-related health problems. I attended multiple online sessions and training offered by Dr. Howell to understand more about critical pelvic-related dysfunctions that plague birthing people, particularly the Black community. This information gave me insight into my experiences with reproductive-based health challenges that are not commonly discussed within dominant health research (e.g., pelvic pain and finding more comfortable sexual positions that promote pelvic health).

Midwife Angelina

Angelina Ruffin-Alexander CNM is a birth activist and homebirth midwife with a digital reproductive justice-based platform on Instagram (~108,000 followers). Angelina has assisted in the at-home and hospital-based birthing journeys of over 500+ babies in the US since 2014. Most of these births included Black birthing people; about a third are from sexual and gender-diverse communities. I interacted with her digital content discussing at-home births to understand more about birthing alternatives I would like to take with my partner in the future.

Queer Birthworker

king yaa, a birth worker, is a queer and transgender reproductive justice activist whose priority is to provide information about how to give gender and sexually-affirming reproductive health care. Their training includes courses on "Intro to Queering up your Practice," "Queering up Reproductive Spaces," and "Rethinking Today's Birthing People." Through this training, king yaa provides examples of gender-affirming care from their perspective as a Black trans person and co-creates action plans to understand language and reproductive rights for the community. I interacted with this digital content to understand more about the Black gender and sexually diverse perspectives of reproductive justice FUBU (for us by us). king yaa also assisted me in my recruitment for this study. Interacting with king yaa also challenged me to think about my sexual and gender identity – which was one of the supportive spaces that led me to come out as a non-binary transmasculine person.

Approaching the Data and Coding

All interview data were transcribed via a machine transcription service offered by Zoom. I deidentified and anonymized the partner's transcription information to protect their identities. I re-reviewed all transcription data produced by Zoom and corrected any errors. Most of the analysis was completed in Nvivo, a qualitative analysis software program (e.g., line-by-line coding and creation of initial themes). The remainder of the data analysis (e.g., visualizing the quotes and creating more prominent themes) took place in Excel. My coding approach was influenced by my desire to bridge my analytical training as a health communications scholar (such as using grounded theory) with my understanding of Black feminism and reproductive justice. Black feminism and reproductive justice guide my methodological and analytical approach to this study through their shared sensitivities. As mentioned in Chapter 1, both

perspectives rely on Black people's storytelling as the primary form of communication to understand Black people's many experiences within society.

Additionally, both perspectives highlight the importance of intersectionality when examining Black people's storytelling. Lastly, both perspectives recognize how gender and sex are social constructs and how societal institutions will utilize racism and sexism to serve them. Thus, I utilized these sensitivities offered by Black feminism and reproductive justice to help guide my line-by-line coding of their transcription data, creation of themes, and my broad interpretations of their gestational experiences as Black Queer people.

Through this approach, I highlight how grounded theory as an analytical approach can be strengthened by including sensitivities offered by Black feminism and reproductive justice. The overall goal of grounded theory is to explain the existence of a phenomenon and its related processes. By infusing grounded theory with Black feminisms with RJ while explaining Black Queer reproduction as a phenomenon, a community commonly excluded from the research process, we can avoid the reproduction of anti-blackness within our research practices through the reimagining of dominant qualitative-based analytical procedures. I do this by including the sensitives offered by Black feminism and reproductive justice within my modified use of grounded theory to help me code and make sense of the multiverses created by Black Queer people's gestational storytelling experiences shared in this study – which resulted in 4,812 quote references, While also tending to my goal of decentering dominant ways of approaching data in the field of health communication.

Being/Knowing/Feeling

First, I completed line-by-line coding of all transcription data to identify initial themes. The initial coding produced 89 codes with 4,812 quotes across all research partners' interview

data. Of the 89 codes, one dominant code, "Being/Knowing/Feeling," emerged at the top across all research partners' interview data and included 422 quote references. This code was conceptualized as "a Black Queer person describes feelings and emotions during their gestational storytelling." When considering the perspectives offered by Black feminism (Nash, 2019; Hill, 2009; Davis, 1981; Jackson, 2020), Being/Knowing/Feeling highlights Black people's self-awareness or their capacity to understand their feelings, emotions of their identity and experiences as an ontological site which produces many differences of truths that disrupt society's dominant ways of knowing. These opposing truths that emerge from Black people's storytelling rupture the continuities offered by society's standard (or dominant) senses by highlighting the differences that exist in one's operation or treatment in society due to their social positioning (e.g., race, sexuality, gender, socioeconomic class, ability, and more).

Like other Black feminists' detail in their work, when I created this theme and noticed how it emerged within my analysis, I discovered how Black Queer people in my study were offering many differences of truths about gestation not commonly detailed by societal institutions (as discussed in previous chapters), particularly within healthcare. Thus, Black Queer Being/Knowing/Feeling emerged as a top theme and the theoretical underpinning for understanding the many occurrences in my study, as seen through the research partners' lived experiences with gestation. So then, I became interested in understanding how the other 89 codes I initially created related to this theme, Being/Knowing/Feeling.

To further make sense of Black Queer people's self-awareness of their feelings and emotions related to their gestational experiences, I ran an analysis in NVivo that allowed me to see the top codes out of the other initial 88 codes most mentioned within Being/Knowing/Feeling. These top codes were: 1) Relevant Institutions, 2) Identity, 3)

Pregnancy Experience, 4) Health Care System, and 5) Relating to the gestational body (please find complete conceptualizations of these codes in Appendix E). Next, I created an Excel sheet with these top codes that emerged within Being/Knowing/Feeling and ascribed the relevant referenced quotes identified in NVivo to help me visualize how these quotes overlapped with one another. For example, all the quotes within the Health Care System as a code overlapped with the Relevant Institutions code because Relevant Institutions was conceptualized as a research partner mentioning or naming institutions relevant to their gestational experience. Thus, if a research partner mentioned the insurance company, hospital, abortion clinic, or any other organization mentioned in the health care system, it was double coded as Health Care System and Relevant Institution. After completing this process, I discovered that Relevant institutions had the most referenced quotes and overlapping codes. More specifically, when identifying the most mentioned institutions by the research partners across the 255 reference quotes, it included: 1) The Health Care System, 2) Education, 3) Media, 4) Employment, and 5) Government.

Health Care System

While Relevant Institutions as a code produced 255 reference quotes, 165 came from research partners discussing their gestation experiences within The Health Care System. Due to the robust and rich data from the storytelling of Black Queer people in this study and my writing limitations for this Dissertation, it would have been a flawed approach to attempt to discuss all these institutions within this chapter. Thus, I focused this chapter on The Health Care System, which included discussions on relevant health-based sites within the institution and conversations that were mentioned in this Dissertation's previous chapters. The health-based sites mentioned by the research partners included: 1) The Hospital and Medical Providers, 2) Abortion Clinics, 3) Fertility Clinics, Insurance Companies, 4) Mental Health facilities, and 5) Non-

traditional Healthcare Spaces. By utilizing the Black Queer Being/Knowing/Feeling theme and exploring this phenomenon within the Health Care System as a primary institution of interest in this study, I explore in the following sections how Black Queer people's experiences within healthcare impacted their gestational journey. Additionally, through this examination utilizing sensitivities offered by Black feminism and RJ, I discuss how their many intersecting sociopolitical identities placed them in an inescapable matrix of power that often denied them the reproductive health care needed to make decisions about their health that ensured their well-being.

Lastly, through my discussion of these findings developed from my interpretations of the Black Queer stories in this study and my knowledge as a Black feminist in health communication, I discuss what can be understood about the current state of reproductive health care and services, and I offer correctives to the maltreatment experienced by Black Queer people in the healthcare system that prioritize the well-being of not only this population but all birthing people.

Quote(s)

It is important to note that to honor the storytelling of the research partners in this study, I did not remove or edit out curse words or slang that was referenced. However, by maintaining these words within the reporting of the data, I hope to uphold the authenticity of the archive of Black people's unique storytelling method and help aid in legitimizing African American Vernacular English (AAVE) as an officialized and recognized sociolinguistic in research.

RESULTS

Hospital and Medical Providers

The hospital within the research partners' storytelling unsurprisingly arose as a dominant institution that Black Queer people in this study interacted with along their experiences with gestation and or caring for their bodies as birthing people. All research partners in this study, except one, detailed an experience they had within this institution through their many interactions with their medical providers during their yearly health check-ups, along their pregnancy journey (e.g., routine appointments), or birthing process (e.g., planning for delivery or labor). The pressing concerns that arose included research partners' access to quality reproductive healthcare being determined by their social positioning in identity-related statuses and the medical providers they worked with ignoring the research partners' emotions and knowing of their bodies when accessing reproductive healthcare.

Determining Access to Quality Reproductive Health Care on the basis of one's Social Positioning

When it comes to the hospitals and the medical providers in this study, the first subtheme that emerged from Black Queer folks' storytelling and their experiences with health providers working in this institution is their belief that their access to quality reproductive healthcare or lack thereof was due to their ***many intersecting identities of race, socioeconomic class, gender expression, sexuality, body size, and ability***. For example, one research partner in their storytelling states:

> **Research partner 7: "intersecting oppressions where like people associate your weight,** with everything that you are experiencing, so like when I was experiencing not having a cycle for years, they will just say "oh, you need to lose weight," and I'm like bitch is plenty of fat bitches out here what are you talking

about? **The medical community, in general, they're just extremely racist and fatphobic, and I feel like they when they see a fat body, especially a fat black body or a woman, they just automatically assume that everything is associated with their weight.** I feel like my weight has played a role in people not taking my own experiences with my miscarriages or just experiences with fertility issues seriously. Cuz I'm fat. People automatically assume that the things that I'm experiencing, especially when it comes to anything biological**, it's because I'm fat. And I'm like, my uterus is not overweight"** (emphasized)

"My uterus is not overweight" demonstrates the experience that this partner, as a self-described Black, fat, non-binary, woman-presenting person, has when interacting with medical providers within a hospital setting. Medical providers usually make assumptions about their health based on what they can see (or their medical gaze) physically, like their race, body size, and gender, that are not rooted in knowledge based on health-related testing but biases (Foucault, 1963; Taylor, 2018). Similarly, this intersecting issue of body size, Blackness, and gender is mentioned by other research partners in the study. For example, one person (p10) mentions having multiple experiences in a hospital setting where the doctors will refuse to touch or provide healthcare until they meet the "healthy" BMI weight parameters for someone their height. In addition, other research partners (p4 and p2) mention being forced by the doctor to take gestational diabetes testing too early along their pregnancy journey or back-to-back despite receiving negative results on the initial testing.

Denying the Patient's Expertise and Feelings

The second subtheme that emerged from Black Queer people's storytelling in this study when interacting with medical providers in a hospital setting is the assumption that the research

partners' beliefs about what is happening to their body are untrue. In return, the medical providers deny the research partners knowledge of their health and assume that they cannot make health-related decisions that impact their bodies. For example, one research partner (p3) in their storytelling states:

> **"**Hey, **we want [the doctor] to talk to us before you do anything.** Let us know you know what's about to happen. We are a part of this process, right? But the nurse looked at my partner. It was just like, he's the doctor. They said **he's the doctor, how dare you want them to explain?** It's very crazy, and he didn't care. He didn't. **He broke my water without telling me.** My partner was like I saw him pull it out." (emphasized)

When the research partner details the nurse's response, "he's the doctor, how dare you want them to explain," and then explains how the doctor proceeded to induce their labor without their permission. These portions of their experience demonstrate the importance of lived needs (e.g., emotional support from the doctor) that birthing people require from the healthcare system during their gestational journey. These lived needs are far less tangible than the material needs of birthing people (e.g., money to pay for healthcare). However, they impact the emotional experience of the gestational journey and may determine their right to bodily autonomy.

Research partner 3's request to be involved in their labor experience and be seen by the medical providers as a partner in their healthcare experience was utterly ignored, and the knowledge they have of their body and desires for their birthing experience was discredited. The medical providers in this example believe that they ultimately know what is best for the patient because of their social status as a doctor, despite the partner in this study being someone who has lived in their body for thirty-five years. In this study, four other research partners (p1, p4, p6, and

p10) spoke about how medical providers discounted or flat-out denied their knowledge and emotion about their bodies and health during their pregnancy and delivery experiences. For example, another research partner (p4) spoke about their doctor during their labor process pressuring them during their deliveries to get a Cesarean section (c-section) despite communicating that they did not want one. While detailing this story, they emphasized, “they always make Black women get a c-section, they think you can't push your child out.” Another research partner (p10) spoke about their stillbirth experience:

> **Research partner 10:** "I just remember **them asking me if I wanted to have a funeral or if I wanted to donate her body to science.** And this literally happened as she took her last breath, and I'm just sitting there, and she was like just think about it, and I'm looking like, huh, **what kind of an emotional decision is that for me to make right now?** (emphasized)
>
> “I just remember them asking me if I wanted a funeral or if I wanted donate her body to science…as she took the last breath,” is evidence within this partner’s storytelling of the lack of support medical providers show to patients even in the most devastating moments. Unfortunately, the research partner’s emotions were ignored, much like the other research partners in the hospital setting. In this instance, she was forced to make after-life arrangements for her baby before processing the loss.

Abortion Clinic

Another institution that emerged within the research partners' storytelling of their experiences with gestation was the abortion clinic. Half of the research partners (p1, p2, p3, p9, and p10) detailed the process of terminating a pregnancy. The most mentioned abortion clinic

among the research partners was Planned Parenthood. Black birthing people in this study detailed the stigma that came before and followed their abortion procedure and discussed how their identity as a Black Queer person resulted in them feeling compounding forms of shame. This shame breeds silence for research partners in this study, and for most, this interview was the first time they discussed the termination process. The effects of the abortion procedure resulted in many emotional and physiological changes for the research partners in this study. Even though time had passed, some were still processing the impacts of this journey.

Breeding Silence and Abortion Stigma

The first subtheme that emerged from Black birthing people's experiences with terminating their pregnancy is that *Abortion Stigma Breeds Silence*. This theme describes the belief that research partners in this study have after they had an abortion, there is no place or person for you to talk to about the gestational termination process due to the stigma and the judgment they will receive from family members, friends, or society. For example, research partner 1, in their storytelling, detailed:

> **Research partner 1:** "They were very nice at that clinic. While the procedure was going on, **I was crying and, I was talking to God like if being a lesbian don't send me to hell, I'm pretty sure this is**, but I just knew that I couldn't deal with it now. After the abortion. I was depressed for a couple of weeks…" (emphasized)
>
> Me: "How did you eventually can work through your emotions after that?"
>
> **Research partner 1: "I didn't think about it."** (emphasized)

When research partner 1 says, "I was talking to God like if being lesbian don't send me to hell, I'm pretty sure this will," it demonstrates the extreme guilt she feels for terminating her

pregnancy and the belief that she will face eternal damnation. Even more emotionally challenging is that she must process the religious-based guilt of not only her decision to have an abortion but also that she is a woman who loves other women. The idea of making both these decisions (e.g., being openly lesbian and terminating pregnancy) feels like magnified sinfulness that causes her to deal with a compounding form of shame.

Another research partner (p3) shares their feelings of experiencing loneliness when discussing how they processed their emotions after the abortion procedure:

> **Research partner 3: "My friends had also had an abortion, but we only had talked about the abortions up until we had the abortions,** and then it was just like we moved on, or the like, could you believe we could have had this kid? **But never really any conversations about like our feelings, or the impact, or anything."** (emphasized)

While this research partner was able to find momentary support from their friends before they had the abortion, there wasn't much space to talk about all the ways that the procedure had an impact on them. This research partner followed up this discussion by explaining how they slept in all day, for days, after their procedure and had the overwhelming feeling that something was missing. As time passed after the abortion, they explained that they began to feel like their relationship to their body shifted.

Disconnecting the Body and Emotion

Due to the silence and stigma perpetuated in society related to abortion care and Black Queer birthing people, there is underdeveloped knowledge about the abortion experiences of this group. Through a close reading of the research partners' abortion storytelling in this study, a second subtheme emerges, *Disconnection between body and feelings*, explores how Black

birthing people encounter difficulty relating to their body post-abortion. For example, research partner 3 further details these bodily and psychological changes:

"I feel like I began to distrust my body more. I don't know if it left a gap. I got sick shortly afterward. **I didn't understand what was happening with my body. I felt like it was doing its own things, and I was just reacting to whatever was happening to my body."** (emphasized) "I didn't understand what was happening to my body…and I was just reacting to whatever was happening," highlights the disconnection this research partner felt with their physicality post-abortion. The body they once thought they knew and understood now seemed foreign. These emotions caused them to feel like they were no longer controlling their body and what their body could do. Similarly, another research partner (p9) spoke about the difficulty of navigating their body post-abortion and feeling like their body was extremely different from what they thought it to be pre-procedure. Research partner 9 detailed that one of the reasons she was interested in my study is that years after her abortion, she still has not figured out how to deal with the disconnection between herself and her body.

Fertility Clinics

Three research partners (p4, p5, and p10) in this study spoke in incredible detail about their experiences interacting with fertility clinics and related institutions (e.g., sperm banks) along their assisted reproductive technology (ART) journey as Black Queer women. Similar themes arose with interactions with the medical community along their family-forming journey as previous research partners' encounters with providers in hospital settings. **Their access to quality reproductive health care was influenced by their social positioning or many intersecting identities related to age, gender, gender-based expression, sexuality, race, and socioeconomic status.** These social positions impacted the advice they received from health

providers, their access to sperm, and their ability to select the type of assisted reproductive assistance technology-based approach they desired for family forming.

Determining Reproductive Health Information and Access on the Basis of Age

Research partner 5 in this study discussed she and her partner's ongoing assisted reproductive technology journey and the biases they encountered due to the research partner's age, sexuality, and gender and her partner's gender-based expression. In addition, she details in her storytelling:

> **"the meeting was super discouraging because we went to the [fertility] doctor,** and it was this old man, and he was just like I was like, hey, I'm really looking to have a kid, and **he literally just looked at us, and he was like how old are you? I was like I'm 32.** I think I was 32 at the time. He was like**, oh, you're fine, you're healthy.** He took my blood pressure, and **he's like you're healthy, you're young, just try to have a kid.** We looked at each other. **He told us, to try to have a kid naturally for a year.** We were just like, so naturally? Like maybe I'm not understanding what you mean by naturally. **He didn't see my partner as female"** (emphasized)

"He's like you're healthy, you're young, just try to have a kid," statement made by partner 5's fertility doctor when seeking ART health information highlights the many assumptions the provider made regarding the course of action that couple should take to family form that was all rooted in identity-related biases. The first bias identified is the assumptions about the perceived reproductive healthiness of research partner 5, which was presumed due to the doctor's medical gaze (Foucault, 1973 The doctor observed research partner 5 and her spouse's physicality, asked a question regarding research partner 5's age, took her blood pressure,

and then determined she was healthy enough to have a child naturally. Upon initial observation, no further questioning or testing occurred after this interaction to confirm his health assessment.

Determining Reproductive Health Information and Access on the Basis of Gender and Gender-based Expression

Research partner 5 also mentions that the fertility doctor recommended that she and her spouse have their child naturally. Natural conception is a method of conceiving that means a woman will become pregnant by having sex with a man. Later in the conversation, research partner 5 details, “he didn’t see my partner as a female.” Earlier in the interview, when I asked research partner 5 to describe her spouse’s gender and gender-based expression, she detailed that her partner is a "masculine presenting" woman, meaning that their partner tends to wear clothing usually associated with men’s attire. Although, at the same time, their partner's gender expression deviates from what society typically expects a woman to present as, the intake paperwork that they filled out noted that they were both women.

Additionally, when the couple sought further guidance by telling the doctor that the natural method was not an option, he replied, "just go to the clinic and get sperm." Unfortunately, this is not the first time the couple experienced misgendering despite providing health information to the clinic beforehand. In another example, the research partner in this study mentions not feeling comfortable with another clinic because the staff kept saying “husband” when she would refer to her partner as “my fiancé.” The events of misgendering are rooted in the idea that the ART journey is for heterosexual couples.

Determining Reproductive Health Information and Access on the Basis of Race

Research partner 4, when discussing their family forming journey relating to seeking ART-related services, encountered hardship during the sperm selection process when trying to find a bank with adequate sperm from Black donors.

"and then really trying to find a black donor. Because you know **we started to notice that a lot of the banks didn't have a variety of black men.** We did research, and you read that sometimes black men don't like to donate their sperm, and it was like, **either we're going to find a black donor or we're not going to have no kid. We need a black child."** (emphasized)

"so, um, so we didn't go through a sperm bank for our donor. **We reached out to a friend that we knew he was a gay black guy. He was like yeah, cool, you know, yeah, we can try it,** so we did." (emphasized)

"We started to notice that a lot of banks didn't have a variety of black men," details the lack of options research partner 4 and their spouse had when selecting sperm for their ART journey. Due to this shortage of Black donors, the research partner chose to go with the at-home insemination process with a known donor who was someone from their community. Interestingly, this couple lives in Dallas, Texas, where almost a quarter of the population is Black and in a state with some of the highest Black populations in the country. The research partner mentions that while researching the shortage's cause, they discovered this was a widespread reproductive health phenomenon. While the couple's original plan was to utilize the sperm of an anonymous sperm donor due to their desire to raise their child solely as a couple, without the interpersonal involvement of the sperm donor, they were instead forced to do the opposite – disrupting their reproductive-based autonomy.

Determining Reproductive Health Information on the Basis of Socioeconomic Status

Not only do the research partners in my study encounter issues when seeking quality reproductive assistance due to their sexuality, gender, and race (as discussed in this section), they also face significant financial hardship that either prevents their access to care or fundamentally

shifts their quality of life. For one research partner (p4), In vitro fertilization (IVF) was not even an option for them because it was too expensive and not covered by their insurance due to the birthing partner not having a history of infertility, which in most state's insurance policy is determined through the lens of heteronormativity (e.g., unsuccessful attempts of trying to conceive "naturally"). Another partner in the study (p5) reported spending well over $20,000 during their three cycles of Intrauterine insemination (IUI). They accrued this massive amount of medical bills due to the costs for sperm vials and the shipping of the vials, storage for sperm, doctor appointments, the insemination procedures, and the required medication. Another research partner in this study (p10) has spent close to $30,000 along their ART journey. To continue paying for ART, they have sacrificed some of their self-care practices (e.g., getting their nails done and eating at restaurants), and even went as far as selling their car. While the two research partners in this study described their financial stability as comfortable, neither has achieved full-term pregnancy via their many ART attempts. Due to their lack of support from their health insurance, they are looking at future exuberant costs associated with their journey.

Insurance System

Due to the financial costs associated with the gestational journey, whether that be the cost of abortions, paying for doctor's visits, the price of sperm and ART, or paying for essential items, health insurance as an institution was discussed by the majority of the research partners (p2, p4, p5, p6, p8, p9, and p10). The research partners in this study detailed the barriers they encountered when maneuvering through the insurance system's many structures and policies along their ART journey. Additionally, research partners discussed the challenges they encounter with having insurance that still does not provide enough coverage to ensure their health or child's well-being.

Navigating the Complexities of the Insurance System

Research partners in this study spoke to the difficulty of navigating the insurance system when discussing their gestational journey. It was an arduous process of contacting people at the insurance company to explain their health benefits, filing claims for not receiving adequate health coverage, and dealing with large amounts of medical bills resulting from lack of coverage. Research partner 10 details their experience with their insurance company along their IVF journey:

> **"I thought I was smart; you know? But I felt like I needed a degree to understand what I qualify for what is paid, what isn't paid what the cost of this is, and that is, and if you're not careful, these people will ruin your life with bills, while you're going through the medical system**. And they're not required to explain insurance to you. It is in their writing like they are not responsible required to tell you what you qualify for what you don't qualify for what is paid, what is it network like they're not required to tell you any of that. I had so many medical procedures that I had a crash course on the insurance system, and **I was just like this shit is a fucking scam.** And, but **yeah, that was my worst experience, I think, is just dealing with the financial part of the insurance"** (emphasized)

"Yeah, that was my worst experience, I think, is just dealing with the financial part of the insurance," quote expressed in research partner 10's storytelling emphasizes the overwhelming pressure that comes with dealing with the insurance system along their ART journey, which for this partner for included loss of a child and many unsuccessful ART-related procedures. Not only did they feel unsupported by the system due to its inability to soundly explain their insurance

benefits during this family-forming journey, but they also suffered through the financial consequences that followed due to this lack of adequate disclosure of their health insurance benefits. The family-forming journey is already a costly process for Black Queer people, and now they must deal with the compounding troubles of medical bills that result from a system that they describe as a “fucking scam."

Other research partners shared similar sentiments about navigating the insurance company and, more significantly, the belief that the system was rigged and intentionally set up for people with many intersecting identities to fail. For example, research partner 9 discussed, at multiple points in her gestational journey, calling the insurance company several times a day for hours just to try to speak to someone about their benefits and feeling like, “It is your job at this point, as this system is designed to not care about me. This system that is designed to not see me and designed to ignore every time I say I’m in pain.” Like the previous research partner, she recognizes that if she wants to get the care and coverage she deserves, it will not come without a fight because she is a Black birthing person.

Experiencing Gestation While Underinsured

Another insurance challenge research partners encountered in this study was that while some research partners may have health insurance, they weren't afforded adequate coverage to fulfill their reproductive desires and needs. For example, research partner 6 explained:

> **“I became a stay-at-home parent because we couldn't afford childcare.** If I went to work, I would be working only to pay childcare, so it made more sense financially. **We lost our apartment with my second child because I ended up being on bed rest for a month and a half in the hospital**, where I couldn't work,

so we couldn't pay. When I came home from the hospital. We ended up **moving in with my mom."**

Research Partner 6 explains, "I became a stay-at-home parent because we couldn't afford childcare," highlighting their inability to decide how to raise their child in the ways they desire but instead out of force. Then, during the research partner's second pregnancy, the research partner became bedridden due to health complications related to the birthing experience. Then, due to the loss of income because of their medical complications, they faced a lack of financial stability along their gestational journey and were temporarily homeless. Like most birthing people in this study, research partner 6 had no other choice but to figure it out and relied on the support of their partner and family. Now, they are in a much better financial situation. However, even with this improvement, they work two jobs out of necessity to have access to health insurance, as only one of the jobs provides insurance. The issue of being underinsured as a Black Queer person along their gestational journey was present in another research partner's (p4) storytelling. Research partner 4, a special education schoolteacher, attempted to utilize health insurance when seeking ART services. However, due to them having no history of fertility and *just being queer,* they would be required to pay for IVF entirely out-of-pocket.

Mental Health Services

Due to the unrelenting unjust institutional practices that the Black Queer research partners in this study encounter along their gestational journeys and the societal stigma they encounter due to their social positions, it is no surprise that conversations about mental health services emerged. The research partners (p2, p3, p5, and p10) in this study spoke about their mental health challenges before and during their family-forming journeys and knowing how particular moments during their process influenced their mental state. Their storytelling of these

experiences revealed themes that emphasized the need for emotional support along their gestational journeys that were unique to them as Black Queer birthing people.

Requiring Emotional Support Along the Gestational Journey

Shortly after research partner 10's loss of their child, they were so overwhelmed by the experienced that they faced a severe lapse in their mental health that resulted in them checking into a psychiatric facility for support:

> **"So, it just I remember ending up having to check myself into the psych ward for 24 hours because it got that bad**. yeah, it got that bad, so I had to check myself and they had to call my parents my mother at that time. To come and check me out and that's when my mom came and stayed with me for some time, but it was bad." (emphasized)

When research partner 10 details, 'just I remember ending up having to check myself into the psych ward for 24 hours because it got that bad. yeah, it got that bad," they demonstrate in that moment ana act of extreme self-care. After the devastating experience of losing their child, the research partner could process their emotions enough to understand that they were not mentally well. Once they realized the lapse in their mental health, they took control of their life and realized they needed the support of professionals and their family. I cannot help but wonder how early this help could have come if the medical providers extended this support to the research partner instead of asking her to decide whether she wanted to donate her child to science or have a funeral.

Other research partners in this study mentioned encountering breaks in their mental health after traumatic gestational experiences. For one research partner (p1), it was shortly after giving up their child for adoption, and for another (p3), it was after going home post-labor while

their child remained in the neonatal intensive care unit. Research partner 3 detailed, “Felt like I had like a break in my mental state during that time, because I could hear her crying. I was just at home, and I would be like, “Don't you hear that? And [my husband] be like, I don't hear anything.” Another research partner (p6) recognized their problems with their mental health before their experiences and decided to proactively seek therapy before having a child. While research partner 2 detailed that while they know therapy to be a supportive space, for many Black people, therapy is still a taboo topic, much like being gay, and is often associated with whiteness. This association between whiteness and therapy details the sinister beliefs that rely on anti-blackness about what types of people deserve access to mental health services.

Non-traditional Methods of Healthcare

Over half of the research partners (p3, p4, p5, p6, p7, & p9) in this study mentioned either working within non-traditional health spaces or having to desire to work within the system. For this study, non-traditional health spaces include having midwives, doulas, and people aligned with reproductive justice as support systems along their gestational journeys. By seeking and or teaming up with non-traditional health spaces, the research partners in this study could receive the emotional support they wanted along their gestational journeys.

Creating a Space for Bodily Autonomy through Emotional Support

For example, research partner 5, during her pregnancy journey, felt much pressure through the unsolicited gestational advice offered by their parents and mother-in-law. At times, this partner felt like her voice and perspective as a mother was not being included in the health decision-making of their health and their child's health. She details in her story:

> **So, I would say my doula is like my therapist if I’m being honest**. All of the small bits of confidence that I had to say to both sets of parents, like oh, I really

don't agree with this, or I talked to a doula, and they told me about this. They're like, oh well, they don't know what they're talking about so on and so forth. **Then the doula when I talked to her, she wasn't like oh, we don't know what they're talking about just like, what do you think like, how do you want mother your child, how do you like the environment, do you want to give while they're like in your womb and she almost made it more of a choice. (emphasized)**

When research partner 5 says, "All of the small bits of confidence that I had to say to both sets of parents, like oh, I really don't agree with this," demonstrates the power her doula gave her to stand up for herself and tell her family no and that she's the one in charge of her pregnancy. This ability to defend and uphold her knowing as a mother was due to the emotional support shown by her doula, who let her know that everything was her choice relating to how she wanted to mother her child, in the womb and after birthing.

Another research partner (p4), in this study faced countless experiences of oppression during their pregnancy and labor process. For example, due to their body size, they were forced to take back-to-back gestational diabetes tests because the doctor felt there was no way the test was coming back negative. Additionally, they were pressured to get a c-section during their birthing experience. Finally, at the hospital, they were made to feel too uncomfortable via snarky remarks because they were in a same-sex relationship. Research partner 4, reflecting on their gestational experiences, stated, "I really wish that we did more research about doulas because now we have a family friend who has her own doula and everything and I really wish we went to do it that way." Perhaps, seeing another birthing person having a doula made them realize that their experiences could have been different, like getting the emotional support they deserved

during their pregnancy or the empowerment they desired to choose what birthing procedure was best for their body.

Locating Supportive Health Care Providers

Lastly, not only did research partners in this study utilize non-traditional spaces to get the emotional support they desired during their pregnancy journey by working with doulas or midwives, but one research partner (p7) used it as an avenue to find supportive traditional healthcare providers. For this partner, a self-described fat, Black woman-presenting, non-binary, disabled person, finding a healthcare provider that acknowledges their many intersecting identities is challenging. Thus, they utilize their relationship with reproductive justice collectives to find doctors who either embody some of their shared identities or can provide the desired care they seek along their health journey.

DISCUSSION

This study centers on Black Queer people's Being/Knowing/Feeling of their gestational journey within the Health Care System to identify the institutional practices and beliefs within the structure that prevent Black Queer people from receiving the reproductive care and services they desire. Understanding their many differences of truths along their reproduction journey helps us understand the gestational experiences of this community and those with shared identities that are not commonly represented in health research, who also happens to be the most plagued by the inequities existing within the reproductive health care space. When considering the findings that emerged in this study alongside existing research about health disparities, I discovered that their experiences also highlight reproductive-based injustices, known and unknown, that impact others in this specific community and other identity-based groups.

Administering Health Justice as Antidote to Fatphobia and Anti-blackness

For example, when looking at Black Queer people's gestational experiences within the hospital, we identify issues of fatphobia and anti-blackness where healthcare providers make assumptions about their health without conducting adequate health testing. This experience is highlighted when research partner 7 mentions, "like it's because I'm fat. And I'm like, my uterus is not overweight." As understood by this research partner, very few studies have shown a relationship between uterine health and body weight. Almost no studies demonstrate a positive correlation between uterine sizes (without fibroids) and body weight. Furthermore, there is insufficient research that includes Black birthing people and uterine health to support the suggestion that their body weight would solely impact their reproductive health outcomes. Despite the dearth of knowledge in this area of fat Black birthing people and their reproductive health, there is a pervasive and sinister myth circulating within the health care system that fatness equals unhealthiness, and when unpacked, within the structures' assertion exists a long history of fatphobia and anti-blackness.

Historically, most societal groups have associated large or fat bodies with socioeconomic abundance and thinness with hardship (Montgomery, 2021). However, there was a shift overtime where larger bodies became associated with poverty as eugenic and race-based scholars work like Darwin (Montgomery, 2021) or Kant and Burke's "Sublime" (Jackson, 2020) contributed information about race and class that created societal hierarchies placing Black people, (and especially Black poor people) at the bottom of what was considered civilized. Within this scale of the most and least civilized, "fatness is used as a marker of uncivilized behavior while thinness was more evolved" (Montgomery, 2021, p. 2). Throughout U.S. history and in health culture from the 19th century to the present, there is a focus on body size and race that informs

beliefs of what is desirable. The politics of desirability, over time, have been used to uphold slavery, racism, and classism, particularly for birthing people (or women) (Montgomery, 2021). In return, these beliefs related to what is desirable have afforded people with "thin white bodies" more ease and access to social systems via their acquisition of cultural capital due to their dominant social positions in race and body size.

Research partner 7's statement, alongside the other research partners' reported experiences in this study, are examples of how the health care system provides a lack of ease and access to reproductive care (e.g., refusing to work with them due to their BMI or making them participate in unnecessary health testing) due to their body size, race, and gender. In addition, previous health-related research advocates that one of the critical components for health justice is to reclaim fat bodies (regardless of race) as healthy and to critique healthism rooted in normative notions of how bodies ought to be (Mackert & Shorb, 2022). Lastly, health scholars who research fatphobia suggest that we must combat this stigma by centering the lived experiences of patients, particularly those whose identities challenge normative ways of being offered by the health care system, to inform more ethical health policies and practices (Lee & Pausé, 2016).

Fighting for Birthing Rights as a Lived Need for Black Birthing People

Another issue in my interview with Black Queer folks about their experiences with the hospital is that the medical providers do not see them as experts on their lives and bodies, particularly during the birthing process. For example, in one research partner's storytelling, the doctor breaks their water during their labor journey without consulting them, even when they ask the doctor to include them. When looking into previous research outside this study on Black people's birthing experiences (Sakala et al., 2018; Peahl et al., 2022; Hoffman et al., 2016), I find similar narratives as research partner 3.

It is widely documented in health research that doctors do not listen to, include, or believe Black birthing people's knowledge about their health (Sakala et al., 2018; Peahl et al., 2022; Hoffman et al., 2016). A survey conducted by the California Health Report found that Black birthing people's birth preferences are least likely to be listened to by health providers compared to other racial/ethnic groups (Sakala et al., 2018). In a recent study, scholars interviewed low-income pregnant Black birthing people about their prenatal care from providers. They found that participants in their study, like mine, wanted a collaborative experience with their providers to meet their unique and diverse needs. However, despite this desire, most patients in their study did not receive equitable healthcare treatment (Peahl et al., 2022). Unfortunately, Black birthing people continue to experience inequities within the pregnancy and birthing journeys by medical providers who do not consider their healthcare needs. To counteract these inequities, medical providers must recognize that birthing people, regardless of race, body size, or gender, are the experts of their lives and bodies and deserve to make personal decisions about their reproductive health that ensure their well-being as understood by them (Ross et al., 2017).

Destroying Abortion Stigma

Research partners within this study spoke about their experiences with abortion as a journey that was not confined by time but had an ongoing influence on their emotions and their sharing and caused a disconnection between themselves and their gestational bodies. As Black Queer people not only were they forced to reckon with the changes that the abortion procedure caused, such as feelings of solus but compounding feelings too of shame at times as they work through the stigma society places on their sexuality and gestational-based decision-making. For example, Queer people in the U.S. statistically seek abortion-related care at higher rates than

their heterosexual counterparts (Charlton et al., 2020), and Black birthing people receive the most abortions (Kaiser Family Foundation [KFF], 2022). While abortion-related stigma is well documented, there are not enough discussions about how Black Queer folks experience intensifying forms of stigma due to them living with many intersecting sociopolitical identities (e.g., queerness, Blackness, disabled, etc.) that are highly disparaged in society.

For example, the foundation of abortion stigma is that abortions are morally wrong and an offense against the gendered norm or belief that people who can reproduce (or have birthing organs) should participate in procreation (Planned Parenthood, n.d.). The beliefs that maintain abortion stigma are similar to the ideals that uphold heteronormativity. Thus, Black Queer birthing people who access abortion care are experiencing heightened exceptional levels of shame from society due to their sexuality, race, and health behaviors being outside the accepted heteronormative and racial categories of what is a civilized human. Abortion clinics, health providers, and health researchers should further their understanding of these experiences by centering and sharing the abortion storytelling of Black Queer birthing people. In return, it can provide more well-balanced knowledge of the health culture norms (such as abortion-related shame) that influence how society responds to people seeking and accessing abortion-related health care.

Connecting the Mind and Body, and realizing the Passing of Time is not a Healer

The societal, psychological, and physiological impacts of experiencing an abortion are not regulated by time. Instead, it is a journey for the research partners in this study that lives within them long after the procedure, whether they overtly address it or not. Interestingly, Planned Parenthood (n.d.), one of the most significant abortion providers in the U.S. on their website, speaks to the emotional and body-related changes post-abortion. However, they discuss

these issues separately and not as related matters. For example, on their website, under their "Caring for Yourself After an Abortion" tab (Planned Parenthood, n.d.), they discuss the physiological changes separately from the emotional changes. Then, within the emotional changes, it states:

> "Feelings of relief, sadness, elation, or depression are **common and may be strong due to the hormonal changes that occur after an abortion. Most people find these feelings do not last very long** (emphasized) (Planned Parenthood, n.d.)." (emphasized)

The explanation of the emotional changes offered by Planned Parenthood lacks depth and context of how birthing people's emotions can also influence their relationship with their gestational bodies to post the abortion procedure. It simplifies the relationship to hormonal shifts that "do not last very long." In this study, after the procedure, research partners experience connected emotional and bodily shifts; thus, these are not separate issues. Additionally, while the abortion procedure is constrained by time, the overall experience and related impacts remain with the person for some time. For example, one research partner (p2) states after their abortion, "I was like so like sick I was like nah I'm not myself and it changed it, I changed…." "It's like it's like a guilt thing…I beat myself up over it every day."

For the birthing people in this study, the linked changes between their emotions and body post-abortion procedure can challenge their ability to make future health decisions as they navigate understanding how their relationship with their gestational body has evolved. When Planned Parenthood distributes information about abortions that includes information that one's emotions and bodily changes are discrete, it perpetuates the dominant position of the mind-body split commonly understood in the health care system. This split is the belief that one's

psychological health is not connected to physical outcomes (Caes, Orchard, Christie, 2017). Health-related institutions should seek to understand more about this abortion-related phenomenon (the mind-body integration), particularly among highly stigmatized groups like Black birthing people whose health experiences are either missing or underdeveloped to produce more holistic understandings of health that inform the development of health information.

Demythicizing the Fertility Cliff

Age-related stigma within fertility-based conversations is well documented within research about reproduction and emerges in one of our research partner's storytelling about their IUI journey in this study. There is a widely spread belief, the "fertility cliff" myth, that assumes that people who are birthing a person's ability to reproduce or fertility declines after 35. However, there is no significant evidence, over time, across varying demographic groups that establish this belief as truth (Boynton, 2021). Research does note that a person born with the ability to reproduce will encounter a cease of their reproductive capabilities once entering menopause due to a halt in their menstrual cycle. However, the age at which menopause happens or a decline in one's reproductive capacities is subjective and varies from person to person (Boynton, 2021). Thus, a person's age is just one of the many factors that influence people with the ability to reproduce. Other factors include their ovulation cycle, eggs' viability, and ovarian reserve (Boynton, 2021). Although all these factors, plus many more health-related aspects, impact a person's ability to reproduce, the fertility doctor in this study still advised research partner 5 without adequately conducting various fertility-related testing.

Understanding Reproducing while Black and Queer

Other issues that emerge in research partners' storytelling about their assisted reproductive technology journey are the biases the fertility clinic system has against Black and

Queer people that influence the health advice they get from the doctors and their access to resources. In research partner 5's storytelling, they detail how the medical community within fertility clinics utilizes heteronormative values to inform their institutional practices. Whether that be the doctor assuming that research partner 5's wife was a male or the staff interpreting her use of the word fiancé to mean husband. Either way, the presence of heteronormativity in reproductive health-based institutions keeps Queer and single people from receiving adequate quality care throughout their fertility journey by assuming there needs to be a man active and present within their process. Future health clinics should promote access to ART services that are not solely focused on infertility, heterosexuality, or couples but inclusive to all who have desires to family form.

Traditionally, not only has a birthing person's sexuality, gender, and age influenced the quality of care that they receive from ART services but their race (like Blackness) too. The shortage of sperm from Black people is a national issue. The Washington Post reported startling facts that in the four largest sperm banks in the country, only 2% of the donors are Black, and when people try to access sperm from a Black person, it can sell out in minutes (Ferguson, 2022). However, when digging more into the social phenomena, I found little to no investment by the health research community in discussing this issue that causes disparities in access to this reproductive-based service. Reproductive justice includes the right to have children and the chosen method that best fits the person(s). Thus, this includes autonomy in the insemination and sperm selection process. However, due to this shortage, Black people are not allowed to have their desired reproductive journey. Even more saddening is the lack of attention the medical community has paid to this issue of access. The dearth of knowledge about why there is a shortage of sperm from Black people is underdeveloped. What is known is that issues of anti-

blackness and homophobia arise in the selection process for sperm eligibility within these sperm banks.

For example, gay men are excluded from donating anonymous sperm due to outdated studies of their increased exposure to HIV (Ferguson, 2022). Then most sperm banks request three generations of medical history. Considering that Black people are only four generations away from the Atlantic Slave Trade, two to three generations from Jim Crow, the genealogical-based parameters set by sperm banks seem intentionally racially charged and exclusionary. Then outside of the issues of race, there is the problem of the cost associated with ART. Exuberant costs are associated with utilizing some reproductive technologies that are increasingly higher for queer couples. Thus, most Queer people in the U.S. opt for at-home insemination or the "turkey-baster" method because it is the most cost-efficient conception method for family form.

Additionally, Queer people in this country deal with a lack of insurance coverage during their family-forming journeys due to their sexual preferences and inability to prove infertility. Even more distressing is how these problems are intensified for Black Queer people. If Black Queer people choose to pay for ART or work in the fertility clinic system, it is nearly inaccessible to almost half of our community since 40% of us live below the poverty line (Choi, Wilson, Mallory, 2021). These compounding forces that Black Queer people experience when seeking reproductive care for family-forming impose on their right to choose to decide their health unfairly. Future research and health communities should seek to understand the unique challenges Black Queer people encounter when accessing ART and advocate for policies allowing more reproductive-based resources for Black birthing people. Addressing the reproductive concerns of Black Queer people inherently causes us to answer the needs of those with nondominant statuses in race, socioeconomic status, gender, sexuality, and other identities.

Ending the Complexities of Navigating Insurance

There have been efforts over the past decade to increase access to insurance coverage for society's most disenfranchised groups through the passing of legislation such as the Affordable Care Act but previous research details how the healthcare system is becoming increasingly difficult and confusing to navigate, causing patients to experience disorientation, stress, and uncertainty about their care (Griese et al., 2020). For Black Queer people, who are documented as some of the most uninsured in the U.S., it is even increasingly challenging to attain the health literacy needed to maneuver through the complexities of the insurance system. While the research partners in this study prevailed through the system's barriers by finding the emotional fortitude to keep fighting for the health care and services they deserved, it still resulted in an arduous journey that would cause many to lose hope, and rightfully, their desire to have children. Many people who encounter these health insurance access issues will choose to delay care or avoid paying the medical cost due to the ongoing stress caused when interacting with the insurance system (Tipernini et al., 2018). Therefore, future health-related research and health stakeholders should seek to understand more about how not having access to insurance coverage impacts Black Queer people's health outcomes and how the lack of disclosure of health policies and benefits impacts their health decision-making too.

Realizing that Just having Health Insurance isn't Enough

In all the research partners' cases, whether it be navigating the complexities of the health insurance system or realizing that the insurance you have access to does not cover your health needs, there is a need to acknowledge the ways that just having health insurance is not enough. Black Queer birthing people in the U.S. are raising children at the same rate as their non-LGBTQ counterparts (Choi, Wilson, Mallory, 2021) but are more likely to be food insecure, unemployed,

and consequently have less access to health care. Due to the positive relationship between being employed and having access to health insurance, most Black Queer folks rely on Medicaid more than their non-LGBTQ counterparts (Choi, Wilson, Mallory, 2021). While Medicaid rates have been increasing slowly over the past decade for the Black population, it still does not cover housing-related expenses. Having housing security contributes to one's health and overall well-being. While there are housing assistance programs, the majority are extremely underfunded; thus, 75% of households eligible for assistance will not receive it (Bailey, 2020).

Health stakeholders such as health researchers and policy reform advocates should support and treat access to affordable housing as a public health crisis. Additionally, there needs to be more research on understanding what unique social and structural challenges Black Queer birthing people encounter when accessing their health benefits to prevent further disparities in the Black population maternal health outcomes. The more complicated the insurance system is to navigate and understand, the more susceptible Black Queer people are to receiving delayed health care or being put in financial situations that cause harmful consequences like the loss of housing or **death** (Flagg, 2021; Kuehn, 2022).

Saving Lives by Improving Access to Mental Health Services for Black Queer People

Black Queer people, whether dealing with the compounding forms of oppression encountered when navigating the health care system or in society due to their many intersecting identities, are at risk for developing severe mental illnesses. For example, one out of four Black Queer people will be diagnosed with depression, and 82% will experience day-to-day discrimination (Choi, Wilson, Mallory, 2021) outside of the mental health issues they may encounter during their gestational experiences. While there is some research, there are still not enough studies on Black mothers' increased risk for postpartum depression and anxiety and their

lack of mental health care services. Even more scarce is research that examines Black Queer birthing people's experiences with mental health challenges post-gestation.

The dearth of literature on the relationship between mental health disorders and the Black Queer birthing journey makes it nearly impossible to understand the population's health challenges during periods of increased mental health strain like pregnancy, abortion procedures, or miscarriages. Research partners in this study discuss their mental health care needs during these gestational experiences, but most go without the care they deserve due to stigma and inadequate access to mental health services. Future research should explore the mental health services available and the mental health desires of Black Queer birthing people to develop support systems unique to the populations' concerns. Additionally, more studies should explore the provider-to-patient communication about seeking mental health services along their gestational journeys, particularly if accessing mental health services is promoted to Black birthing people.

Rectifying the Violence by Working with Non-traditional Reproductive Health Spaces

Several research partners in this study speak to their experiences working with doulas and midwives and how it created a safe space for them to move along their reproductive health journey. Within these non-traditional health spaces, they could find the autonomy they needed during this process to make the health decisions that they felt were best for their journey. One research partner (p5) in this study utilized it as a space to find quality health care providers within the traditional health care system who could understand them as a fat Black Queer disabled birthing person. However, the traditional healthcare system does not acknowledge the benefit of seeking gestational-based support in non-traditional healthcare spaces. When exploring the storytelling of research partner 3's pregnancy journey, they detail asking their doctor in the

hospital how he felt about natural birth. His response was, "Everything natural is not good. Hurricanes are natural, and earthquakes are natural. Cancer can be natural. I also cried." Unfortunately for this partner, the doctor mocked their desire for a natural birth and compared it to experiencing severe, deathly illnesses and weather-related catastrophes.

This belief that the traditional healthcare systems are the best place to receive healthcare versus non-traditional spaces is perpetuated by healthcare providers and the insurance system. The insurance companies across most states do not financially support birthing autonomy as a right by not covering the costs associated with labor if you choose to give birth outside a hospital (National Academy For State Health Policy [NASHP], 2023). Then for most states with legislation that permits health insurance coverage to cover labor outside of hospitals, the midwives must have a certified nursing degree (National Academy For State Health Policy [NASHP], 2023). This restriction imposed by the state through insurance policies creates a hierarchy in care related to reproduction where the most power is given to those with health knowledge informed by traditional healthcare systems.

Interestingly, when exploring the history of birthing and particularly medical-based birthing procedures, precolonial research documents successful caesarean deliveries in central Africa dating as far back as the mid-1800s, where there was no presence of a medical doctor (Dunn, 1999). This example notes the archival data on the success of birthing experiences outside of a hospital setting, specifically within the Black community. Then, looking at present-day c-sections in the U.S., one study found that compared to obstetricians, midwifery patients had significantly lower intervention rates, and there was about 30% lower risk for first-time mothers experiencing a c-section (Souter et al., 2019).

Additionally, the most extensive study examining at-home birth outcomes found that across 17,000 midwife lead births in the U.S., 98% of birth were successful and did not require postpartum maternal or transfers to a hospital (Cheyney et al., 2014). Even though there is documented success in birthing experiences administered by non-traditional healthcare providers, there is a lack of support for birthing people who choose to experience this form of care. Future studies should explore the birthing experiences of people in non-traditional health spaces, specifically Black birthing people who historically experience disproportionate maternal mortality in hospital settings, to understand the potential benefits of care outside the traditional health care system.

Interacting with Institutions within the Health Care System as a Collective Experience

Most of the research partners in this study interact with multiple institutions within the healthcare system along their reproductive health journey. For some, that included having experiences terminating a pregnancy through abortion clinics, then deciding to give birth to a child at a hospital later in life while navigating the insurance company via both processes. While each research partner's experiences vary on what institutions they worked with during specific moments along their journey, one institutional practice that covertly or overtly emerges across many health spaces: *Access to Quality Reproductive Health Care Determined by Social Positions.*

This dominant institutional practice emerges when research partners in this study navigate the insurance system while being Black and Queer, fighting against the stigma related to abortion services or accessing reproductive care from hospitals and fertility clinics. In all these moments, the research partners in this study discuss the inescapable matrix of power they are placed in because of their many intersecting identities or differences, impacting the reproductive

care or lack thereof they receive. For example, they are not giving the tangible and lived resources needed to family form like access to desired sperm, insurance coverage to cover assisted reproductive technology, or options to choose their birthing experience. These compounding experiences of inadequate care for multiple institutions wreak havoc on their gestational journeys and emotions, leaving them responsible for finding the strength to endure unnecessary trauma caused by the healthcare system.

Limitations

While this study addresses an underdeveloped, and in some ways a wholly missing, narrative of Black Queer birthing people's experiences with gestation, it, like all studies, has limitations. The first limitation is the inability to talk to more research partners due to geographic and time constraints. This study's time frame was limited to the scheduling constraints of the dissertation. While it is one of the largest studies to date to address the phenomena of gestation within the Black Queer community if given more time and financial resources, I could work with other researchers, community centers, and health spaces to reach a larger population. Additionally, future studies should develop and implement more methodological approaches to exploring Black Queer people's gestational experiences. For example, by implementing a phenomenological approach by collecting research partners' objects like clothing worn during pregnancy, materials received by doctors, diary entries, and pictures of hairstyles, etc., novel methodologies could help further our understanding of their lived experiences.

CONCLUSION

This contemporary study centers on the storytelling of Black Queer birthing people's experience with gestation in the health care system at various stages to understand the material and lived needs of this community related to reproductive health care. Through my interpretation

of the research partners' gestational storytelling and their deep reflection on their experiences within the health care system, we highlight the ways that insurance companies, hospitals, abortion clinics, and fertility clinics, through their institutional practices, deny them the birthing, termination, or family forming journeys they desire. These institutional practices are informed by societal beliefs that rely on violent assumptions of how people ought to be that develop from anti-blackness and heteronormativity. Through this discovery, this study highlights how Black Queer birthing people's gestational journeys call attention to the reproductive health inequities encountered by many people (e.g., single people, fat people, poor people, non-white people, etc.).

Research partners in this study, due to their interactions with many forms of violence throughout their journeys, face increased stigma, silencing, and mental health challenges, causing them to seek aid from non-traditional forms of health care like doulas, midwives, and reproductive-based grassroots collectives. Often, for those aware of these support systems, this support seeking is done on their own accord with little to no help from institutions within the health care system. However, through these unorthodox channels of receiving health care and health information, research partners in this study can receive resources that empower them to make gestational-based decision-making that supports their reproductive needs and desires (e.g., working with doulas and midwives).

As a result, this study highlights how Black Queer Being/Knowing/Feeling is a lifesaving praxis for our understanding of current health disparities in reproduction and what resources and beliefs are needed for the future of reproduction that addresses everyone's needs. Therefore, to address further the future of reproduction through a Black Queer lens, the next chapter of this dissertation will utilize the insights of Black Queer people in this study to explicate this needed

new approach. More specifically, the last question research partners were asked in this study, in some form, was, "As a Black Queer person, if you could reimagine a world where people received the reproductive care and services they desired, what would that look like?" Thus, the future chapter seeks not only to use Black Queer perspectives as a disruptive tool for dismantling commonly understood beliefs about reproduction circulating throughout society (as seen in this chapter and chapter 2) but also to demonstrate the world-making power our (us Black Queer people) Being/Feeling/Knowing have in recreating a future where all birthing people are happily, freely, and readily dwelling in spaces that naturally possess the resources that necessitate bodily autotomy.

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APPENDIX A: SEXUAL AND GENDER INDENTITIES

Research Partners' Sexualities	Definitions (these listed definitions are not representative of everyone's relationship to these self-identities)
Queer lesbian/Lesbian	A non-cisgender/non-binary person who is emotionally, romantically, or sexually attracted to other women. Women and non-binary people may use this term to describe themselves.
Women loving women queer	A non-cisgender/non-binary person who is emotionally, romantically, or sexually attracted to other women. Women and non-binary people may use this term to describe themselves.
Queer fluid	*A person who is* nonbinary and their sexual and gender identity are not fixed and are capable of changing over time.
Pansexual	Describes someone who has the potential for emotional, romantic, or sexual attraction to people of any gender (regardless of assignment at birth) though not necessarily simultaneously, in the same way or to the same degree. Sometimes used interchangeably with bisexual.
Bisexual	A person emotionally, romantically, or sexually attracted to more than one sex, gender or gender identity though not necessarily simultaneously, in the same way or to the same degree.
Demisexual	Is a person who does not experience primary sexual attraction, defined as sexual attraction that based on sight, smell, or other instantly available information. Demisexuals experience secondary sexual attraction after knowing more about the person over time, and this time varies person by person.

Table A1: Sexual Identity

Research Partners' Gender Identities	Definitions (these listed definitions are not representative of everyone's relationship to these self-identities)
Female	A cisgendered woman (biologically assigned female as birth) whose sex aligns with what they consider to be female.
Androgynous	A gender identity that is simultaneously a blend of both or neither of the binary genders (man/woman). They can also identify as neither feminine or masculine, or neither female nor male.
Spiritual being (Yoruba)	The Yoruba recognize a Supreme Being, Olorun or Olodumare (who is without gender).Yoruba language is *largely gendering neutral* and traditional Yoruba culture is gender balanced. It does not conform to the heteronormative values developed within Western Society.
Non-binary/Gender Fluid	An adjective describing a person who does not identify exclusively as a man or a woman. Non-binary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories. While many also identify as transgender, not all non-binary people do. Non-binary can also be used as an umbrella term encompassing identities such as agender, bigender, genderqueer or gender-fluid
Non-binary woman presenting person	A non-binary person who also acknowledges that their gender expression is perceived by others as cisgender woman/female.

Table A2: Gender Identity

APPENDIX B: RACIAL AND ETHNIC IDENTITIES

Race/Ethnicities	Definitions
African American	Is a Black person born in America that is of African descent.
Black	Is self-descriptive and political term used among Black people to associate as someone from the African diaspora.
Black Black	A self-descriptive term used among Black people. To say Black twice means to be Black to the maximum capacity and way to separate oneself further from whiteness, happily.
Cameroonian	A person who is native of Cameroon (a country in Africa)
Nigga Nigga	A term among of endearment among some Black people (used from one black person to another) to describe themselves or another. To say it twice means to be a nigga to the maximum capacity and way to separate oneself further from whiteness, happily.

Table B1: Race/Ethnicity

APPENDIX C: RECRUITMENT FLYER

Figure C1: First Page of Recruitment Flyer

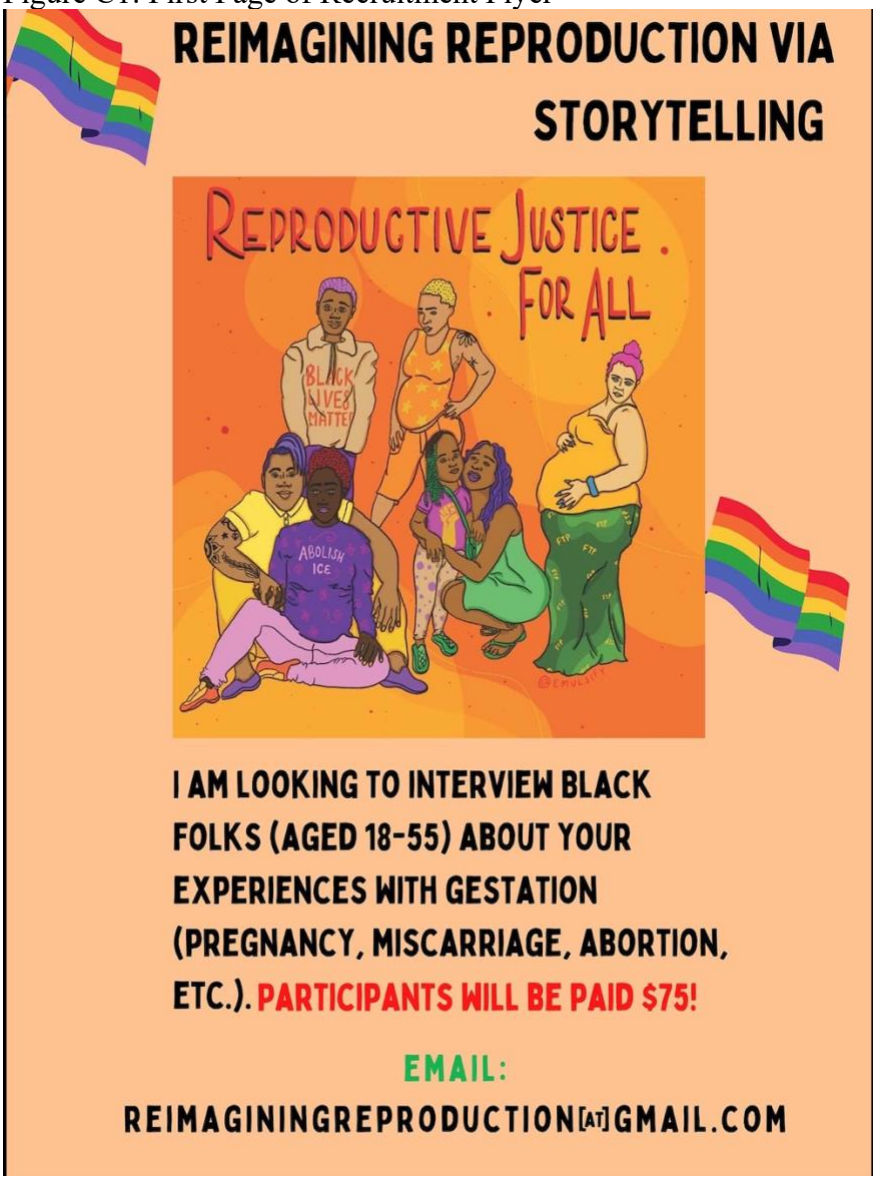
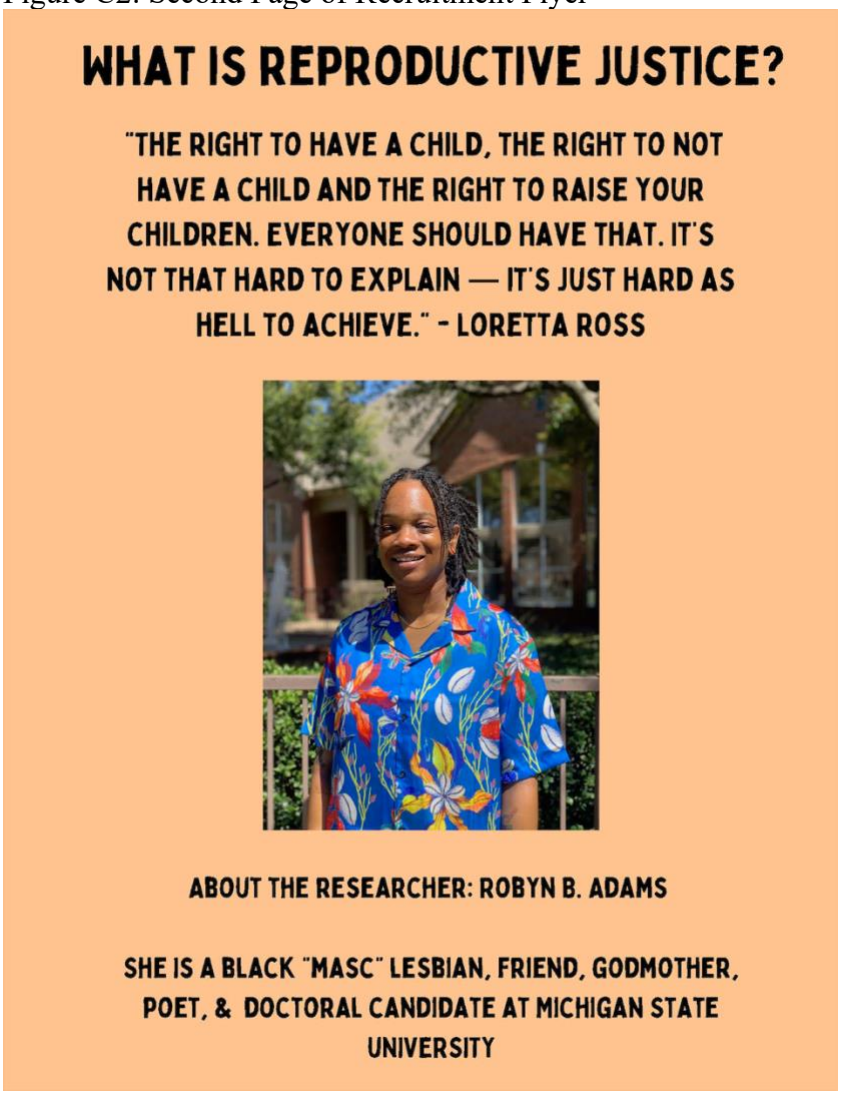


Figure C2: Second Page of Recruitment Flyer



APPENDIX D: INTERVIEW QUESTIONS

1. *Consent*	Introduce who I am. I'd like to talk to you for about an hour about your experiences with gestation. I'll anonymize it to protect your privacy. You can also ask that any or all information I have be deleted, at any point in this interview. Do you have any questions before we get started? Are you ok with me starting the recorder now? [**BEGIN RECORDING**]

2. *Present (identity questions)*	***Goal: acknowledge both physicality and being/knowing/feeling How do Black "Queer" women participate identity-related construction?*** 1. Presently how would you describe your race? 2. Presently how old are you? 3. Presently how would you describe your sexuality? 4. Presently how would you describe your gender/gender expression? 5. Presently how you describe your socioeconomic status? 6. Presently, how would you describe your relationship status?

3. *Past (identity questions)*	***Goal: acknowledge both physicality and being/knowing/feeling How do Black "Queer" women participate identity-related construction? (overtime)*** 1. Five years ago, how would you describe your race? 2. Five years ago, how would were you? 3. Five years ago, how would you describe your sexuality? 4. Five years ago, how would you describe gender/gender expression? 5. Five years ago, how you describe your socioeconomic status? 6. Five years ago, how would you describe your relationship status?

4. ***Past and Present Desire for gestation***	***Goal: acknowledge both physicality and being/knowing/feeling Black "Queer" women's desire to experience gestation? (overtime)*** 1. Presently, how would you describe your desire for children? 2. 5 years ago, how would you have described your desire for children?

5.*Gestational journey*	***Goal: acknowledge both physicality and being/knowing/feeling Black "Queer" women's experience with gestation? (overtime)*** 1. How would describe your family forming journey via gestation? What was the process like for you? Probes or helpful guides for the partners storytelling…(all of this is paraphrase it*) 1. Why or why not did they opt in or opt out of the health care system? 2. Who does your family dynamic look like as it relates to your gestational and parenting journey? Are they co-parenting with a partner or another individual? If so, what was the role of each person? 3. Costs of associated with their journey (social and financial) 4. Role of institutions and institutional-based discourse along their journey? (Such as government informed policies, insurance, media, etc.) 5. Support Systems: informational seeking, emotional seeking, finances, instrumental, etc. 6. Feelings throughout the process?

6. ***Final Question***	***Goal: What did I miss?*** 1. Is there anything else, you think I should know about your feelings, thoughts, and experience with your gestational journey?

APPENDIX E: TOP CODES

Top Codes	Definitions
Relevant Institutions (referenced 255 times)	"Any time a speaker names any institution that intersected with their gestational journey"
Identity (referenced 193 times)	"These are declarative statements of identity including race, class, gender, sexuality, geography, socioeconomic status, etc"
Pregnancy Experience (referenced 189 times)	"These are descriptions/conversations related to their pregnancy experience"
Health Care System (referenced 165 times)	"When the health care system is mentioned during pregnancy experience"
Relating to gestational body (referenced 144 times)	"Declarative statements about the speaker's relationship to their own gestational body"

Table E1: Top Codes

CHAPTER 4: BEING/KNOWING/FEELING: THE FUTURE OF REPRODUCTION FROM A BLACK QUEER LENS

BACKGROUND

Reimagining reproduction from a Black Queer lens is my radical attempt to address reproductive health disparities for my community, which is being murdered by the hands of the healthcare system, the government, and this country at a disproportionate rate compared to any other group within the U.S. The purpose of this last chapter is to deeply engage with Black Queer being/knowing/feeling as an ontological site for reimagining reproductive politics, reproductive health care, services, and health information about reproduction. Through deep reflection and analysis of discussions from Black Queer partners in Chapter 3's response to: "What is the future of reproduction from your perspective?" the reproductive health information gained from the field sites, and my engagement with these many sources, I create a series of short poems (via my creation of black-out poems) and construct health communication materials that address the future of reproduction. I reimagine a world where reproductive justice materializes within the short poems and health materials. Through these examples, I reengage the Black Queer being/knowing/feeling of the partners in this work and my own lived experiences as a Black Queer person with discussions of reproduction utilizing epistemological techniques offered by Black feminism as a research practice from a justice-oriented lens.

Through this untraditional methodological approach to addressing this phenomenon of Black Queer reproduction from my perspective as a Black feminist in health communication, I intentionally disrupt dominant ways of designing and reporting health research within the field. This approach means I am disinterested in continuing the standard approach established through the positivist research philosophy for reporting data, which often relies on deductive reasoning,

and avoiding using the researchers' common sense due to the fear of bias in reporting research findings. Furthermore, I reject the idea science must be value-free or that I, as a researcher, should be detached or neutral in a conversation related to reproduction (Ramanathan, 2008). Instead, I build off the works of Black feminist perspectives like the Combahee River Collectives (1977), who notes the importance of continual self-examination and self-criticism of our politics as a pertinent aspect of the research practice. As I merge this theoretical perspective into my practice of research studying reproduction from a justice-oriented approach, I must disengage from dominant research paradigms within health communication that are complicit in excluding the human (lived) experience within health research that replicates anti-blackness and shift to perspectives that counteract this approach.

How will we get Free? "I am a Maroon. We are Maroons."

Black feminist Dill (2022), in her article "Maroons: Blackgirlhood in Plain Sight", provides a theoretical opening to remake, reimagine, and resist structural bondages that seek to keep the discourse of Black people in life and in this study tethered to white supremist ideologies and research practices. What are Maroons?:

> Maroons n. 1. fugitive Black slaves [**ME**]; 2. former enslaved people who physically fled their enslavement to maintain absolute sovereignty; 3. descendants of such enslaved people [**WE**]. Maroonage (also: marronnage, maronage) v. 1. to leave; 2. to resist bondage [**WE WILL**]; 3. to survive (emphasized)

I am a Maroon. The Black Queer people in this work, we are Maroons. We will be free from all the systems of oppression informed and built by white supremacy that seek to hold us captive from reproductive freedom. How will I work to get us free? I will center the storytelling of Black Queer people and our reproductive journeys and build power within my community by treating

us as experts in our lives of body. To this end, I am especially interested in intentionally reimagining the practice of reporting findings that develop from the Black Queer people in this study's response to the future of reproduction. I will do this by implementing research practices that align with Maroon's disruption of the systems that are products of slavery (e.g., education and the health care system).

1. I deny the government's attempt to control Black people through law-making tactics like the overturning of Roe and Casey that seek to remove our bodily autonomy.
2. I criticize systems of labor that do not adequately provide Black people the fruits of their labor, for example, through the denial of sufficient health insurance coverage.
3. I continue to fight against the traditional or dominant institutions' attempt to manage and control how Black people choose to form families or not reproduce through their many institutional practices (as outlined in Chapters 1-3).

As a *Blackgirl maroon-in-plain sight*, how do I go about this in reporting my research on Black Queer reproduction? In this next section, I create and disseminate visual art and a series of poems as an alternative to traditional forms of reporting health communication research that provides Black Queer folks health information about reproductive health, services, care, and politics that ensure the protection of their reproductive freedom. The forms of cultural reproduction are directly inspired and informed by us – the Maroons.

What is the Future of Reproduction?

Each partner in this study reimagined a world through their lens as a Black Queer person where reproductive justice freedom exists. Based on these partners' responses (or their transcriptions), I created a series of "blackout poems" as a form of oppositional knowledge that allows Black Queer people to self-define what reproductive justice looks like. Much like Collins

(2009), I reengage with these Black Queer folks reimagining to "resist the negative controlling images of Black" people and reproduction that are often constructed and distributed by institutions like the healthcare system, the government, and media (as discussed in the previous chapters). For example, Collins (2009) speaks to the "solidification of the distinctive ethos" historically present within the Black community regarding how we speak, pray, walk, establish family, and form community. These ways of knowing and living are the spirit of culture and act as a resistance to the white patriarchal society, and these injustices that come from it. Collin's work intentionally centers the oppositional knowledge constructed and reconstructed by Black women (femme or those with the archetype of the Black woman (such as nonbinary people)) in the U.S., as learned via our distinctive ethos. Through my deep engagement with Collins, I think about my construction and reconstruction of oppositional knowledge as a non-binary, trans-masculine Black person that stems from the ways of knowing I gain from the Black Queer people in this study and my life. As I ruminate, I feel the need to develop and reimagine what health communication materials look like when utilizing the ethos of Black Queerness, particularly as a Black feminist in health communication.

Thus, in these following few sections, through my interpretation of the Black Queer stories shared in Chapter 3 and my life in connection to the Black Queer community, I create a series of blackout poems and multimodal health communication materials to participate in my construction and reconstruction of oppositional knowledge. Through these creations of my reimagining of health materials, their experiences (Black Queer storytelling) become my experience, a collective experience – where we, as maroons, break free!

REIMAGINING REPRODUCTION: "BLACK" OUT

Mind Your Business: the world is not perfect!

The world havea picture-perfect life. Life is not perfect. Nobody's perfect. people have emotions, they have feelings, they have thoughts Abortion is not talked about miscarriages are not talking about. The trauma is not talked about. they don't want to keep the baby There is no talk about the mental health isno talk about the physical health every woman, every case, every situation different don't judge me like judging and just being critical with your opinions, that's why the world so damaged for me to flourish, I just gotta do me just mind your business. The business that makes you happy because my business not going to make you happy Everybody mind your own business and if its popsicles the lollipops, you need to go over there with popsicles and lollipops I'm doing it. that's what the world needs to do.

Visualizing Community: a careful connection.

My imagination is so community based it's important that, communities organize We take care of each other My perfect world is communities and everyone is involved community-based physicians community-based trades cross community trade we got technology the lbenefit of technology, be more in connection in their perfect world , you call the neighbor down the street to come help watch your baby Make sure you stay healthy like it should be communal

My dream is to have lots of villages.
inA field with a bunch of herbs easy simple
life Wake up when you want you feel You learn
there's fruit on trees. The
sun is our friend life where you're have power
conversations
need to be rooted in reproductive justice
building community
going to be there and help you raise this child

Ain't I a Mother: the art of feeling.

Emotional stability plays such a big part
Over anything else
I still haven't successfully completed pregnancy
l your emotions, plays a huge partisnot being constantly
stressed
every
time when I think it's going to happen I feel something I'm
stressed out about not trying to be stressed would love to hearsome
it doesn't happen, the first time the first three timesandthat's okay
having some caring courageous
conversations I'm struggling too
It's okay to have emotions and feelings
What do you do with those emotions ?
, how can I communicate that I'm not 100%
that doesn't make me lesser of a
mother

Demystifying Reproduction: happy hours and abortions.

, what reproduction looks like like for different people
that's far more important
if we focus more on just the conversation around reproduction
it will de-mystify miscarriages fertility issues and sexual
dysfunction
it will create a
world
. It will allow people to experience the world
I'm nonbinary

imagine being in a space where someone's gender identity is not the hot topic Or somebody getting an abortion's oh yeah girl it's Wednesday. I got an abortion I can't go to happy hour

Unapologetically Black: fighting for my son's life!

I have to trust that he's going to be in an environment of people who want to see him for him he has to be very inspirational, strong unapologetically black let him be who he is. t doesn't take a man and a woman to have a babylike stop putting people in the box of what families are we're going to have to continue to fight for my son's life he doesn't need a dad He just needs loving people a community in his life build him up . It takes a village raise your child.

more women live in their truth We want to wear of men's clothes doesn't take away our ability to reproduce I would love to see more of society be more accepting to all women to be respected earth I would love tsee it grow let's be honest here you know the truth about our stories and that everyone doesn't have the same. some women just chose to be with a woman, Everybody has a different story. I feel comfortable, rather feel comfortable and you know

Just Be Yourself: a dyke, a lesbian, a kid!

My life changed with kids nothing compares to having your own and if I could have done it differently, I wouldn't. I would love to see people see us Just come into our own if you are a lesbian a dyke s a kid my problem all these things that people say about met doesn't mean shit

you know it’s hard to liveikeyou know it’s scary for people they can't talk they become suicidal, depressed they go through so much just being yourself just be yourself.

To Be Remembered: being seen and being heard!

so much of like my journey has been community. It is very important age we see a lot more midwives .We see a lot more doulas. a lot more people trying to make the connection. invested in seeing me healthy think when all forms of healthcare come from a position of , being seen, being heard I want to be whole so much of the health industry mistrust, lack of communication we're all just people trying to survive We want for more time. legacy, a part of you able to be remembered.

A collision: create life and believe!

, I am a firm believer that we are spiritual being you bring a life into this world you’re adding into this world an energy source there is no larger power so magical preserve your life create life. you are vessel believe believe in a world See it a cool collision be beautiful some things will teach you not quitting on myself I learn a lessonin

[redacted]

WHAT IS THE FUTURE OF HEALTH COMMUNICATION?

In this next section, I reimagine and design health communication materials inspired by the Black Queer narratives shared within my series of blackout poems. These health materials aim to design health information that places the material and the lived reproductive desires of Black Queer Being/Knowing/Feeling within a reproductive justice framework. My job as a Blackgirl maroon-in-plain sight within the field of health communication is to disrupt dominant approaches to health and construct and reconstruct oppositional knowledge through my designing of health messaging that often excludes the insights of Black Queer birthing people. Additionally, my designs needed to include a multimodal approach. For these upcoming sections, I pull from my interpretations of multimodal literacies (Kress & Jewitt, 2003) through a Black feminist lens (Greene, 2022; Kynard, 2023). Traditionally, multimodal literacies are concerned with challenging the dominant ways of language, learning, and representation, where each mode within a text functions distinctively to complete a narrative (e.g., comics, graphic novels, and dance (i.e., movement and sound)). In their work, Greene (2022) and Kynard (2023) discuss how freedom and autonomy for Black girls are found through creative control, particularly within digital literacies, as this multimodal approach serves critically as a method for counteractive narratives to the dominant misrepresentation of their identities. Thus, these upcoming health materials that I create open a window of new ways of engaging with health materials by including audio and visual modalities to reimagine health literacy rooted in oppositional knowledge from Black Queer artists.

Reproductive Justice Politics

Through their narratives, the partners in this study imagined a world where doulas and midwives were accessible and a place where no matter what your gender identity is, you could get the care you deserved. However, the partners also spoke of life, wanting to be remembered, and the desire to not have a child or leave a legacy behind through their children. Thus, the first infographic health communication material addresses the implementation of reproductive politics (see Figure 5) that ensure the health-related well-being and desires of all birthing people (regardless of sex assigned at birth or gender expression), socioeconomic status, and health-related desires. While also attending to the need to address the Black morbidity crisis steadily increasing in the U.S. All reproductive policies recommended in my health material design are current state-level house bills waiting to be heard by legislators or recently passed laws. You can check out the full details of these proposed or passed laws by googling their referenced numbers and the information detailed within the flyer.

Figure 5: Reproductive Politics

The Reproductive Politics section and the creation of Figure 1 were heavily inspired by the perspectives revealed by the partners in this study and my experience in the field of reproductive justice. On March 2, 2023, I traveled to the Texas Capitol with the Afiya Reproductive Justice Center to speak with Texas legislators about pertinent bills that ensure that

reproductive justice is a protected right in this country. Through my experience, I learned that being a reproductive justice advocate means that I center the experience of Black storytelling in my research and become a reproductive justice voter. Someone who not only votes for abortion care and access but advocates for laws that protect one's bodily and birthing autonomy, like gender-affirming care and doula reimbursement.

Additionally, I must be aware of the health issues that disproportionately impact Black people. For example, I live in Arlington, TX, a region that is almost one-third Black and has one of the highest rates of people living with HIV. Thus, if I want to ensure the well-being of my community, I have to vote for policies that provide them with physical access to adequate health testing. Furthermore, in the words of one of the partners of this study, "we [should] focus more on just the conversation around reproduction." Lastly, through my time at The Afiya Center and talking to Texas State legislators, I realized the importance of creating materials about reproductive justice that were legible to both communities. My creation was inspired by the desire to get to the facts like the current house bills waiting to be heard by legislators and having a visual representation (e.g., image and language inclusive identity-related markers of race/ethnicity and gender-based expression) of the Black birthing people.

Community and Reproductive Justice

Most, if not all, partners in this study highlighted the importance of community in reimaging the future of reproduction. Their stories included a world where people had villages that aided in raising their children from tasks like watching their child while they were away or teaching their child that they could be strong, loved, and safely be whom they wanted. The partners also spoke of communities where people had lived in sustainable communities that included access to quality goods and environments with trees and clear, pollution-free skies

where they could feel the closeness of the sun. Finally, they want a world where people organize and have a purpose, whether being a community-based physician or utilizing technology to unite communities. The following health material poster (see Figure 6) visually represents how Black people have historically advocated for the importance of community and the relationship to community and living a quality life. Additionally, I highlight our influence on modern-day understandings of justice-oriented education, social support, food equity, and sustainable environments, and how we have been denied our desire to achieve these ways of living.

Figure 6: Justice-oriented community

In Figure 6., more specifically, I wanted to relay not only the ways that Black people and organizations in the past and modern-day history have advocated for a justice-oriented community that has led to the protection of everyone but also the ways that Black communities are attacked systematically due to their existence. For example, despite the Federal Bureau of Investigation has a 2 million dollar bounty on former Black Panther Party (BPP) member Assata Shakur, or listing the organization as an extremist terrorist group, BPP influenced one of the most prominent food and child equity-based laws in this country. Black people constantly encounter violence at the hands of the government through government-based discourse and land-sanctioned violence.

To this end, it was essential to commemorate all the lives lost in New Orleans due to Hurricane Katrina, particularly those living in the lower ninth ward. This area was and still is occupied by a large majority of poor Black people whom Hurricane Katrina disproportionately impacted due to the infrastructure negligence of the state and city's leadership, who refused to protect those residents by maintaining the levees or contribute adequate funding to restore the ward, even almost 20 years later. Unfortunately, this story is just one of many horror stories of environmental justice encountered by Black people. As we fight for reproductive justice, we must also fight for the right to sustainable communities and living.

Black Life and Reproductive Justice

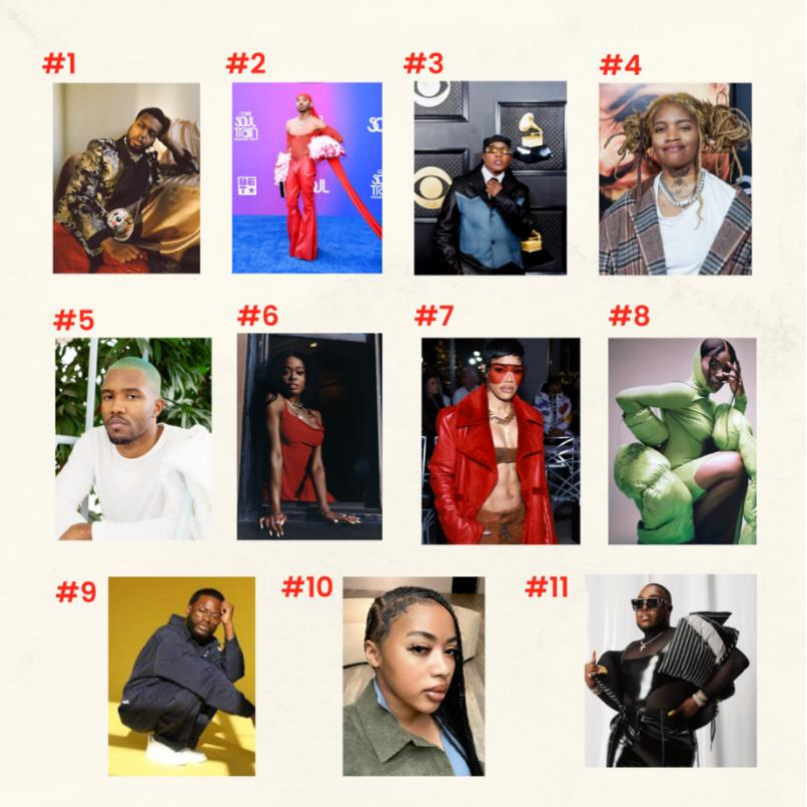
#BlackLivesMatter is directly related to the conversation of reproductive justice because no matter age, when a Black life is murdered, whether that be due to state-sanctioned violence, the lack of quality of health care offered by the health care system to Black birthing people, or through the act of self-administered death, a parent loses their right to raise their child. The partners in their narratives shared and spoke to the magic of life, the desire to survive, live, be accepted, be heard, and be seen. In this last health material (see Figure 7 and Figure 8). I

sonically create a world by providing a tracklist from Black Queer musicians where Black people are heard and believed by the health care system (e.g., doctors and mental health professionals), free from police brutality, their lives are preserved, and they are allowed to have the power to create a world where they are safe. Each tracklisting includes a timestamp of the portion of the song that I want the world (and you to listen to) for your convenience.

Figure 7: Curated Musical Playlist of Black Queer artists.

Figure 8: QRC OR “Click” to listen to the playlist on Spotify

Figure 9: Photos of the Black Queer artists featured in the curated playlist.



In Figures 7,8, and 9, I unpack the conversations of Black life sonically through music by Black Queer artists, discuss their gender identities, their experiences with state-sanctioned violence, their desires for intimacy through Black Queer love, their dealings with socioeconomic hardship, and feeling of only understood by those are just like them – Black. I curate this playlist to build off the works of Black feminists studying multimodal literacies (Greene, 2022; Kynard, 2023) to bridge perspectives from Black girl studies with the field of health communication to improve our development of culturally informed health messaging that centers the oppositional knowledge of the Black Queer community. To this end, I reimagine health literacy that seeks to meet Black Queer people at their ethos to address the critical need to improve the inclusion of the Black Queer community in conversations related to reproductive justice. For example, in the intro of *Mango Butter*, Durand Bernarr unpacks their gender fluidity when they sing out, "**I'm a bad bitch and I'm that nigga**, I don't think you heard me?" Durand Bernarr, through their lyrics

and outfit (in Figure 9), blurs the lines of the gender binary imposed by society and creates a life where they can be both genderless and the best of both worlds. Ambré's *Illusionz* speaks of community and how she feels that no one, other than Black people, understands her or will put their life on the line to save hers. She bellows out at the beginning of this clip, "**Nobody knows me like my nigga**. One that go to war for you and **they die with you**. Ain't no fear when it come to true ones!" Frank Ocean, in a segment of his song, *Chanel*, highlights his experience with state-violence by addressing his feelings when interacting with the police as a 30-something-year-old Black man. Frank writes, "**Police think I'm of the underworld. 12 treat a nigga like he 12**. How you lookin' up to me and talkin' down?" Through these few examples, we discover how these Black Queer people transmute their experiences in the world with their many intersecting identities into music and art for sharing with others to understand their unique being/knowing/feeling.

CONCLUSION

Chapter 4 is just a tiny piece of the experience of what freedom would look like for me as a Black Queer feminist in health communication and this world. Through my many creations of health communication materials and information, I develop culturally-centered and multidimensional health texts informed by Black feminism and Black Queer thought. These many forms of health materials elicit the engagers to immerse themselves in Black Queer art (e.g., music and visual art), Black Queer history, Black Queer literature, and Black being/knowing/feeling to travel through worlds where reproductive justice is described and created through a Black Queer lens. Through this understanding, we learn that reproductive justice is not just conversations about reproduction but includes: environmental justice, access to quality food, access to quality education, community engagement and participation, equitable

laws and policies that protect the lives of all, and world that is accepting of all humans (no matter the gender identity, sexual orientation, race, class, ability, etc.).

Black Queer (Being/Knowing/Feeling): The Future

This work was a journey of my freeing from the ways of knowing and being as a researcher and scholar. Through each chapter, page, and sentence, I free myself from the chains of white supremacy, shame, guilt, fear of loss and abandonment, unworthiness, and all the negativity engrained in me since I was born. While I cannot identify the distinct points where these feelings, these unwanted things, are attached to my being – I do remember the day I decided to get free.

It happened sometime in the Fall of 2022, on a lonely night in my bedroom, where I could only hear my self-deprecating thoughts. I wondered what life would be like in another dimension – off this planet. Would I be able to start over? Would my life be less painful? Would I be free from a world that constantly makes me say my name while telling me I don't know who I am? I cried for hours, asking for a sign from whoever would listen. Then, I felt the overwhelming presence of my great-grandmother, Nanny. While I only got to meet her once, near her departure from earth, her presence made me feel like I had been in her arms 1,000 times before. Our encounter felt like generations of women before telling me, "It's okay," and "We loved you in many ways before you walked this earth." That feeling and those words were enough to keep me moving and to get me to this very point of the Dissertation.

Now, months later, I am far stronger as a scholar, researcher, friend, family member, and human than I was that lonely night. I understand my purpose, and now I am boldly walking in it. A bit of my purpose is in this Dissertation; fortunately, I did what I needed to do. What is that? It was to follow my path of freeing myself and those from the systems and people who wish to

silence our stories. No matter what my committee thinks, the college has to say, or if this work never goes past this point – it still lives. Our stories as Black Queer people have already infiltrated the spaces of your mind, Michigan State's system, and the universe - we are free because we said so. This Dissertation added another spec of energy to this world that will help advance our freedom, and it is well in my soul.

Then lastly, Dr. Teresa Mastin, who is one of my biggest supporters and mentors of my dreams and life goals, asked, "I wondered if the freedom and equality you illuminated is best situated in the existing healthcare structure or if it should exist in an "equal" parallel system?" My response to that question is partially answered within this Dissertation, another part of my response is here in this paragraph, and the last part is still floating somewhere unknown in the hearts and minds of Black Queer people who have yet to walk this earth.

This Dissertation sits at the pit of both life and death. Like others before me, I call death to the current ways of knowing, permeating in anti-blackness and white supremacist ideals that directly inform how social structures described in the previous chapters determine reproductive care and access for people worldwide. While simultaneously pointing to the inevitable areas of creation for reimagining a new world where reproductive justice lives that is present in the metaphysical existence of Blackness - Black thoughts, Black art, Black feelings, Black desires! The Black Queer people in this study made me conclude that the answer to your question is a community, but not a community that is a physically movable structure, but the materialization of community, where our needs and desires are met by the knowing that everything and everyone around us (even the intangible) wants us to live and will actively give and do what they need to do to help us accomplish our goal of life. Thus, the paralleled system replacing the current healthcare structure that I imagine is shapeless, untouchable, and unstable, for it constantly

evolves. Perhaps our mistake is trying to create something so tangible that it relies too much on what can be understood at a particular juncture versus what has yet to be thought of, felt, or seen. My response leaves so much to be discussed and expanded on, but that is intentional because I haven't quite figured out the rest, and maybe I never will. Maybe my contribution is to leave this opening for the next living Black Queer person (here or in the future) to walk through and extend my answer, and then the next person adds – leaving room for endless possibilities.

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EPILOGUE

What's next for me? By the time this Dissertation defense happens, I will be on my way to Toronto for the International Communication Association to discuss Chapter 2 for the feminist division. Second, I'll start subcontracting as a research consultant on an NIH reproductive justice-based grant. I am on the executive research team at the Afiya center, the only Black women-led and founded reproductive justice center in north Texas. Additionally, I am preparing to host a reproductive justice panel alongside the leading scholars at the National Women's Association Conference. Also, moving forward with my goal of reimagining health communciation from a Black feminist perspective, I have partnered with Womanly magazine, a New York City-based, Black-owned women's health and wellness magazine that provides accessible health information to women and non-binary people through art and creative experiences. Through this partnership, we will publish a print and digital issue that profiles Black Queer people's expeirences with gestation, a direct building from this Dissertation. Finally, I will start my tenure-track remote job at Texas Tech University in Advertising & Brand Strategy – becoming the first Black tenure-track faculty in my college's history.

Then lastly, I will have submitted my first NIH R01 grant as a CoPI, where I am proposing an interventional study involving Black and Black LGBTQ+ birthing people and pregnancy-related health, set in a low-income, predominantly Black neighborhood in Dallas, Texas, suffering increasing maternal mortality rates, shrinking access to health care, and high rates of food genocide. By partnering with the only Black women-operated and founded reproductive justice organization in north Texas and their midwife, doula, and mental-health collective, and implementing a multimethodological research approach of objective health measure testing and collection of gestational-based lived experiences to study pregnancy-related

disparities in the Dallas-Fort Worth community. My team and I provide a timely and adaptive online and in-person community-based supportive care intervention to mitigate the unique identified social, structural, and health access barriers causing compounding comorbidities for Black and Black LGBTQ+ birthing people from early pregnancy to one-year post-partum. In short, my work in Black Queer reproduction is not over!