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REPRODUCTIVE JOURNEYS OF INDO-CARIBBEAN WOMEN FROM TRINIDAD AND TOBAGO AND GUYANA TO NEW YORK

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REPRODUCTIVE JOURNEYS OF INDO-CARIBBEAN WOMEN FROM
TRINIDAD AND TOBAGO AND GUYANA TO NEW YORK

A Dissertation Presented

By

TANNUJA DEVI ROZARIO

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

FEBRUARY 2023

Department of Sociology

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Trinidad and Tobago and Guyana to New York

A Dissertation Presented

By

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DEDICATION

*To my parents who crossed oceans for me to accomplish my dreams:
Devika Rozario and Dennis Rozario*

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As an immigrant Indo-Caribbean woman, I am extremely grateful and proud to accomplish this educational dream. First, I would like to thank my mom and dad for your love, inspiration, and care that gave me the strength and resilience to complete this dream. I would like to thank my grandparents, who also raised me with their endless love. To my partner, Trevor, I value you immensely as you continue to inspire me to break boundaries every day and lead passionately. To my aunts and uncles, including Aunty Indra, Uncle Bishan, Uncle Ricardo, Aunty Andrea, Uncle Rajendra, Aunty Sherry, Uncle Vincent, Aunty Patricia and my many cousins that refused to let me doubt myself and their unconditional support, thank you.

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ABSTRACT

REPRODUCTIVE JOURNEYS OF INDO-CARIBBEAN WOMEN FROM TRINIDAD AND TOBAGO AND GUYANA TO NEW YORK

FEBRUARY 2023

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Given the lack of support by the U.S. federal government for reproductive health, this dissertation examines a puzzle: why are Indo-Caribbean women from Guyana and Trinidad journeying to New York for reproductive health care? I focus on a global community in Queens, New York, to unravel this puzzle. I conducted semi-structured in-depth interviews with 82 Indo-Caribbean women and participant observations in women empowerment groups hosted by activists in New York. Each chapter in this dissertation focuses on various motivations and negotiations during reproductive journeys. First, this dissertation finds that social networks and grassroots organizations in New York facilitated reproductive journeys and challenged gendered norms around motherhood through gender consciousness-raising at events, workshops, and dialogues. I also found that these challenges and negotiations were informed by their class, as women from middle-income households are more likely to challenge gender norms outwardly. In contrast, women from low-income households are more likely to challenge gender norms

secretively. Secondly, these journeys became a home away from home that exposed journeyers to new ideas and values within the Indo-Caribbean community while also being surrounded by family, food, and music that reminded them of Guyana and Trinidad. Culture also became important during doctor visits as some health care providers were aware of the norms in the Indo-Caribbean community. Some women wanted culturally distant doctors due to their experiences of discrimination in their home countries. Thirdly, I found that intimate partner violence influenced women to obtain reproductive health care and create distance from abusers. I contextualize their experiences within the histories of colonialism in Guyana and Trinidad to understand the current structural conditions that contribute to IPV and reproductive injustice.

Importantly, experiences of intimate partner violence led to reproductive control, lack of access to reproductive health care, and maternal health risks. While these findings serve as reasons why they journeyed, they also navigated various hardships in New York. This dissertation expands on sociological theories of gender, gender-based violence, medical tourism, migration, and grassroots organizing. Importantly, I show the importance of understanding reproductive health experiences through a reproductive justice lens. I center the work of black and brown feminists and womanists in my study and draw from their methodological tools to carry out this research. Ultimately, I shed light on the broader systems influencing transnational reproduction to lead to healthy reproductive lives.

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CHAPTER 1

INTRODUCTION

A woman grabbed onto my mother's arms and screamed from the abdominal pain. Medical neglect, inadequate resources, and a medical system unresponsive to reproductive health care services remain in my unshakeable memory as a seven-year-old girl, a world away in Guyana. My family later migrated to the U.S., although this memory became more surreal for me when I learned that my mother suffered for twenty-three years from a displaced uterus due to inadequate care when she gave birth to me in Guyana. I almost lost my mother, and I know many Indo-Caribbean children have lost their mothers through the unmet need for reproductive health services in their home countries, such as Guyana and Trinidad.

Currently, in Guyana and Trinidad, access to permanent contraception, long-acting reversible contraception, and other medical services depend on one's socio-economic status (de Leon et al., 2019), geography (rural vs. urban), and treatment from nurses and doctors (Rambarran and Simpson 2016). As a result, unsafe abortion is the leading cause of maternal mortality. Similarly, many women in Guyana and Trinidad also die from severe bleeding after childbirth and disorders that lead to maternal deaths that medical professionals ignored.

As I started my doctoral studies, I realized that, like my mother, Indo-Caribbean women in Guyana and Trinidad journey to the United States to escape these health care systems that do not value their bodies and reproductive health choices. Yet, this also presented a puzzle, given the lack of support by the U.S. federal government for

reproductive health. There was very little research that discusses the Indo-Caribbean experiences with reproductive health care and journeys that focus on accessing basic reproductive health services.

My dissertation grew out of this curiosity and my personal experiences, the stories of my mom and other women like her, and the stories of women who were challenging their home health care systems and familial barriers to reproductive health care. My curiosity led me on an ethnographic journey to understand women's reproductive journeys in Guyana and Trinidad and why New York has become a destination for obtaining reproductive health care. Interviews with women who journeyed, women who remained in their home countries due to class and citizenship barriers, and women who are grassroots leaders in New York help illustrate the various moving parts in reproductive journeys. In addition, following and participating in activism in New York presented ways to understand how these journeys are facilitated and how information is shared locally and globally, fostering diasporic communities of activism for reproductive justice. In this project, I refer to the Indo-Caribbeans who journeyed to New York as women because they all identified as women. Two of the activists that I interviewed was non-binary.

As Indo-Caribbeans grapple with reproductive justice, their experiences and activism highlight how local and global health inequalities impact their reproductive health. This dissertation centers on these inequities by showing how gender, ethnicity, class, and citizenship shape access to resources, social capital in social networks and grassroots organizations, and health care. Such transnational and local hierarchies determine who can journey to New York for reproductive health services and illuminates

how they navigate their journeys differently. Encounters within these locations' present new cultural navigations, connections with people, organizations, and interactions with new economies. While this project focuses on the intersections of inequalities that Indo-Caribbeans experience, it sheds light on the broader systems that influence transnational reproduction to lead to healthy reproductive lives. The stories presented in this dissertation illustrate how these inequalities contour women's reproductive health care choices.

Reproductive Health Access in Guyana and Trinidad and Tobago

Casanova and Sutton (2013) introduced the concept of transnational body projects to show how gendered bodies can become constructed during travel across and within nation-states. This concept links bodies and globalization by showing how individual bodies can use the resources that stretch across borders to accomplish their self-identity and refashion their bodies. Deomampo (2016) argues that foregrounding the transnational aspects calls attention to how these journeys are stratified. Global restructuring through trade agreements, international financial institutions, and financial markets shape access to health care and influence which bodies are more valued than others (Pande 2014; Rudrappa 2015; Deomampo 2016; Inhorn 2015; Colen 1995).

The two-tiered health care system of public and private facilities in Guyana and Trinidad creates barriers for women who wish to access reproductive health care. Public facilities care for minor medical conditions, and reflect a lack of trained specialists, poor sanitation, long waiting periods, inadequate equipment, and insufficient providers, especially for reproductive health care. Some public hospitals and facilities do not have the equipment to perform safe reproductive health procedures, and information and

resources on health resources and services are limited (Nunes 2012). Private facilities are often costly and unaffordable for those not wealthy, especially if long-term treatment is required. As a result, women may turn to dangerous routes and unqualified persons for reproductive care access.

Abortion access is challenging in both Trinidad, where it is illegal, and Guyana, where it is legal. In Trinidad and Tobago, unsafe abortion is the leading cause of maternal mortality (Martin et., 2007). According to a report from the Ministry of Health (2013) in Trinidad and Tobago, an average of 2000-3000 women annually are admitted to public hospitals suffering from complications due to unsafe abortions. The Offences Against the Person Act in Trinidad states that abortion is illegal except in cases where it is for the preservation of physical and mental health or saving the life of the person giving birth. In Guyana, access to safe and effective abortion is limited by the inaccessibility of providers and information about abortion. According to the Medical Termination of Pregnancy Act in Guyana, abortions during the first eight weeks are legal for any reason. After eight weeks, an abortion is legal if two medical practitioners provide it. While the legality of abortion differs between Guyana and Trinidad, accessibility remains challenging.

Even though access to contraception is legal in both Guyana and Trinidad, it is inaccessible, especially for low-income women. Costly private facilities are the primary source for long-term contraception, such as sterilization and intrauterine devices (Demographic and Health Survey of Guyana, 2009). Low-income women cannot afford these contraceptive methods and may turn to public facilities for short-term contraception. In Guyana, less than 5% of women are on permanent contraception and long-acting reversible contraception, and 10% of women in Trinidad are on long-term

contraception (de Leon et al., 2019). In fact, Trinidad and Guyana lag in the Latin America and Caribbean region in offering long-term contraception (U.N. Contraception Use by Method, 2019).

Access to care is further exacerbated by living in rural locations in Guyana and Trinidad. According to the World Bank, the rural population in Guyana and Trinidad is reported at 73.31% and 46.81%, respectively. According to the USAID Contraceptive Security in Guyana Report (2006), women in rural areas can be seen by community health providers; 70% of physicians who perform reproductive health procedures are in urban areas. The report also shows that facilities in urban areas provide long-term contraception and reproductive health surgeries—care lacking in rural community health centers. In Guyana, the total fertility rate (TFR) in urban areas is 2.1 children per woman; in rural areas, it is 3.0 children per woman (Demographic and Health Survey of Guyana, 2009). This suggests that there may be an unmet need for reproductive services in rural areas, the very places that lack such resources. Similarly, in Trinidad, health facilities outside of urban areas also lack medical staff and equipment. The TFR in Trinidad and Tobago is 1.6 children per woman (ICPD, 2014). However, there is no data for the rural and urban breakdown of the total fertility rate.

The United States became a destination for Indo-Caribbeans from Trinidad and Guyana when the United States opened its doors to more immigrants in 1965. According to the Indo-Caribbean Alliance, New York is the home of more than half of all Guyanese immigrants and 40% of all Trinidadian immigrants in the United States. As a result, New York has become a home away from home for many Indo-Caribbean people, providing neighbors with similar cultural experiences, network support, familial ties, and cultural

connections with doctors. It may seem that women would be more likely to travel to neighboring Caribbean countries that provide greater access to reproductive health care, but this can be more costly than journeying to New York due to transportation costs. Martin (2016) argues that the United States is a destination for reproductive health care due to its status as a global destination for high-quality and safe reproductive care, its additional clinics and trained physicians, and its scientific and technological resources.

According to a report on Trends in U.S. Health Travel (2015), people from the Caribbean make up one of the three largest groups of travelers to the United States for medical services (44% of all travelers on arrival). People from the Caribbean journey to the United States for better care, facilities, technologies, and affordable health care. Such journeys are often supported through familial and network support in destinations. However, citizenship and socio-economic status continue to serve as barriers to journeying to New York. My dissertation expands our understanding of why people journey to specific locations for health care and the uneven disparities people experience in obtaining care.

Reproductive Journeys

Given such access to care in Guyana and Trinidad and Tobago, women undergo reproductive tourism, a form of medical tourism (Connell 2013; Pennings 2002). However, much research on reproductive tourism focuses on the Middle East and European context and centers on the experiences of privileged groups seeking assisted reproduction services and surrogacy. Thus, little is known about the factors influencing less privileged groups to seek medical care outside their home countries, such as Indo-Caribbeans.

Medical tourism is an umbrella term referring to traveling to another country to seek treatment to improve health, though it is challenging to identify how many medical tourists exist (Connell, 2013). One area of medical tourism is reproductive or infertility tourism. Feminist scholars like Inhorn and Patrizio (2009) disagree with using terms like medical tourism and reproductive tourism because they imply pleasure, leisure, and relaxation through traveling. They also argue that these terms underplay the physical and emotional challenges people encounter through their travels and the barriers people experience in their home countries that influence their journeys.

Inhorn and Patrizio (2009) argue that reproductive exile better captures these travels by uncovering the emotional and physical challenges people may encounter. However, this term can assume a compulsion to travel across borders for reproductive healthcare (Pennings 2005). Some scholars have recently adopted cross-border reproductive care (CBRC) to represent this travel. Cross-border reproductive travel involves any movement of patients to obtain reproductive treatment, such as through assisted technologies (Whittaker and Spicer 2010). However, this term primarily concerns patients receiving treatment through assisted technology. Reproductive experiences abroad go beyond obtaining assisted reproductive technologies. Questions about abortion access, contraception, and other reproductive health services also play a role. Martin (2016) also argues that the neutrality of the phrase “cross-border reproductive health care” obscures power relations and economic transactions involved in seeking reproductive care abroad.

Thus, in this dissertation, I frame women's experiences as “reproductive journeys” to capture the various decisions, pathways, and reasons for seeking reproductive health

care. I asked my participants how they would describe their experiences of obtaining reproductive healthcare in New York, and many described it as a journey. They did not think of it as being in exile or experiencing “travel.” Their journeys began with the many barriers in their home countries that led them to seek reproductive health services abroad. Reproductive health seekers may also face various constraints and negotiations. Some may enjoy their host destinations and wish to stay there, while others return to their home countries. The term reproductive journey captures reproductive health experiences as multidimensional, which represents the various outcomes, experiences, and reasons for journeys beyond assisted reproductive technologies while acknowledging their choices and constraints in home countries and host destinations.

Transnational reproductive journeys are influenced by various decisions and depend on people's agency, choice, and possibility (Gilmartin et al., 2011). These journeys are stratified (Cohen 1995). Access to reproductive health services is differently experienced based on hierarchies of class, race, ethnicity, gender, place in global economy, migration status, and cultural constructions of parenting (Cohen, 1995). These hierarchies are structured by social, economic, and political forces that are enforced through state policies. Another important factor that influences reproductive journeys are ties to culture in the host destination. Cultural affinity with religion, food, norms, language, and relationships with doctors and others within the host destination increase comfort (Connell 2011; Bergmark, Barr, and Garcia 2010). Connell (2011) also found that there is a relationship between culture and health care. People gain greater trust in the healthcare system and perceive less discrimination. Journeys to similar cultural contexts

may also influence people to stay longer as they build relationships with people from the same culture and visit family and friends in their host destinations.

Networks in host countries also become drivers for transnational reproductive journeys by becoming important support systems and ‘care networks’ to offer support and information for these journeys (Parr 2002). Networks play a role in helping journeyers shop around and educate themselves to receive the best quality treatment (Mathijssen 2019; Lee et al., 2010; Barnett and Kearns 1996) and provide recommendations for medical providers. The care of families and friends becomes important, especially in cases of childbearing. This produces the feeling of ‘comforts of home’ with others’ support (Mathijssen 2019). Friend and family networks may also influence people to stay longer in their host destinations (Connell 2011)—this becomes important for women who need long-term treatment. Such connections can also turn journeys into migrations.

Reproductive Justice: Challenging Gender Injustice

Reproductive justice is a global issue (Rozario 2020). Coined by Black feminists in 1994, reproductive justice is defined as the human right to power and resources to maintain personal bodily autonomy, deciding whether or not to have children, and to parent children in safe and sustainable communities (SisterSong 1998). Reproductive justice is about access, not just choice. Even when abortion or other reproductive health services are available, marginalized communities may not have access to their nearest clinic or have the financial means to obtain services (Silliman et al., 2004). Reproductive justice activists also reveal that the fertility of women of color is undermined by systemic and structural obstacles (Price 2020). The reproductive justice

framework helps us understand and identify the power systems circumscribing race, gender, and class that impact reproductive health services access. Ross (2002) argues that what happens to our bodies is continuously challenged by these power systems. The negotiations and constraints women experience must be located within the economic and social realities that shape their lives and ability to access a good life. As I focus on women who are journeying from Guyana and Trinidad, I am aware of how these systems shape their journeys, and I am interested in how we can create reproductive justice for these women to achieve their sexual, reproductive, and parental desires.

Gender is central to women's reproductive journeys as they challenge and resist gender norms that serve as barriers to access care. Reproductive justice scholars argue that women of color are subjected to sexist stereotypes (Silliman et al., 2004), which impacts the gendered expectations for how they enact sexuality and reproduction. Women's gender performances reflect the gendered expectations as they constantly engage in practices of re-doing, un-doing, and doing gender, which maintain gendered structures (West and Zimmerman, 1987; Mojola 2014; Alfrey and Twine 2016) or challenge gendered hierarchies and positions. Feminist scholars have regularly shown this instability of gender (Snorton 2017; Butler 1990), explaining that the ways we perform gender in always changing.

For the people undergoing reproductive journeys, they challenge gender norms that restrict their access to care and reform their own understanding of gender. Snorton (2017) argues that as people are moving, their gender is transforming. Gender "operates, usually simultaneously, at multiple spatial, social, and cultural scales" as people travel or migrate to a different location (Mahler and Pessar 2006:43). Traveling or migrating to

another location leads to new freedoms to expand gender practices (Andrews 2014; 2018). Others argue that migration reinforces male dominance over women as men adapt to new ways of expressing masculinity (Boehm 2008). Much of this depends upon the cultural context of gender norms operating in the specific sending country compared to those operating in specific receiving societies, whether women migrate with families or solo, and what type of migration it is (economic, familial, educational, and so forth). Either way, such travel, and movement reconstitute new forms of gender transformation (Malhotra, Misra, and Leal 2016; Mahler and Pessar 2001; Pessar and Mahler 2003; Hondagneu-Sotelo 2003, 1994; Menjivar 1997; Gold 2005).

This is no different for Indo-Caribbean women. Access to reproductive health care for Indo-Caribbean women reflect the stereotypes and traditional norms they are expected to uphold. Some feminist scholars argue that Indo-Caribbean women share similar cultural values with other Asian Indians within the diaspora—expecting women to be obedient mothers and wives and upholders of Indian morality (Choudhry 2001; Kallivayalil 2004). Indian women in the Caribbean are expected to obey traditional gender roles, patriarchal community expectations and repress their sexuality (Roopnarine et al., 2009; Hosein 2011; Kanhai 2011), which shapes how they enact their sexuality and reproduction. Reproductive justice scholars argue that we believe we do not feel like we are in charge of our own reproductive and sexual destinies by internalizing these sexist and gendered expectations (Silman et al. 2016)

However, Indo-Caribbean scholars argue that Indo-Caribbean women are constantly renegotiating patriarchal and imperial conceptions of power (Mehta 2004; Kanhai 2011). For example, Mehta (2004) argues that Indo-Caribbean's resisted caste

systems and gendered norms in India through their migration to the Caribbean in 1838 as indentured laborers. Kanhai (2011; 1999) also argues that Indo-Caribbean women found empowerment and creativity by developing and exploring their gender and ethnic marginalization. Kanhai uses an event, Matikor night—a night where Indo-Caribbean women gather to celebrate weddings and the transformation of the meaning of the Bindi to show that Indo-Caribbean women are progressive. The Matikor night represents a community of women coming together to challenge gendered ideologies; this community reflects women's networks that facilitate reproductive journeys.

Moreover, Despot (2016) found that Indo-Caribbean women who migrated to the U.S. experienced a transformation of gender practices because they had to manage the household and obtain jobs. Such transformation reveals gender and power negotiations as women challenge conceptions of gendered expectations—disrupting assumptions that Indo-Caribbean women are one-dimensional and highlighting women challenge norms in their own ways.

Even though Indo-Caribbean women are challenging norms, there remains a tension between traditional values, career, empowerment, and demands within their familial lives (Youssef 2011). These tensions can be more difficult for some to challenge depending on their social positioning, such as class (Hoesin 2013). Gaining reproductive health care access abroad becomes important journeys for Indo-Caribbean women as they negotiate and resist gendered practices and norms to attain reproductive justice.

Social networks become important reproductive justice advocates as they facilitate reproductive journeys and help women challenge patriarchal norms and gendered structures, such as the family (Hondagneu-Sotelo 1994) in Guyana, Trinidad,

and New York. These social networks revolve around friendships, kinship ties, and family. These networks provide resources and help women negotiate their travel with their families (Menjivar 1997; Gold 2005). Social networks can also work alongside reproductive justice grassroots organizations to share information and resources about healthcare. Thus, reproductive justice grassroots activists also become important for me as I focus on the immense influence they play in women's reproductive health journeys and their access to related services.

Grassroots Organizing and Reproductive Health

Throughout my dissertation chapters, I also explore how grassroots organizations facilitate reproductive journeys and educate and build awareness about reproductive health in the Indo-Caribbean community. Sociologists have long explored how participation in grassroots groups can bring about change. However, Luna (2020) argues that sociologists' recent interests in grassroots organizing largely focuses on incarceration and housing, with little attention to health care. Reproduction receives less attention among sociologists, despite controversy in the United States around reproductive health services. Sociologists also have paid too little attention to how less prominent health organizations organize for reproductive justice. For example, Nelson (2011) details how the Black Panthers fought against racial bias of health providers and the development for community healthcare centers. Luna (2020) also examines how the prominent reproductive justice organization, Sistersong uses the human right framework as a mobilization strategy to advocate for reproductive health. I shift my focus to local grassroots groups that promote reproductive justice. Local grassroots groups become

especially important for marginalized groups, such as poor women, immigrants, and women who are viewed as “outsiders”—often silenced within their communities.

In this dissertation, I adapt the definition of grassroots reproductive justice organizations from reproductive justice scholars. Grassroots reproductive health organizations are groups that raise consciousness about health and health problems, promote self-empowerment processes to control our health practices and lifestyles through educational programs, outreach, and research to produce social change (Silman et al. 2004; Epstein 2003; Arno 1986), and participate in policy and advocacy efforts to create opportunities to build leaders in communities that are most impacted by reproductive oppression (Ross 2006). Moreover, grassroots groups provide spaces for women to articulate their stories and experiences to challenge injustices within communities and contribute to consciousness raising (Chaudhuri and Morash 2019).

Grassroots groups can also challenge gender-norms and promote reproductive health. Grassroots organizations play an important role in challenging gender-norms in the family and community by engaging in culture shifts and collective acts of resistance (Bell 2001; Martin 2009; Majic 2014). Grassroots organizations cannot address education, healthcare, and cultural practices without addressing gender inequality. For example, Majic (2014) found that these organizations challenge gender ideologies through daily practices, such as developing campaigns to disrupt stigmatizing narratives, challenging gender injustices amongst institutions, such as healthcare and actors that harm membership, and creating resources and educational awareness about membership experiences through a peer-run environment.

This becomes especially important for reproductive justice grassroots organizations as they play a critical role in facilitating discussions on the impact of gendered and sexual norms on reproduction (Zavella 2020; Silliman et al 2016; Sexton, Johnson, and Austin 2018). These discussions in women's health groups serve as a space for the "mutual sharing of information, knowledge, and skills" which "culminates in a woman's active control of her health care" (Thomas 2000:144). Thomas also found that education and information about women's health and health care options became an important driver to seek care as they reduce the physical and social distance between the health care providers and patients.

As groups that work at the local level to provide resources, improve communities, and form a collective to challenge structural violence, I examine how local organizing can produce social change that spans beyond the local context into a transnational context. While grassroots organizations may have a great impact on local communities, migrants, medical journeyers, my study examines how women on transnational reproductive journeys are able to leverage grassroots resources and information to attain reproductive health services and information.

Dilemmas and Approaches: Ethnography and Community-Engaged Research

As an Indo-Caribbean woman entering a field where I grew up, I experienced many dilemmas as an ethnographer. Many questions about my approach to this research project arose for me in the field, including my positionality, reflexivity, and ensuring that I am capturing the authentic and complex experiences of reproductive journeys. As Barriteu (2002) states, "For too long, our experiences have been forced to fit into explanatory frameworks whose assumptions do not mirror the conditions of our lives.

Our multiple experiences have been cut and pasted, thus denying complexities and contradictions.” To capture these complexities and contradictions, I wanted to work alongside the community in my field to understand their experiences and center their experiences as I thought about questions during interviews, sampling, and recruitment.

As a result, my approach to this dissertation was community-engaged research. Community-engaged research (CEnR) involves partnerships with communities, such as community-based organizations, to understand the knowledge and resources in your field. This can inform the design of your research, such as who you want to interview, questions you ask during interviews, and where you conduct your observations (Irby et al. 2021). Much CEnR research has been done to cultivate a deeper and informed understanding of health inequities and development solutions, and in this case, reproductive health inequities are under the microscope. As a researcher, my goal was not only to have a deep understanding of my field, but to improve access to reproductive health across the Indo-Caribbean diaspora. This approach gave me greater insight about the power systems circumscribing race, gender, and class that impact reproductive health services access and locating their experiences within the economic and social realities that shape their lives and ability to access a good life.

Importantly, I approach this project through feminist and womanist methodologies. For example, Hartman (2008) calls for additional reflexivity. At first, I assumed that I understood this culture, but I soon realized that my perspective was limited and that our culture, and how it plays out in different households, is varied. Taking assumptions from my upbringing into the field could prevent me from seeing all standpoints. To uncover these various standpoints, I used Gomez-Barris's (2017) method

—engaging a submerged perspective. During interviews, I ask questions that go beneath the surface of the transnational phenomena occurring and think about the historical and social contexts that are complicit in the process. Such questions focused on the structure of women's everyday lives, women's roles in their communities, and gendered ideologies within women's families and across generations, which can influence and reflect larger transnational phenomena. This method provides me with reflexivity as I ask questions during interviews. It is difficult to feel like an outsider when you share similar identities with your participants (Hartman 2008) but considering issues of standpoint and inclusion are critical to my analyses.

During my time as a graduate student, I drew on womanism to think about my approach to research in relation to the tenants of centering community care, love, and thinking about communities holistically as a product of history and oppressive institutions that continue to shape our lives. Womanism has taught me that it is critical to think about how the realities of who, what, and where our research focuses on is informed by these histories. Womanism also taught me that research can be used as a mechanism to bridge communities with academia. For example, Toni Morrison, argues that womanism serves as a bridge to connect dialogue between the oppression we experience, consciousness reflection of that experience, and our action to resist and eliminate that oppression. Thus, community-engaged research became important for me to ensure that this bridge was created.

My womanist method in this project entails the following:

1. Drawing in the ethical and empowering negotiations involved in creating and distributing knowledge about the world that women inhabit;
2. Recognize, respect and draw on the intellectual capital of the region and diaspora voices;

3. An emphasis on reflexivity, connection and responsibility of researcher to protect the authenticity of the experience and perspectives of the researched;
4. Engage in community activism and recommend policy solutions from participants perspective.

(Medwinter and Rozario 2020)

These approaches were important as I grappled with my positionality, reflexivity, community-engagement, and analyses. As a result of this, my dialogue with participants informed my interview questions as we collectively identified the problems and issues around reproductive health care. I also develop initiatives by leading workshops and creating programs to engage in culture shift and sharing information about reproductive health care by cultivating a deep understanding of reproductive injustice and inequalities in the Indo-Caribbean experience.

Data Collection and Analysis

In August 2018, I started to collect data for my dissertation. For this study, I focus on a global community in Queens, New York. This location is a useful case study because it is the region home to the largest cluster of Indo-Caribbean people in the United States, with a population of 82,000 Trinidadian and Guyanese immigrants (Indo-Caribbean Alliance 2014, para. 4). Participant observations and interviews are my chosen methods because it enabled me to explore in detail the experiences, opinions, and motives of my participants as I try to uncover various processes involved in women's reproductive journeys (Rubin & Rubin 2012; Marshall & Rossman 2011).

First, I conducted semi-structured in-depth interviews with 82 Indo-Caribbean women, which make up 32 women who journeyed for Guyana and 21 women who journeyed from Trinidad and Tobago for reproductive health services in New York, 14 women living in Guyana and 8 women living in Trinidad who did not have access to

financial resources or the citizenship status to journey, and 7 activists who are part of grassroots organizations and networks that facilitate journeys. All women identified as Indo-Caribbean and their ages ranged from 22-52 years as shown in Table 1. Their socioeconomic status also varied. Low-income households were classified as less than \$415 USD per month and middle-income households were classified as \$600-850 USD per month for women journeying and living in Trinidad and Tobago and Guyana. All seven activists living in New York identified as middle-income.

Table 1: Demographic Characteristics of Participants

Characteristic	Description	Number	Percentage
Gender	Women	80	98%
	Non-binary	2	2%
Income ¹	Low-income	45	55%
	Middle-income	37	45%
Education	Did not graduate high school	12	15%
	High school education	43	52%
	Certificate training and high school	8	10%
	Certificate training	5	6%
	College/Attending college	14	17%
Country of Birth	Guyana	48	58%

¹ Low-income households were classified as less than \$415 USD per month and middle-income households were classified as \$600-850 USD per month for women journeying and living in Trinidad and Tobago and Guyana. All seven activists living in New York identified as middle-income.

	Trinidad and Tobago	31	38%
	U.S. born	3	4%
Religion	Hindu	46	56%
	Christian	16	20%
	Muslim	13	16%
	None	7	8%

During interviews, I asked women about their reproductive health experiences in their home countries and New York, motivations for journeying to New York, their negotiations, and constraints during their journeys, interactions with social networks and grassroots organizations, and how these journeys impacted their lives and decisions after returning home. Interviews lasted between 55 minutes to 110 minutes. Before the pandemic, I conducted in-person interviews with women who were in New York. For women who returned home, I conducted interviews through Skype, Facebook Messenger, Whatsapp, and Zoom. During the pandemic, all interviews were conducted through these virtual platforms. All interview data was recorded and transcribed.

To understand the reproductive health services, resources, and education women receive when they arrive in New York, I conducted participant observations. I conducted participant observations in the women empowerment groups hosted by the activists in the organizations that I call, Indo-Caribbean Women Empowerment and Queens Women's Empowerment. Events hosted by empowerment groups consisted of sister circles, educational events, and events that focused on cultivating a better future for Indo-Caribbean women in New York and the diaspora. I was also invited to many internal meetings for women empowerment groups to understand how they develop their programming. However, during COVID, all events became virtual. The virtual events

invited more participants in the diaspora to attend and women who are currently living in Trinidad and Guyana. From March 2020 to October 2021, I attended 48 one-hour long meetings with organizations and 39 events.

I participated in these events as a participant-observer. I participated in conversations during the sister circles and educational workshops. Through these conversations, participants were defining the issues they were experiencing, which informed my research design. I also volunteered at some of the events by helping organizers set up before the event, helping organizers during the event, and becoming a facilitator for some workshops. During these events, I had a notebook to make jottings of interactions and conversations. I then wrote detailed analytical memos after leaving the field site on the same day.

I used various recruitment strategies to obtain participants for this study. I shared my recruitment flyer on my social media (Instagram, Facebook, and Twitter), and I encouraged my friends and family to reshare. I recruited many participants from Instagram because many people in my social circles and activist networks reshared my flyer. I also reached out to several community-based organizations in Queens that serve the Indo-Caribbean community to share with their membership. I developed relationships with several organizations before this study and my gatekeeper, an Indo-Caribbean woman who was part of women's networks. I also relied on respondent-driven sampling by asking every participant at the end of each interview whether they know someone who might be interested in participating. Respondent-driven sampling was my most successful recruitment method.

All interview data was audio-recorded and transcribed verbatim by using the software Otter and professionally transcribed before a multi-stage data analysis. I managed interviews and field notes using NVIVO qualitative coding software. First, I conducted a line-by-line analysis to develop analytical and theoretical codes. I then coded all themes that emerge, not just the themes that support my theoretical expectations. I then analyzed twenty interviews at a time and field notes I collected within this time frame—writing analytical memos about my themes, creating categories, and mapping the connection of concepts and themes (Corbin and Strauss 2008; Glaser 1998). For example, once I identified that women challenged gendered norms differently, I returned to my data, and was able to identify how class background is related. After analyzing interviews and field notes within these intervals, I then re-coded all interviews and field notes based on new connections and themes. After this, I conducted matrix coding to examine differences between groups, such as women living in Guyana and Trinidad, women living in urban and rural locations, women that came to New York and those who did not, and socioeconomic status (household income). After this multi-stage data analysis, I then selected the best quotes representative of my participants' experiences.

Mapping of Chapters

The following chapters explore various reasons why Indo-Caribbean women are journeying to New York for reproductive health care services. In Chapter 2, "Diasporic Reproductive Journeys of Indo-Caribbean Women," I explore the role of culture in feelings of home during reproductive health journeys. Feelings of home, such as being surrounded by family, food, and music that reminds women of Trinidad and Guyana produces comfort and less stress about their procedures. These journeys became a *home*

away from home where women were also exposed to new ideas and values within the Indo-Caribbean community in New York, such as different norms around motherhood, marriage, health, and autonomy. Culture also played an important role during doctor visits. While some health care providers do not share patients' culture, many were aware of the norms around motherhood and marriage in the Indo-Caribbean community, and some women were happy that doctors were culturally *distant* due to their experiences of discrimination in their home countries. In this chapter, I also discuss the various pragmatic reasons for their journeys to New York, such as the cost and quality of care, long-term treatment, and gaining additional opinions from medical professionals.

Chapter 3, "Reproductive Journeys: Indo-Caribbean Women Challenging Gendered Norms," I discuss how Indo-Caribbean women's reproductive journeys are influenced by sexism experienced within communities, households, and doctors' visits in their home countries. I examine how these experiences are influenced by global systems that create inequalities. I also explore how social networks and grassroots organizations with other women facilitated these journeys and challenged gendered norms around motherhood through gender consciousness-raising. These journeys and challenges are informed by their class as women from middle-income households are more likely to challenge gender norms outwardly, while women from low-income households are more likely to challenge gender norms secretly after their journeys.

In Chapter 4, "Indo-Caribbean Women Journeying for Reproductive Health Care: The Intersections of Reproductive Justice and Intimate Partner Violence," I explore the intersections of intimate partner violence (IPV) and access to reproductive health. I found that intimate partner violence was a driver for these journeys to obtain care and create

distance with abusers. I discuss how histories of colonialism shape current colonial violence and inequities are a product of this history. I ground their experiences of IPV within their social and economic realities in their home countries to shed light on the structural conditions that contribute to IPV and reproductive injustice. I also shift our gaze from cultural explanations of violence to understand these realities. Importantly, this chapter tells the stories of women who experience reproductive control, lack of access to reproductive health care, and effects on their maternal health due to IPV. Through a reproductive justice lens, I examine how intersections of gender, ethnicity, and citizenship shape IPV and access to reproductive health care.

In the concluding section, I discuss how reproductive journeys became more than obtaining reproductive health care. As women journeyed to New York, they participated in the community, as well as activism, gathered resources, and challenged various barriers they experienced, such as gender norms around motherhood. Their journeys became a direct resistance to their reproductive health experiences in their home countries and other inequities they experienced. I also discuss the power of a global diasporic activism, which plays an important role in consciousness raising and increasing health education and services. I discuss the impact of Covid-19 on these journeys and the possibilities Covid-19 presented for health care systems and grassroots organizing for public health. I end by creating recommendations to increase access to reproductive health care as well as what we can do to attain reproductive justice.

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CHAPTER 2

DIASPORIC REPRODUCTIVE JOURNEYS OF INDO-CARIBBEAN WOMEN

Introduction

Medical tourism continues to rise on a global scale as patients search for affordable quality care. In our current globalized context, journeying abroad for health care helps solve barriers to health care in home countries. There has been significant interest among scholars examining the processes, reasons, and experiences of patients seeking health care abroad (Inhorn 2015; Connell 2006). One explanation for how patients choose sites for medical tourism is the diasporic dimension. Most studies on diasporic journeys focus on patients who journey back to their home countries for care (Inhorn 2015; Gilnos et al., 2010; Lee et al., 2010). Yet, I flip this logic, by examining patients who look for health care in countries with large populations of migrants from their home country. Given the growth of migrants globally and the increased connectedness between countries of residence and origin, experiences of accessing health care among diasporic communities represents new links between nations and health care systems. However, empirical studies on the diasporic dimension of medical tourism are scarce, and even more so for the diasporic dimension of reproductive healthcare (Mathijssen and Mathijssen 2020.) I extend and shed light on this dimension by centering the experiences of Indo-Caribbean women who journey from Trinidad and Guyana for reproductive health care in New York.

In this paper, I ask: (1) What motivates diasporic reproductive journeys to New York for Indo-Caribbean women? (2) How does the reproductive medical culture

promote patient outcomes, particularly given cultural differences? (3) How do grassroots organizations that focus on the Indo-Caribbean community facilitate diasporic journeys and foster empowerment for Indo-Caribbean women?

Drawing from 82 in-depth interviews with Indo-Caribbean women who journeyed to New York for reproductive health services, women who could not journey due to economic and citizenship barriers, and activists, as well as participant observations at local women's empowerment events in Richmond Hill and South Ozone Park in Queens, I find that journeying to an environment that is culturally similar to their home country plays a significant role. Queens, New York is home to the largest Indo-Caribbean population in the United States, and a significant part of Queens is called, 'Little Guyana.' Indo-Caribbean migrants in New York continue to maintain their culture and relationships with their home countries—engaging in transnationality that bridges the United States to Guyana and Trinidad.

Scholars have shown that this bridge between host and home countries can influence diasporic medical journeys as patients seek care from environments that are culturally and linguistically familiar (Ormond and Kaspar 2019). I further show that this familiarity makes navigating their reproductive health journeys easier. I explore how the feelings of home, such as being surrounded by family, food, and music that reminds them of home makes their journeys less stressful, especially if they are journeying without their partners and families from home countries. I also find that there are various pragmatic reasons to journey to New York, such as the cost and quality of care, possibilities for long-term treatment, and opportunity to gain additional opinions from medical professionals.

In this paper, I explore the experiences of reproductive health journeyers that journey from their home countries to a location that is culturally similar but provides necessary medical support. I argue that their journeys to New York become a *home away from home*. While women are journeying to a location similar to their culture, they are exposed to new ideas and values within the Indo-Caribbean community in New York, such as different norms around motherhood, marriage, health, and autonomy. Thus, I show how they engage with these new ideas during their journeys. This occurs through their interaction with their social networks, activists, doctors, and workshops that gender justice organizations host.

Lastly, I show how women navigate a reproductive health care culture in New York with health care providers that serve the Indo-Caribbean community. While some health care providers do not share patients' culture, many are culturally aware of the norms around motherhood and marriage. Thus, I argue medical providers that are culturally sensitive can better support diasporic patients. I also show that even when medical providers do not share the same culture with diasporic patients, patients may be happy that doctors were culturally *distant* due to their experiences of discrimination in their home countries. While Indo-Caribbean women hope for quality care treatment and a journey that is a home away from home, I also show that women also experience hardships and feelings of isolation, which is informed by their class, length of treatment, and citizenship status.

Literature Review

Diaspora

According to the Records of the Indian Indentured Laborers, Indian indentured laborers were imported from India to destinations like Guyana, Fiji, Trinidad, and Jamaica from 1833 to 1920. Guyana and Trinidad received the largest number of Indians from 1838 to 1917, totaling approximately 383,000 (Williams 1970). Today, Guyana and Trinidad have the largest population of Indo-Caribbeans. In Guyana, Indo-Caribbean's make up the largest population at 39.8%, followed by Afro-Caribbeans at 28.3%, mixed races at 19.9%, and Amerindians at 10.5%. In Trinidad, Indo-Caribbean's compose 35.4% of the population, followed by Afro-Caribbeans at 34.2%, mixed races at 23.0%, and 8.4% of other ethnic groups (Central Intelligence Agency).

The United States became a destination for Indo-Caribbeans from Trinidad and Guyana when the United States opened its doors to more immigrants in 1965. During the 1970s and 1980s in Trinidad and Guyana, there were social, political, and economic upheavals that led to an increase in Indo-Caribbean migration to New York. According to the Indo-Caribbean Alliance, New York is the home of more than half of all Guyanese immigrants and 40% of all Trinidadian immigrants in the United States. The Indo-Caribbean population from Trinidad, Guyana, Suriname, Jamaica and other Caribbean countries and islands make up 20% of the US Census Bureau's Total South Asian Population. Thus, while South Asian populations have been growing in the United States, it's important to remember that a large subgroup comes from the Caribbean.

New York has become a home away from home for many Indo-Caribbean people, providing neighbors with similar cultural experiences, network support, familial ties, and cultural connections with doctors. It may seem that women would be more likely to travel to neighboring Caribbean countries, but this can be more costly than journeying to New

York. Martin (2016) argues that the United States is a destination for reproductive health care due its status as a global destination for high-quality and safe reproductive care, its clinics, trained physicians, and scientific and technological resources.

In this paper, I consider diasporic reproductive health journeys as a *home away from home*. Home represents the socially and culturally constructed meaning of belonging (Valentine 2001; Lee, Kearns, and Friesen 2010). People's search of 'home' and sense of belonging can be seen amongst immigrant societies (Jacson and Penrose 1993). Migrants, and in this case people on their reproductive journeys are in search of a place that is similar to their home environments. Familiarity gives people a sense of security, belonging, trust amongst community members, and identity (Easthope 2004). This feeling of home is created through the processes of transnationalism and the development of diasporic communities. Indo-Caribbeans engage in a process of transnationalism as they forge and maintain relationships across borders through goods, people, information, and capital (Basch et al., 1994; Tanikella 2009). They also strive to create diasporic communities that represent "an idealization of the real or imagined ancestral home and a collective commitment to its maintenance, restoration, safety and prosperity, even to its creation" (Cohen, 2008:17). Drawing from Cohen's definition of diasporas, the Indo-Caribbean community in Queens have a commitment to assert their cultural presence and retain their communities.

As Indo-Caribbeans journey to New York, the experience leads to shifts in their identity, which ultimately facilitate the formation of diasporic communities, as these communities become their home away from home. Those engaging in reproductive journeys, particularly those whose trips are not very short, must learn to live in two

cultures, the culture of their home country and host country. Due to this Indo-Caribbean immigrants create a hybrid culture as they negotiate their belonging (Berry 2005).

Diaspora becomes a process and relationship (Das Gupta et al., 2007; Khan, 2007; Thomas and Clarke, 2006). Hall (1990) further states,

The diaspora experience as I intend it here is defined, not by essence or purity, but by the recognition of a necessary heterogeneity and diversity; by a conception of “identity” which lives with and through, not despite, difference; by hybridity. Diaspora identities are those which are constantly producing and reproducing themselves anew, through transformation and difference (235).

As people strive to retain values of their old homes and their *home away from home*, they are producing and reproducing their identities in new ways. Thus, in this paper, I understand diaspora through Hall’s and Cohen’s work as communities that strive to retain their cultural identities tied to their homelands, while engaging in a process of adapting hybrid identities as they navigate and negotiate their host culture with friends, families, and social networks.

Understanding diaspora through this lens shows how this also becomes a critical process for women seeking reproductive health care within Indo-Caribbean diasporic communities in New York as they navigate alternative cultural norms, as well as the norms embedded within their home countries. As a result, they also engage in a process in consciousness raising among their social networks, families, and friends to adapt new ways of thinking of their reproductive health. This consciousness raising occurs through events, workshops, conversations, and even family events (Reynolds 2006). While journeying to be amongst Indo-Caribbean diasporic communities, they become part of this transnational process of information sharing, health care, and creating new identities.

Diasporic Medical Journeys

In this paper, I focus on how reproductive journeys can become diasporic journeys. Diasporic medical journeys are a component of medical tourism. Diasporic medical travel is defined as a journey in which people return to their ‘home’ destinations or destinations with a similar cultural context for medical care (Connell 2006). Scholars call these patients, ‘migrants returning for healthcare’ (Lee et al., 2010), ‘patient movements of returners’ (Glinos et al., 2010), ‘return reproductive tourism’ (Inhorn 2011), and ‘medical returns’ (Horton and Cole 2011).

Empirical research on diasporic medical journeys is relatively sparse (Mathijssen and Mathijssen 2019) and much research only captures the experiences of people in Europe (Gilmartin 2011; de Frietas 2006), America, Horton and Cole 2011; Bergmark, Barr, and Garcia 2010), and Asia (Lee, Kearns, and Friesen 2010). Moreover, much literature of diasporic medical travel focuses on the experience of people who return home for care, rather than those who leave home for care (Connell 2013; Horton and Cole, 2011; Wallace, Mendez-Luck, & Castaneda, 2009). People return ‘home’ for medical care for various reasons, such as feeling more comfortable with the health care system, quality of care, diverse facilities and choices, transparency of coverage networks, and affordable costs (Mathijssen and Mathijssen 2019; Bergmark, Barr, and Garcia 2010). Patients may be confused and dissatisfied about their foreign healthcare system and health insurance costs (Migge and Gilmartin 2011).

Culture is a significant factor in diasporic medical journeys. Cultural affinity with religion, food, norms, language, and relationships with doctors and others within the host destination increases comfort (Connell 2011; Bergmark, Barr, and Garcia 2010). La Parra and Mateo (2008) and Lee, Kerns, and Friesen (2010) found that cultural factors

can be very significant factors for returning home for Koreans in New Zealand and British migrants in Spain, quite apart from any economic rationale. Connell (2011) found people experience greater trust in familiar healthcare systems and perceive less discrimination. Journeys to similar cultural contexts may also influence people to stay longer as they build relationships with people from the same culture and visit family and friends in their host destinations. Diasporic medical journeys may not occur in distant places, but even in the ‘backyard’ of travelers (Ormond 2008; Connell 2013). People may also travel to nearby areas with similar cultural contexts for medical care. India is a prevalent host country where people from Bangladesh, Nepal, and Sri Lanka travel for medical services (Connell 2011). Crossing nearby borders to neighboring countries minimizes costs and may have similar facilities and language.

Aside from the importance of culture, education about the healthcare system and treatment become an important deciding factor for diasporic journeys. Scholars have shown that diasporic travelers will shop around and educate themselves to receive the best quality treatment (Mathijssen and Mathijssen 2019 ; Lee et a., 2010; Barnett and Kearns 1996). Patients may screen and choose the best doctors, based on the recommendation of trusted people in the host destination and internet resources (Mathijssen and Mathijssen 2019). Networks in home countries for diasporic travelers may become important support systems and ‘care networks’ to offer support and information for these journeys (Parr 2002). The care of families and friends become important especially in cases for childbearing. This produces the feeling of ‘comforts of home’ with the support from others (Mathijssen and Mathijssen 2019). The ‘comforts of home’ from

friends and family may also influence people to stay longer in their host destinations (Connell 2011).

While these are many factors that influence diasporic journeys, these journeys are stratified. Cohen (2009) argues that access to reproductive health care is stratified as access to journeys are determined by hierarchies of class, race, ethnicity, gender, place in global economy, and migration status. Class and immigration status allows women of middle- and upper-class to access reproductive health services abroad (Bochow 2015; Moll et al. 2022; Inhorn 2015). Bochow (2015) shows that middle- and upper-class women who were experiencing infertility were more likely to have access to a visa and finances to seek treatment abroad. Many of these women were also highly educated professionals, comfortable with international travel, or traveled for work or study related reasons. In this paper, I also show how diasporic journeys reflect class and immigration status.

Even though scholars have recognized that diasporic medical journeys occur when people return 'back home' or journey to nearby locations with similar cultural contexts, I show that diasporic medical journeys can also occur by journeying away from home countries to host destinations are not nearby, but are similar to one's culture, I call this 'home away from home' journeys. However, not everyone can undertake these journeys. Little research has also shown the barriers to these diasporic journeys, especially if one is journeying away from home. Research on diasporic reproductive journeys is also limited. However, these scholars push us to think about how reproductive journeys can become diasporic journeys and suggest what motivates reproductive journeys.

Transnational and Diasporic Reproductive Journeys

Medical tourism is an umbrella term referring to traveling to another country to seek treatment aimed at improving health (Connell, 2013). However, Connell argues that definitions of medical tourism are limited because it is difficult to identify how many medical tourists exist. One area of medical tourism is reproductive or infertility tourism. Reproductive tourism has been directed at wealthy North American/European couples who travel to other developed countries to access assisted reproductive technologies and in-vitro fertilization (Pennings, 2002; Inhorn and Patrizo, 2009). Others have also used the term “abortion tourism” whereby women travel to have an abortion procedure in another jurisdiction (Gilmartin and White, 2011; Serrano Gil and García Casado, 1992). However, feminist scholars like Inhorn et al., (2009) disagree with the use of the term’s medical tourism and reproductive tourism to understand the transnational experiences of patients traveling for reproductive health care access.

Inhorn and Patrizio (2009) argue that reproductive tourism implies pleasure, leisure, and relaxation through traveling, underplaying the physical and emotional challenges that people encounter through their travels and the barriers people experience in their home countries that influence their journeys. Even though the term “reproductive exile” captures the emotional and physical challenges people may encounter, the term can assume a compulsion to travel across borders for reproductive healthcare (Pennings 2005). More recently, scholars have adopted the term ‘cross-border reproductive care’ (CBRC) to represent this travel. Cross-border reproductive travel involves any movement of patients to obtain reproductive treatment through assisted technologies across borders (Whittaker and Spicer 2010).

The transnational mobility of reproductive care is dependent on people's agency, choice, and possibility (Gilmartin et al., 2011; Cresswell 2010). This journey is also contingent on a person's nationality, class, and race. Gilmartin et al., 2011 found that women in Ireland that are not Irish, undocumented, and at the bottom of the socioeconomic hierarchy experience transnational mobility in different ways. They were less likely to have reproductive autonomy than women from privileged classes. Oakley (1985) defines reproductive autonomy as a possibility that allows for access to overcome involuntary childlessness and elimination of involuntary reproduction.

Blyth and Farrand (2005) draw on the concept of reproductive autonomy to show the factors that encourage reproductive tourism: individual countries may prohibit services for religious or ethical reasons, there is a lack of expertise (more high-tech facilities are in the developed world), certain categories of individuals based on age, marital status, sexuality may not receive services, and services may be cheaper in other countries. Another factor that restricts reproductive autonomy and encourages reproductive tourism is restrictive legislation (Pande 2014; Rudrappa 2015; Inhorn 2015; Shenfield et al., 2010; Blyth and Farrand 2005). Restrictive legislation can reproduce stigma and support sexist ideologies that can serve as a reason to prevent care (Briggs 2017). After collecting data from 46 ART centers in six European countries Shenfield et al., (2010) found that many patients travel to evade restrictive legislation in their own country. Legal reasons were predominant for patients traveling from Germany (80.2%), France (64.5%), Italy (70.6%), and Norway (71.6%).

There has only been one study that captures the transnational reproductive health experiences of Caribbean women in New York City. More than thirty years ago, Chavkin

and Elman (1997) analyzed all births and infant deaths occurring in New York City from 1980-1984. They show that poor birth outcomes are due to high parity (five or more children) and low socioeconomic status and education of women. A striking result from analyzing birth certificates shows that non-Latinx women from the Caribbean made up the highest proportion of self-paying women. Thus, women from the Caribbean experienced financial barriers. Yet little research explores the *transnational* reproductive health experiences of people in the Caribbean and how their experiences are diasporic. This paper seeks to remedy this gap.

Analyses of diasporic reproductive journeys are underdeveloped in the literature, with only few exceptions (Inhorn 2003, 2011). Inhorn (2011) uses the term ‘return reproductive tourism’ to describe reproductive diasporic journeys with three key features: a return to a ‘home’ country for assisted reproduction technology, a ‘holiday visit to families in home countries, and other motivations different from cross-border reproductive care. Through her exploration of diasporic reproductive travel, Inhorn (2003) found that Middle Eastern diasporic couples return to the Middle East for assisted reproduction technology. Their decision to return to home countries for reproductive care is grounded in the affordability of assisted reproduction services, greater trust in the medicine of their home countries, and the comfort of undertaking their procedures in a familiar environment (Inhorn 2003;2011). Couples seeking treatment had nostalgic attachments of home and wanted to speak the same language of the medical staff to understand the treatment offered to them and the medical terminology.

I extend on the little research that has been done on diasporic reproductive journeys by showing that this journey does not necessarily mean that people ‘return

home,' but rather people can travel to far distances with similar cultures. Moreover, these journeys go beyond receiving treatment for assisted reproduction, rather my participants obtained abortions, reproductive care check-ups, contraception, and various reproductive health surgeries, as well as gave birth . I also further build on the various motivations for diasporic journeys of Indo-Caribbean women.

Methods

This paper untangles a larger puzzle that examines why Indo-Caribbean women are journeying from Trinidad and Tobago and Guyana to New York for reproductive health services, despite reproductive health restrictions in the United States. Participants journeyed to Queens, New York, which is a home for the largest cluster of the Indo-Caribbean community in the United States (Indo-Caribbean Alliance 2014). In this project, I rely on a community-engaged research approach. This approach fosters partnerships with community-based organizations to identify issues, the effects of inequities, and improving community health (Irby et al. 2021). Interaction and inquiries of knowledge about the community can also inform your research questions, method, and questions you ask during interviews. Importantly, working alongside community-based organizations can build trust with community members and make recruitment of participants easier. I also adapt this approach to work with the community to develop solutions and improve access to reproductive health care.

As an Indo-Caribbean researcher going back to my community in Queens, New York to conduct research, I thought about my positionality in my field sites and strategies to be reflexive. Implementing a community-engaged approach informed my reflexivity as I worked along-side community members and community-based organizations to think

about the transnational journeys, health inequities, and reproductive justice in Indo-Caribbean communities. Moreover, this approach helped me understand how ethnicity, gender, class, and citizenship status shape reproductive health experiences by situating the economic and social realities of participants. This approach allowed participants to situate themselves and their authentic experiences.

I conducted interviews and participant observations in this study. I conducted interviews with 82 participants, which make up 32 women who journeyed from Guyana and 21 women who journeyed from Trinidad and Tobago to access reproductive health care in New York, 8 women living in Trinidad and 14 women living in Guyana who did not have the citizenship status or socioeconomic status to journey to New York, and 7 activists who were part of social networks and leaders of community-based organizations. During interviews, I asked participants why they journeyed to New York for reproductive health services, what were their experiences when they arrived in New York, what were their experiences with health providers in New York and their home countries, and how community-based organizations helped women access information and services about reproductive health care. Interviews lasted between 55 minutes and 110 minutes. Before the pandemic, I conducted interviews at the location of the participants' choice and on Zoom, Skype, Facebook Messenger, and Whatsapp for participants living in Guyana and Trinidad and Tobago. During the pandemic, all interviews were conducted virtually. All interview data was recorded and transcribed.

My community-engaged approach helped me recruit participants. I was engaged with many community members through social media, such as Instagram, Twitter, and Facebook. I posted my recruitment flyer on these outlets, and Instagram was my most

successful social media outlet for recruitment. I also shared my flyer with community-based organizations and attendees during events and workshops. I also relied on an Indo-Caribbean woman who connected me with women in Trinidad and Guyana that was part of social networks and community activism. I further recruited participants through respondent driven sampling, which was my most successful recruitment method.

I conducted approximately 150 hours of participant observations from March 2020 to October 2021 at 48 hour-long meetings and 39 educational workshops and events that lasted between one and four hours to understand how journeys were facilitated and supported through grassroots organizations. These events and meetings were hosted by two organizations that I engaged with in the community, which I call Indo-Caribbean Women Empowerment and Queens Women's Empowerment. During these events and meetings, I served as a volunteer, facilitator of workshops, and participated in conversations. I took notes and jottings with the use of a notebook and wrote my field notes the same day.

Participants who journeyed to New York had various reproductive health reasons for obtaining care, such as contraception, endometriosis, abortion, regular check-ups, and cervical cancer. All people and organizations in this project are given pseudonyms. The ages of participants ranged from 22-55. Women had various initial concerns for their journeys, such as abortion, infections, fibroids, and contraception. Everyone on their reproductive journeys identified as women and two activists identified as non-binary, as shown in Table 1.

I analyzed and managed data from interviews and field notes using the Nvivo qualitative software using a grounded theory approach (approach (Glaser and Strauss

1967). I developed analytical and theoretical codes, and then mapped connections between the various themes and concepts. I then wrote analytical memos about my themes. For example, I considered how experiences of medical cultures, support and empowerment, and access to reproductive health care services were experienced in home countries and New York differently. I also made connections to class, citizenship, and familial responsibilities.

Findings

Home away from home

While scholars have shown that women return to their home countries for reproductive care (Inhorn 2011), I show that women can also journey to a *home away from home* that reflect their diasporic communities for reproductive health care. Women wanted to journey to a location that is familiar to them, which also includes staying with their family and friends. The support from their family and friends made their journey to New York feel like home as well as the comfort of the same food, music, and language. These comforts of home were shared among social networks and also made women's families back home comfortable with their journey to New York as well. Even though many women kept their reproductive health journey a secret to New York, some women told their partners about seeking care. These partners were concerned about the experiences of their wives and wanted to ensure that they were being cared for during treatment. Giselle, who journeyed from Guyana to seek treatment for heavy bleeding discusses her partners' reaction about journeying to New York:

He was mostly concerned about who was going to take care of me while I was in New York. He kept asking me if my mom or sisters will take off from work to take me to the doctor or who will be home with me after my

procedure. . .I think he only agreed because he knew I was going to be with my mom and sisters.

Her partner was comfortable with her journey because he knew she was amongst people that cared for her. Like many women that journeyed to New York, their partners could not stay with them during lengthy visits due to financial and familial reasons. Inhorn (2010) also found that partners who knew about their reproductive health journeys wanted family members, especially mothers and sisters to care for their wives. Giselle's mother and sister were there for her throughout her journey in New York, helping her navigate the health care system, providing her with a place to stay, cooking for her, and going with her to doctors' visits. Such support made women's journeys feel like a home away from home, and partners felt the same.

While some women told their partners about their journeys, many did not due to intimate partner violence (which I discuss in more detail in the next chapter), the stigma associated with their reproductive health procedures, and fear that their partners would not let them undertake such a journey. Thus, the comforts of being in a place that is a home away from home also became especially important for women traveling without their partners. Radha who journeyed from Guyana and did not tell her partner about her reproductive health journey discusses this:

I was still coming to a place that I did not know much about, and I didn't have my husband or children with me, so having my friends there made me feel better about the journey. I know I wasn't going to be alone, and they are like family to me...if my friends weren't there, I don't think I would have come.

These journeys can become lonely, and for many of the women that did not tell their partners about their journey, they needed the comforts of friends and family. One of the hardest parts of this journey for some women was being away from their children.

Many of their friends and family they stayed with had children in their homes, and often the women took care of the children while friends and family were at work. Taking care of the children also gave them comfort and provided income during their stay.

Like Radha, other women's diasporic journeys were also facilitated through their social networks. These networks of friends, family, and activists made it possible because women felt like they would be surrounded by love and care, especially when their partners were not journeying with them and when medical procedures had higher probabilities of complication (Mathijssen and Mathijssen 2019). Radica talks about support that made her feel like she was living in Guyana:

When I stayed at my friend's house, I ate chicken curry, listened to our favorite songs by Babla and Kanchan, and even got to hang out in the hammock in my friend's backyard with everyone else. All of this made me feel like I was in Guyana while I was visiting the doctor.

The food, music, and hangouts gave women the comforts of home and shows the importance of being in a home environment while undergoing their treatments. The songs of Babla and Kanchan became a representation of home as she recalls listening to their songs every day in Guyana. This environment made women like Radica feel relaxed even when they were worried about their reproductive health procedures. Similarly, Inhorn (2011) found that staying in a home environment while receiving reproductive care abroad alleviates stress, discomfort, and empowers them to manage the care they need. Such feelings also create the belief that their procedures will go well if they have such support. Julia, who journeyed from Guyana to treat her heavy bleeding stated:

I just knew that coming to New York would be better for me. I felt that everything was going to go well for me if I was surrounded by my friends. I knew that nothing was going to happen to me in the hospital, and the procedure would work.

Julia's belief that *everything was going to go well* is echoed throughout my interviews. Studies have shown that people journeying to a new location can experience various stressors, such as feelings of loneliness, finances, settling in, and leaving their family and relationships behind (Straiton, Ansnes, and Tschirhart 2019). Feelings of home and familiarity reduced such stress of navigating a new environment and created positive feelings for their procedures, which led to beliefs that their procedures would be a success.

While women journeyed to New York because they wanted to go to a home away from home, these expectations were not met for eight of the fifty-three women who journeyed to New York. Kimmy who journeyed from Trinidad to obtain a hysterectomy discusses this:

The plan was to stay with my family during my time in Queens, . . . I stayed there for two weeks and they told me that I had to pay rent for the one bedroom. Can you believe they wanted to charge me six-hundred and fifty dollars for one room? . . . We got into many conflicts, and I was so fed up so I left and rented my own place. . . I felt so alone and so isolated after this.

For women like Kimmy who needed a longer-term treatment, her feelings of home away from home were short-lived. Finding a permanent place to live, obtaining an income to sustain their daily lives, and undergoing treatment all together was difficult. Access to a place to live was also determined by their class because many women did not have immediate access to finances to leave their friends and family. Conflicts also occurred with family and friends, which also increased feelings of isolation. Friends and social networks were important for many women. However, feelings of home may not be present when women did not have emotional support.

Reproductive Medical Culture: Patient Empowerment

Reproductive medical culture between providers and patients became a driving factor to journey to New York for reproductive health care services. This reproductive health culture consisted of gaining familiarity of the health care system through social networks, patient-centered care, affective healthcare, and expectations of being discriminated against less than their care in home countries. Social networks, families, and friends share information about their reproductive health experiences during doctor visits, and ultimately, these doctor visits and sharing of information served as a screening before recommending to journeyers. This resulted in less discrimination during doctor visits in New York. Studies have shown that immigrants perceived the health care system in their country of residence as culturally distant—these created feelings of being seen as an outsider or misunderstood (Mathijssen and Mathijssen 2019).

While there was cultural distance from the health care system in New York in comparison to Guyana and Trinidad, I found that the reproductive health culture fostered a sense of community and empowerment for women during their journeys. While some providers in Queens, New York identified as Trinidadian and Guyanese, women felt comfortable speaking with providers who did not identify as Trinidadian and Guyanese. However, these providers were culturally sensitive to the Indo-Caribbean community. Erin discusses her experience of receiving care for her fibroids from a physician that was culturally sensitive,

My doctor was a white male. . .I told him that it took me a while to visit the doctor because of how I was treated back home every time I went to see the ob-gyn, and that is why my fibroid grew to the extent that it was. He was very understanding and said it was common for women in my community to have this issue. . .I felt so understood because I did not have to explain myself.

This was a common experience among the women. Doctors who served the Indo-Caribbean community were familiar with the discrimination, stigma, and experiences women may have in their home countries even though they did not share the same culture with patients. Since these doctors were serving the Indo-Caribbean community, women felt that they were understood, like Erin stated. This creates a sense of trust and familiarity with the doctors, what Lee, Kearns, and Friesen (2010) refer to as “affective health care.” Patients in social networks recommended doctors based on affective health care.

Cultural competency among providers is further discussed by Angel during a workshop on birth control hosted by Queens Women Empowerment, she journeyed from Trinidad to New York for contraception,

When I told my doctor that I wanted an IUD (intrauterine device), it was like she understood why I came all the way over here to get it. We had a long conversation about me feeling shame and how I was scared of being judged by not only the doctor, but I was also scared that the word would get out to my family that I got it done. . . She did not judge me at all, instead she was so sympathetic about the negative reactions that I would experience, and she knew the shame I would face in Trinidad. . . She also took her time and explained my options for IUD with encouragement to go for it.

Social norms and stigma around contraception limited Angel’s access to care in Trinidad. She anticipated shame and negative reactions from her doctor and community in her home country. Her doctor in New York was aware of the cultural expectations around pregnancy and parenting. Her doctor also empowered her by educating her about her options for an intrauterine device. Angel became a co-creator of her medical care through the conversations she had with her doctor. In this sense, she was able to become proactive in her care management due to the education she received during her visit: a

form of patient-empowerment (Glinos et al., 2010). Due to the medical culture, there was greater personalization for care, transparency, and more engaging experiences between her doctor and herself than when she was seen by doctors at home.

Reproductive health care doctors also empowered women through events that community-based organizations hosted—ensuring that information sharing of reproductive health care occurred beyond doctor visits. I attended a reproductive health workshop by Queens Women Empowerment and observed the collaboration between health care providers and community-based organizations. The excerpt below is from my fields notes:

The doctor started the discussion by sharing her own personal experience about the stigma she experienced as a woman of color when she went to her OBGYN. She spoke about her distrust with health care providers and advised attendees on how they should speak to their health care providers if they are scared. She also provided many educational tips for birth control access and abortion access.

One attendee stated, “This space opens room for conversations that I never had before.” Another attendee stated, “I am always afraid of getting slut shamed to be on birth control or my doctor will view me in a negative light, now I know that I need to choose a provider that is right for me. If I am not comfortable, I should not go to that provider again.” The doctor also shared important resources and which doctor offices to visit for reproductive health care.

Patient empowerment not only occurred during doctor visits, but also various empowerment workshops that occurred in New York. Health care providers empowered attendees during these events to take control of their health and provided information and guidance on how they should navigate their doctor visits. This became important for both women currently living in New York and women journeying from their home countries. Studies have shown that women of color and immigrant women have mistrust in the medical system due to low quality care, discrimination, and poor health outcomes

(Sullivan, Vaughn, and Wright 2020). These workshops bridge this gap as women are able to hear from health care providers to make informed decisions about their reproductive health.

Such collaborations amongst community-based organizations and health care providers brought resources to where women are in the community. These resources flow through the social networks of women who are journeying to New York for care. Such transfer of information becomes critical for diasporic reproductive journeys because it helped women shop around for care and addressed some of their concerns of experiencing stigma. Moreover, these workshops created conversations that help destigmatize reproductive health care, a concern amongst the attendees during this workshop. Queens Women's Empowerment organization continues to host workshops that invite health care providers to speak to community members.

While grassroots organizations try to bridge the gap between mistrust between patients and providers and many women hoped for better medical treatment and care from doctors, seven of the fifty-three Indo-Caribbean women who journeyed did not experience this. Joy who journeyed from Guyana to seek treatment for her fibroids discusses this:

I came to New York to treat my fibroids. . . For the entire time that I was there [New York], I was so confused. First, I was on pills, then injections, and it was just wasting my time. I wanted to go back home. . . I knew the fastest way was to get the surgical removal, and I kept asking for this, but they always told me to come back. I had to change my doctor three times to get the surgical removal. . . I feel like they just gave me the run around because I was new to there [New York].

The distrust in the medical system in the United States among women of color and immigrants also stems from their experiences during their doctor visits, such as

miscommunication, wait times, and discrimination based on race, ethnicity, gender, citizenship status, and socioeconomic status; this is particularly true for members of Latinx and Black communities (Sullivan 2020; Samson 2016; Roberts 2014). These experiences were highlighted during Joy's reproductive health journey through miscommunication and experiencing distrust as she changed her provider three times. Even though women had the social capital and connections with medical providers provided by their social network, for seven women they had similar experiences of obtaining care in their home countries. Through this experience, women's confidence in the health care system reduced, and they did not receive the care they envisioned.

Pragmatic Reasons

Diasporic reproductive journeys amongst Indo-Caribbean women were influenced by pragmatic reasons, such as relative cost, relative waiting time, diversity of facilities, shopping for the best quality health care, and time availability (Deloitte 2016; Mathijssen and Mathijssen 2019; Inhorn 2011; Bergmark et al., 2010; Connell 2011, 2016). More than one reason can influence a patient's choice to journey for reproductive health care abroad, and certain motivations can also reinforce each other. The cost of reproductive health treatment in home countries relative to the cost in New York became an important reason to seek treatment abroad. The cost was dependent on the number of times women needed to visit hospitals and doctors' offices, the availability of flight options, financial support from social networks, availability of accommodation by friends and family, and access to health insurance. Indo-Caribbean women became aware of these costs based on the information given by their social networks and shopping around (Lee et al., 2010) for

health care providers and flights while still in their home countries, as a result positive experiences of health care was a result of social network screening.

Diasporic reproductive health travelers have an advantage in shopping around due to the personal experiences of friends and relatives and their ability to verify the credentials of health care providers (Mathijssen and Mathijssen 2019). Shopping around allowed women to compare the costs, Movina who needed ongoing medical treatment due to endometriosis discusses her experiences of shopping around for health care while she was living in Guyana:

I called many of my friends to find out the availability of health insurance, what their co-payments looked like, and information about their doctors. . .we talked about how I can get health insurance and they even helped me convert the US dollars to Guyana dollars to help me compare costs.

Like many women, Movina leveraged her social network in New York as her medical expense was increasing due to her ongoing treatment in Guyana, she further states:

I was so fortunate to go to a private hospital called Mercy Hospital. I had a good paying job as a spare parts business owner, but even with this job, I could not even afford all the bills. I had to pay for everything in cash, and it came up to over a million dollars (Guyanese) in medical bills, and even at that point there was no certainty of what was wrong with me.

The structure of the health care system in Guyana requires patients to pay out of pocket for medical treatment in private facilities. Movina was lucky enough that her middle-class status afforded her several visits to a private facility, however she quickly realized that she could not afford all of the medical visits she needed for her treatment. As she stated, her medical bills cost over a million Guyanese dollars, approximately \$5000 USD. These payments require a cash payment—a payment many cannot afford. Thus, shopping around for alternative care in New York becomes a practical option for many women. This experience of shopping around for care with their social networks

influenced their diasporic journeys as they learned about the health care system before journeying to New York.

Altia further discusses the cost of reproductive health care treatment during her pregnancy in Trinidad, she states:

My first bills came up to around three thousand US dollars. I was like holy shit; I have to mortgage my house in Trinidad to pay these bills. . . I said no way. . . My friends told me that if I am pregnant, my medical costs would be covered in New York. . . I could have lost my house and my mom's house in Trinidad if I had to pay those bills [medical costs in Trinidad].

Altia experienced many complications during her pregnancy which also required her to visit her doctor frequently. She could not keep up with the payments, and thought she had to mortgage her house in Trinidad to help cover the costs of her bills. It is important to note, that doctors in Guyana may face several constraints that contribute to ongoing visits, such as the lack of technological advancement and costs for certain procedures. With the help of her diasporic communities, they informed her that she would receive health insurance coverage during her pregnancy if she journeyed to New York. These personal recommendations from friends became important (Connell 2016) in guiding women's decision making, and in all of the stories of women undergoing diasporic reproductive health journeys, they were afraid they would lose something due to the enormous medical costs—their lives and even their homes.

For many of the women that were seeking ongoing medical treatment, diasporic reproductive health journeys were further influenced by longer stays. While previous studies show that diasporic medical travel serves as routine health care for non-critical conditions (Connell, 2016)—these long-term stays occurred for critical conditions. Long-term stays also allowed women to spend time with their families and friends. In terms of

duration, long-term journeys ranged between 3 weeks to 2 years. Women wanted to feel comfortable during the lengthy stays and wanted to be in a location that reminded them of home. Eliza, from Trinidad was experiencing heavy bleeding and needed treatment over a period of months, she stated:

I wanted to be around my family and friends and feel at home. . . We have a business back home and I knew my husband couldn't stay with me the whole time, so I wanted to make sure that I was around people that would help me.

Eliza spent 3 months and 2 weeks in New York for continuous doctor visits and the ability to obtain medication during her treatment. During this time, she rotated her living spaces amongst family and friends, but mostly stayed with her mom. In the Indo-Caribbean communities, mothers often provide childcare and support for their daughters during their pregnancies and beyond (Roopnarine and Jin 2016). Thus, it was assumed that families that knew about women's reproductive health journeys would take care of them upon arrival. This also became especially important for women who were pregnant.

Women who were also experiencing complications during their pregnancies also had to stay in New York for a long period of time. Their mothers played an important role during their stay. Natasha, who journeyed from Guyana during her second trimester discusses why she journeyed to New York and the role her mom played:

I was experiencing complications during my entire pregnancy, and Guyana did not have the hormonal medications that I needed. My progesterone levels kept going low and I knew I had to stay in New York throughout my pregnancy in case anything happened. . . I had my mom there that was able to give me a place to stay for the whole time and she was able to drive me to all my doctor visits and stay with me.

Natasha stayed in New York for 11 months for treatment during and after her pregnancy. She had support from her mom while she was here, and she gave birth to a

healthy baby. Natasha's partner also stayed with her during the last trimester of her pregnancy. Similarly, Inhorn (2010) found that elderly women, often mothers, attended doctor visits with their daughters and sons during their reproductive health treatments. The seven women who journeyed to New York to give birth were all supported by their families, especially their mothers during their lengthy stays. These diasporic reproductive health journeys made this possible.

Another pragmatic reason for journeys to New York was to obtain additional opinions from reproductive health providers. Not only were women concerned with the best price for care, but they also wanted the best quality care. Looking for the best quality of care and seeking a second opinion may drive patients to journey to destinations with diasporic communities (Lee et al., 2010; Lokdam et al., 2016; Sekercan et al., 2014). Prem, from Guyana who discovered she had endometriosis when she arrived in New York discusses her experiences of seeking a second opinion:

They kept giving me birth control. I kept telling them that it was not helping me, and they did nothing. I knew it was more than that, why else would there be so much pain and bleeding? My mom contacted people she knew in New York, and they told her to get me up there right away. Come to find out, I had endometriosis. I never heard of this term from any of the doctors in Guyana. Maybe they knew what it was but didn't tell me. . . I needed surgery to remove the excess tissue. . . If I didn't come to New York for a second opinion, I would have probably continued to suffer back home.

Prem did not trust the diagnosis from doctors in Guyana due to her continued experiences of heavy bleeding and pain, despite her use of birth control. Since her mother knew family and friends in New York, she contacted them to seek advice. One month after this contact was made, Prem journeyed to New York.

Like Prem, when patients did not feel comfortable with their diagnosis or did not trust their doctors in their home countries, they put their trust in health care providers in New York. Such discomfort can stem from the quality of care received, equipment, false diagnosis, lack of testing, and prolonged wait time for doctor visits and results. Caroline, who is from Guyana, was diagnosed with cervical cancer when she arrived in New York, she shares her experiences that reflects many of these discomforts:

After I was recommended to the urologist, I was then recommended to the Cancer Institute of Guyana. . . In this time span, it has been months, and still no clear diagnosis. I did not feel comfortable with the result of the scan, so I saw another doctor in the Institute. At this time, I was scheduled to do a biopsy and the doctor told me that he did not trust the labs here in Guyana, he wanted to send it to a lab in Trinidad. He was more confident with that lab, but even before that he told me that I needed to start chemotherapy right away. I was so confused because I did not even do the biopsy yet, and no one told me that I had cancer. This was the first that I was hearing of this. . . I told him that I wanted to wait for the results of the biopsy and then we can start the chemotherapy. After waiting for the results for about a week, I got more sick. At this moment, my dad was calling everyone he knew overseas for me to seek treatment in the US. Within a few days, I was in the U.S. The flight was horrible because I was bleeding the entire time. . .the following day, I was in the hospital in New York.

According to Globocan (Global Cancer), Guyana has one of the highest rates of cervical cancer patients and deaths. Caroline's experience gives us some insight on her experiences of obtaining a diagnosis and treatment for cervical cancer in Guyana. Her health was deteriorating for months, while health care providers in Guyana were "brushing" off her pain. Caroline's experience reflects many Indo-Caribbean women who journey to New York as they experience distrust echoed by the doctors in the health care system, miscommunication, confusion, and discomfort. These are the pragmatic reasons for diasporic reproductive health journeys. Fortunately, Caroline was a television producer in Guyana and had applied for a visa before her health deteriorated. Due to this,

she had access to a visa to seek treatment, and with the help of her father's friend that worked in the hospital in New York, she was seen immediately. Caroline was not connected with social networks and relied on the very few people she knew in New York to assist her. She lived with an elderly Indo-Caribbean woman for a few months, and then moved to New Jersey to stay with a friend. She constantly traveled long distances to receive care in New York. Her long-term treatment required a long stay, and her friend eventually told her to leave. Caroline moved back to Queens and stayed with friends until she found a job to rent her own apartment. Throughout her search for a place to stay, she was constantly in pain and felt weak due to her chemotherapy. While she received the medical treatment she needed, and survived, she experienced many hardships to sustain her daily life.

Importance of Community-Based Organizing and Diasporic Journeys

As Indo-Caribbean women interacted with activists, women in their social networks, and health care providers, they negotiated their belonging within these diasporic communities and the culture of their home. Berry (2005) found that immigrants create a hybrid culture where they also negotiate their belonging. Women's networks and activists adapt and rework ideas of womanhood beyond marriage, family, and motherhood to also include equitable households, making their own bodily choices, and financial decision-making. While women journey to a home away from home, they are also engaging in new ideas of womanhood and create their own identities and practices. This complicates the diasporic medical health literature because diasporic journeyers also participate in this process of identity formation. Maria, an activist for Queens Women's Empowerment, states,

We are little Guyana, but while we try to hold on to our culture, there are many harmful things throughout our generations that we need to let go of...we were taught by larger systems of colonialism and indentureship that we must remain under the control of something, rather than be in control of ourselves...we try to break this intergenerational trauma and engage in storytelling to create our own selves.

Maria, who is on her own reproductive health journey in New York, is a leader for the organization, Queens Women's Empowerment, which is a gender justice organization serving women and gender-expansive people in Queens. As an Indo-Caribbean immigrant, she discusses how the history of colonialism and indentureship caused trauma and the idea of remaining *under the control* of something, like the institutions and norms that produce and maintain harmful gender-practices. She uses this understanding to guide her work and help Indo-Caribbean women through their trauma and gaining control over their own lives. Women on their diasporic journeys get to learn about these histories, and how their experiences are reflective of these histories.

Much of the work at Queen's Women's Empowerment focuses on storytelling. Sacha, who journeyed from Guyana for reproductive health check-up and contraception attended a community circle (a gathering hosted by Indo-Caribbean Women Empowerment), where she engaged in storytelling:

Growing up you always hear the old aunties asking you when you are going to getting married or have a baby, and how they want to come dance at your wedding, but when I went to the circle an older aunty kept telling me, "Gyal live yuh life." She then went on to tell me the story of how she became a mom and then had four kids and then she told me that she had to stop going to school to take care of them. . .she spoke to me like a mother to me and told me that I shouldn't listen to the other aunties and how I should further my career.

These workshops become important for women on reproductive health journeys as they reflect on their own experiences, as well as hear from other Indo-Caribbean

women in New York—who are also using these spaces to understand their own experiences of inequalities in New York and reflect on their lives. Such storytelling and dialogue with women in the diaspora create spaces for participants in the workshops to develop new practices, solutions, and insights as they work together (Poland and Cohen 2020). The power of such stories builds awareness in the community and creates networks of women coming together, while also educating women how their relationship to colonialism and indentureship take new forms in their communities and relationships. Maria hopes that through this, women can create their *own selves*. For Sacha, these workshops affirmed who she wanted to be and helped her talk through the pressures of motherhood in the Indo-Caribbean culture. Organizers from Indo-Caribbean Women Empowerment further state that these workshops:

Explore what it means to acknowledge this part of our lived experience, and to be on a healing journey where we are for our mental health by creating our own cultural practices that are anchored in joy, comfort, and ease.

Through these workshops, women on diasporic reproductive journeys help create new practices that become important as they eventually journey back to their home countries. Through dialogue of lived experiences, women living in and journeying to New York challenge each other on harmful narratives around reproductive health care. They also learn to adopt practices of self-care and healing, such as breathing and journaling exercises to implement in their daily lives. Activists hope that they can apply these new practices to their daily lives and encourage women in home countries to do the same.

Developing practices that affirm who they are and letting go of harmful practices was important among the women I interviewed, as well as in the workshops I observed.

During a workshop on feminist organizing, Indo-Caribbean Women Empowerment brought several items that represents the Indo-Caribbean culture, such as the cutlass (a large knife), alcohol, and ornaments of Hindu goddesses. Through this workshop, forty-five participants engaged in holding items from their culture and imagining what they signify and how these items can be used in the future that they want to create for themselves. An excerpt from my fieldnotes, talks about the reimagination of the cutlass,

Everyone was split up into groups and each group consisted of 6-8 people. Participants were asked to write their reimagination of the object they received. One group in particular had to reimagine the cutlass. On the paper, they wrote, the cutlass became a representation of, “economic independence, community collectivism, creating opportunities to explore beyond the norm, and ownership.”

At the end of the workshop, I spoke to an Indo-Caribbean immigrant about the representation of the cutlass, she stated,

“This cutlass is a constant reminder of the women that lost their lives and even continue to lose their lives back home with the use of this. . . This cutlass represents everything we go through as women, and it represents the warrior in me. The warrior to fight for what I want and be who I want. I want to imagine that I am cutting down everything in my way with this tool.”

These workshops helped both women living in and journeying to New York. Through this workshop, women reimaged this object as a tool of power, rather than a tool of gender-based violence and control. Economic dependency and gender-based violence are key barriers to access reproductive health (Moore and Miller 2012; Hasstedt and Rowan 2016). The cutlass also created visions of shifting patriarchy and building long-lasting infrastructures to create economic independence for women and letting go of dependency, empowering women to reimagine who they want to be. These workshops helped women think about intersectionality in their lives as they made the linkages between their various experiences. As Indo-Caribbean women in New York challenge

gender norms around motherhood and marriage and create their own ideas of womanhood, women on diasporic reproductive journeys do the same—and further influence other women to journey to New York.

Conclusion

Overall, this paper focuses on the diasporic dimensions of journeying for reproductive health care among the Indo-Caribbean community. Indo-Caribbean women journey to New York for reproductive health services to seek care in an environment that is culturally familiar, which produced a feeling of a home away home as they were surrounded by their friends, family, women networks, and grassroots activists. They also felt comforted with familiar music, food, and cultural items that reminded them of home. Such comforts made their journeys less stressful and produced feelings that their treatments will be a success. This feeling of home was also important for women who did not tell their partners about their journeys. A feeling of home reduced feelings of isolation, guilt, and fostered feelings of love and support from friends and family. Partners who knew about the reproductive health journeys were also more comforted to know that their wives will be with family and friends.

Moreover, pragmatic reasons of quality of care, gaining additional opinions, cost of care, and treatment from doctors who are familiar with Indo-Caribbean patients were also important to women. While culturally sensitivity to their experiences were important, some women were also happy to be treated by doctors who were culturally distant to avoid their experiences of discrimination that occurred in their home countries. Importantly, grassroots organizations that worked with the Indo-Caribbean community in New York played an important role in facilitating diasporic reproductive health journeys,

and empowered women during their journeys. Women did not only interact with health care providers, but also received education and resources regarding reproductive health care. They were also exposed to new values within the Indo-Caribbean community around motherhood, health, and their families. Thus, this shows that

These experiences were echoed by many women; however, diasporic journeys are also filled with various negotiations and hardships. While women had expectations of a destination that is a home away from home, they had a difficult time sustaining their daily lives as they were forced to move numerous times, experienced financial struggles, isolation, and doctors that did not understand their needs. For women who had a long-term treatment, they had to obtain a job and permanent living due to the difficulties of staying with their friends and families for a long period of time. These difficulties were contoured by their class, familial responsibilities, and the length of treatment.

This paper expands on our understanding of diasporic medical journeys, and in particular an understudied area focusing on reproductive health. This paper also sheds light on the various reproductive health care procedures that occur through these diasporic journeys, while vast literature focused on infertility treatment and surrogacy. By looking at other reproductive health procedures, this paper highlights the various negotiations and experiences to obtain essential reproductive health care in their home countries. Importantly, while previous literature has shown that people from the Caribbean have been traveling to the United States for health care, there has been no study to understand why people are traveling away from their home countries and neighboring countries. In this paper, I argue that these journeys can be influenced through the feeling of a *home away from home*.

This journey is facilitated through many factors such as familiarity to networks, friends, family, culture, and information of the medical system. Importantly, grassroots organizations played an important role to facilitate these journeys by encouraging women to journey through information sharing and empowering women during their journeys. Thus, not only did women receive reproductive health care, but they also attended local women empowerment events and obtained education and resources to take back home to transform their own reproductive health journeys—and ultimately encourage other women to create their own diasporic reproductive health journeys.

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CHAPTER 3

REPRODUCTIVE JOURNEYS: INDO-CARIBBEAN WOMEN CHALLENGING GENDERED NORMS

Introduction

Feminist scholars have long theorized about why people travel to specific locations to obtain reproductive health services. Scholars refer to “reproductive tourism” (Blyth and Farrand 2005), “reproductive exile” (Inhorn and Patrizio 2009), and “cross-border reproductive care” (Whittaker and Speicer 2010) to represent these experiences. I use the term *reproductive journey* to describe women’s multidimensional experiences who seek to obtain reproductive health services abroad. Reproductive journeys go beyond travel for assisted reproductive technologies, and include birth control and other reproductive health procedures. Much research on reproductive journeys documents the barriers people encounter in home countries, their hardships in host countries, and the booming industry of fertility treatments (Inhorn 2015). However, we know little about the gendered negotiations and constraints people experience and how class informs these negotiations during these journeys. Reproductive journeys can help women directly challenge gendered norms, practices, and institutions. As the class-diverse Indo-Caribbean women in my study journey to New York for reproductive health services, they challenge gendered norms of motherhood and reform their relationships with partners.

To understand Indo-Caribbean women’s reproductive experiences, I ask: (1) What influences Indo-Caribbean women to take reproductive journeys to Queens, New York? (2) How do Indo-Caribbean women challenge gender norms during their

reproductive journeys? (3) How does women's class status inform how they challenge gendered norms? (4) How do women navigate disparities in the healthcare system? I focus on how gendered norms influence reproductive journeys and how women challenge norms throughout their journey. I also focus on influential factors that shape women's decision-making during their reproductive journeys, such as their social networks, grassroots organizations, class, and citizenship. I pay particular attention to the disparities in the health care systems and the unevenness of the global/regional economy.

I conducted 82 in-depth interviews with Indo-Caribbean women from Guyana and Trinidad and Tobago who seek reproductive health services in New York, women who could not journey due to citizenship and class barriers, and activists. To understand the influence of social networks and grassroots organizations on journeys, I also conducted participant observations at meetings and empowerment events hosted by grassroots organizations. I find that sexism experienced within households, communities, doctors' offices, lack of proper care, legal restrictions, and unaffordable treatment influences women's journeys to obtain services and ultimately travel to New York for continued access to resources. Women experienced these barriers for reproductive health care they sought in home countries, such as abortion, contraception, and treatments for heavy bleeding, fibroids, and infections. Doctors often neglect cases that prevent women from becoming pregnant.

Another driver for seeking reproductive health services is the encouragement and support provided by social networks and grassroots organizations in New York. As women receive support from women's networks, they challenge gender norms of motherhood, caretaking, and decision-making in their relationships in both visible and

guarded ways, varying based on their class. Women from middle-income households are more likely to challenge gender norms outwardly during their reproductive journey. In contrast, women from low-income households are more likely to challenge gender norms in more guarded ways.

As a result of these experiences, a gendered duality develops as women challenge norms secretly and outwardly but still need to cope with restrictive gendered systems such as the family and health care systems. In my study, women's reproductive journeys uncover the classed and gendered transnational processes of economic disparities and inequality. I find that these women's bodies are entangled in globalization as they try to navigate health care systems as transnational body projects (Casanova and Sutton 2013). Later in the dissertation, I further discuss how histories of colonialism in Guyana and Trinidad shape these inequalities. As they navigate these systems, they also negotiate their gender and experience consciousness-raising of gender through social networks. Reproductive journeys can become gendered movements.

Literature Review

Transnational Bodies in Seeking Health Care in an Unequal World-System

Casanova and Sutton (2013) introduced the concept of transnational body projects to show how gendered bodies can become constructed during travel across and within nation-states. This concept links bodies and globalization by showing how individual bodies can use the resources that stretch across borders to accomplish individual self-identity and refashion bodies. Global restructuring through trade agreements, international financial institutions, and financial markets can shape access to health care and influence which bodies are more valued than others (Casanova and Sutton 2013).

Inequalities persist globally as bodies are marginalized through international labor markets, sexual violence among borders, and the renting of wombs by elites (Casanova and Sutton 2013). Such transnational phenomena enable the construction of new gendered bodies as people reform their understanding of their gender practices.

The two-tiered health care system of public and private facilities in Guyana and Trinidad can create barriers to access reproductive health care. Public facilities care for minor medical conditions, but reflect a lack of trained specialists, poor sanitation, long waiting periods, inadequate equipment, and insufficient providers, especially for reproductive health care. Some public hospitals and facilities do not have the equipment to perform safe reproductive health procedures, and information and resources on health resources and services are limited (Nunes 2012; Delph and Nunes 1997). Private facilities can become costly and unaffordable for those who are not wealthy, especially if long-term treatment is required. As a result, women may turn to dangerous routes and unqualified persons for reproductive care access.

Abortion access is challenging in both Trinidad, where it is illegal, and Guyana, where it is legal. In Trinidad and Tobago, unsafe abortion is the leading cause of maternal mortality (Martin et., 2007). According to a report from the Ministry of Health (2013) in Trinidad and Tobago, an average of 2000-3000 women annually are admitted to public hospitals suffering from complications due to unsafe abortions. The Offences Against the Person Act in Trinidad states that abortion is illegal except in cases where it is for the preservation of physical and mental health or saving the life of the person giving birth. In Guyana, access to safe and effective abortion is limited by the inaccessibility of providers and information about abortion. According to the Medical Termination of Pregnancy Act

in Guyana, abortions during the first eight weeks is legal for any reason. After eight weeks, an abortion is only legal if two medical practitioners agree to it provided that the pregnancy involves substantial risk to the life of the pregnant person, where the pregnancy was a result of rape or incest, and if the pregnant person is known to be HIV positive.

Even though access to contraception is legal in both Guyana and Trinidad, it is inaccessible, especially for low-income women. Costly private facilities are the primary source for long-term contraception, such as sterilization and the use of intrauterine devices (Demographic and Health Survey of Guyana, 2009). Low-income women cannot afford these contraceptive methods and may turn to public facilities for short-term contraception. In Guyana, less than 5% of women are on permanent contraception and long-acting reversible contraception, and 10% of women in Trinidad are on long-term contraception (de Leon et al., 2019). Another barrier for reproductive health services reflects neglect from medical caregivers, such as nurses and doctors (Rambarran and Simpson 2016; Collins 2016). In Guyana, there are several cases of maternal death due to severe bleeding that women experienced after childbirth ignored by nurses and doctors.

Access to services is also further exacerbated by living in a rural location. According to the USAID Contraceptive Security in Guyana Report in 2006, community health providers are located mostly in rural areas, yet 70% of physicians who perform reproductive health procedures are in urban areas in Guyana. The report also shows that facilities in urban areas provide long term contraception and reproductive health surgeries. In Guyana, the total fertility rate (TFR) in urban areas is 2.1 children per woman, compared to rural areas at 3.0 children per woman (Demographic and Health

Survey of Guyana, 2009). This suggests that there is an unmet need for reproductive services in rural areas. Similarly, in Trinidad, health facilities located outside of urban areas also suffer from the lack of medical staff and equipment. The TFR in Trinidad and Tobago is 1.6 children per woman (ICPD, 2014).

The United States became a destination of Indo-Caribbeans from Trinidad and Guyana when the United States opened its doors to more immigrants in 1965. According to the Indo-Caribbean Alliance, New York is the home of more than half of all Guyanese immigrants and 40% of all Trinidadian immigrants in the United States. New York becomes a home away from home with similar cultural experiences, network support, familial ties, and cultural connections with doctors. Moreover, journeying to neighboring countries in the Caribbean can be more costly than journeying to New York as transportation costs are similar to going to neighboring countries that do not have legal restrictions or provide greater access to reproductive health care. Martin (2016) argues that the United States is a destination for reproductive health care due to lax regulations, its status as a global destination for high-quality and safe reproductive care, its additional clinics and trained physicians, and its scientific and technological resources.

According to a report on Trends in US Health Travel (2015), people from the Caribbean make up one of the three largest groups of travelers to the United States for medical services (44% of travelers on arrival). People from the Caribbean journey to the United States for better care, facilities, technologies, and affordable health care. Such journeys are often supported through familial and network support in destinations. However, citizenship status and socio-economic status continues to be a barrier to journeying to New York. In chapter 4, I extend on this analysis by showing how histories

of colonialism can influence these journeys as it impacts the current colonial structures that shape women's economic and social realities, including health care. This paper expands our understanding of why people journey to specific locations for health care and the uneven disparities people experience to obtain care.

Gender Transformation and Social Networks

Gender is an organizing force within our institutions, practices, and policies. Gender expression can be complicated by race, ethnicity, sexuality, and class (Collins and Bilge 2016). These factors shape norms and traditional expectations that impact our access to jobs, social positions, and resources. We are continually engaging in practices of “doing gender,” and are held accountable if we do not perform gender as those around us expect (West and Zimmerman 1987). The doing, un-doing, and re-doing of gender can lead to the maintenance of gendered structures (West and Zimmerman, 1987; Alfrey and Twine 2016; Mojola 2014) or challenge gendered hierarchies and positions. Yet, feminist scholars have regularly shown this instability of gender (Snorton 2017; Butler 1990). Butler claims that gendered acts and identities do not exist without each other; therefore, gender becomes an identity that is continually constituting itself. Gender similarly is also seen as a “performance” for West and Zimmerman (1987).

Some feminists argue that traveling or migrating to another location leads to new freedoms to expand gender practices (Pessar 1999; Andrews 2014; 2018). While only some women migrate to New York as part of their reproductive journeys, they can also experience similar gendered transformations through short travels. Understanding that gender is always in motion produces many questions for scholars who study gender as they examine the impact of journeys on gender performances. Some argue that migration

reinforces male dominance over women as men adapt to new ways of expressing masculinity (Boehm 2008). However, such travel and movement reconstitute new forms of gender transformation (Mahler and Pessar 2001; Hondagneu-Sotelo 2011, 1994; Menjivar 1997; Snorton 2017). Mahler and Pessar (2006, 43) argue that gender “operates, usually simultaneously, at multiple spatial, social, and cultural scales” as people travel or migrate to a different location.

This is no different for Indo-Caribbean women. In Guyana, Indo-Caribbeans make up the largest population at 39.8%, followed by Afro-Caribbeans at 28.3%, mixed races at 19.9%, and Amerindians at 10.5%. In Trinidad, Indo-Caribbean’s compose 35.4% of the population, followed by Afro-Caribbeans at 34.2%, mixed races at 23.0%, and 8.4% of other ethnic groups (Central Intelligence Agency). Scholars argue that Indo-Caribbean women share similar cultural values with other Asian Indians within the diaspora—expecting women to be obedient mothers and wives and upholders of Indian morality (Kallivayalil 2004). Indian women in the Caribbean are expected to obey traditional gender practices, patriarchal community expectations and repress their sexuality (Roopnarine et al., 2009; Youssef 2011; Kanhai 2011). However, Mehta (2004) posits “Kala pani” discourse as an analytic frame to rearticulate Indo-Caribbean diaspora by showing that women continuously renegotiate patriarchal and imperial conceptions of power as they move from one location to another. The Kala Pani refers to the dark waters that indentured laborers crossed as they migrated to the Caribbean in 1838. Through these waters, resistance to caste systems and gendered norms in India became a reality as Indo-Caribbeans sought to challenge these systems through their journey. Indo-Caribbean women continue to resist gendered expectations in the diaspora and beyond by coming

together as a community to explore their gender and ethnic marginalization--this community reflects their networks of women.

Moreover, Despot (2016) found that Indo-Caribbean women who migrated to the U.S. experience a transformation of their gender as they manage their households and obtain jobs. Even though Indo-Caribbean women challenge gendered expectations in their families, there remains a tension between traditional values, career, empowerment, and demands within their familial lives (Youssef 2011). These tensions can be more difficult for some to challenge depending on their social positioning, such as class (Hoesin 2013). Gaining reproductive health care access abroad becomes an important journey for Indo-Caribbean women to negotiate and resist expectations of motherhood and caretaking.

An essential aspect of traveling or migrating to new locations is the role of social networks. Much research on social networks focuses on their influence on migration. However, this paper shows that social networks are also essential for medical journeys. While studies on social networks have often been “gender-blind” and “indifferent to gender” (Boyd 1999), others have shown how gender relations structure social networks and, in turn, influence migration paths and processes (Curran and Saguy, 2001; Hondagneu-Sotelo 1994). These social networks revolve around friendships, kinship ties, and family. Hondagneu-Sotelo (1994) argues that social networks in host countries play a role in helping women challenge patriarchal norms and gendered structures, such as the family. These networks provide resources and help women negotiate their travel with their families (Menjívar 1997). For example, women craft letters to migrants’ husbands to

convince them to let their wives migrate, secure smugglers to get them across the border, or even give them financial assistance (Hondagneu-Sotelo 1994).

Nawyn et al. (2009) argue that gender theory can inform our understanding of the connection between gender relations and practices and journeys to a new location. For many migrant women, the gendered institutions shape their decisions and opportunities for migration and tourism. These institutions are their family (Grasmuck et al., 1991), the global labor market (George, 2005), and the state (Cheng 2003). Many studies on travel ignore the power relations between men and women within these institutions and how these power relations shape the gendered expectations of these women. Thus, studies on migration and tourism need to examine the power relations between genders.

During reproductive journeys, social networks can play a critical role. Much literature focuses on the influence of social networks on migration. Social networks can influence individuals' choices and attitudes to travel abroad by the access and flow of resources and information they provide (Berkman et al., 2000). Social networks connect migrants, former migrants, and non-migrants through ways that provide information and assistance beyond home countries. Migrant social networks contribute to the continuation of international migration by maintaining these social relationships and the exchange of information (Massey et al., 1993).

Recently, scholars have shown the influence of social networks on medical journeys. Hanefeld et al. (2015) explore the role of social networks as an influence on medical journeys. Some of their participants were seeking in vitro fertilization (IVF), intracytoplasmic sperm injection, egg donation, and sperm donation. Patients were more likely to travel to locations recommended through their networks and support groups.

Researchers also argue that social networks provide physical, emotional, and financial support during medical travel by accompanying travelers to their treatment centers and providing lodging (Yeoh et al. 2013).

These networks become “collective care” networks (Parr 2002). These networks have readily available resources and information to manage care and guidebooks to support patients who are traveling abroad. Although Hanefeld et al. (2015) touch on social networks’ influence on patients seeking reproductive health care, we know little about these interactions and resources provided to patients to seek reproductive health care. I show that networks can become more than collective care networks; networks can also actively challenge gender norms.

I uncover the barriers women experience in their home countries and influences to journey to New York, such as supportive women’s networks. Social networks provide more than resources, information, and emotional support. They also help women actively challenge gender norms in both invisible and visible ways. Class positions further influence the decision to challenge gendered norms. Therefore, the movement for reproductive journeys became a way to challenge gendered barriers through social networks.

Method

This study is part of a larger project that aims to uncover why Indo-Caribbean women journey to Queens, New York, for reproductive health services. I approach this project through community-engaged research as I created partnerships with community-based organizations (Irby et al. 2021) to understand health inequities in the Indo-Caribbean community, used discussions and information shared by community members

to inform my method and question asked during interviews, and ultimately develop solutions to improve access to reproductive health care. For this study, I focus on a global community, Queens, New York. This location is a useful case study because it is the region home to the largest cluster of Indo-Caribbean people in the United States, with a population of 82,000 Trinidadian and Guyanese immigrants (Indo-Caribbean Alliance 2014, para. 4).

First, I conducted semi-structured in-depth interviews with 32 women who journeyed for Guyana and 21 women who journeyed from Trinidad and Tobago for reproductive health services in New York, 14 women living in Guyana and 8 women living in Trinidad who did not have access to financial resources or the citizenship status to journey, and 7 activists who are part of grassroots organizations and networks that facilitate journeys for a total of 82 participants. During interviews, I asked women about their reproductive health experiences in their home countries and New York, why they choose New York specifically for their reproductive health care, the negotiations and constraints they face during their reproductive journey, and the role of social networks during this process. Interviews lasted between 55 minutes to 110 minutes. Before the pandemic, I conducted in-person interviews with women who were in New York, and conducted interviews through Skype, Facebook Messenger, Whatsapp, and Zoom for participants who returned to Guyana and Trinidad after treatment. During the pandemic, all interviews were conducted through these virtual platforms. All interview data was recorded and transcribed.

Women who came to New York for reproductive health services were recruited through social media, such as Facebook and Instagram, the help of grassroots

organizations, and a gatekeeper within the social network. The gatekeeper is an Indo-Caribbean woman from Guyana who encouraged many women from Guyana and Trinidad to obtain reproductive health services in New York. She currently lives in Richmond Hill, Queens. I met her in Richmond Hill at an event that focused on women's empowerment. She provides women with information about services, advice and helps women navigate their journeys at no cost, helping them navigate Medicaid and resources for free care. She also opens her home for women to stay during their journeys. I also recruited participants through respondent-driven sampling by asking participants if they know of anyone that shares a similar experience at the end of the interviews. Even though women journeyed to New York for reproductive health services, they also took advantage of other services and organizations in New York and visited family members.

To understand the access to services and the work of grassroots organizations, I conducted participant observations from March 2020 to October 2021. I conducted approximately 150 hours of participant observations, which make up 48 hour-long meetings and 39 educational workshops and events that lasted between one and four hours. These events and meetings were hosted by two local grassroots organizations in Queens, New York, which I call Indo-Caribbean Women Empowerment and Queens Women's Empowerment. At these events and meetings, I facilitated workshops, engaged in discussions, and served as a volunteer. I wrote my field notes the same day from the jottings and notes in my fieldwork notebook.

Although I share the same ethnic identity with the women in my study, Hartman (2008) calls for additional reflexivity. At first, I assumed that I understood this culture, but I soon realized that my perspective was limited and that our culture plays out in

different households in varied ways. To uncover these various standpoints, I used Gomez-Barris's (2017) method —engaging a submerged perspective. During interviews, I ask questions that go beneath the surface of the transnational phenomena occurring and think about the historical and social contexts that are complicit in the process. Such questions focused on the structure of women's everyday lives, women's roles in their communities, and gendered expectations within women's families and across generations, which can influence and reflect larger transnational phenomena. This method provides me with reflexivity as I ask questions during interviews.

All participants identified as Indo-Caribbean women, except two of the activists who identified as Indo-Caribbean nonbinary people, and varied in age and class (See Table 1). The age of the women ranged from 22-52 years. Women had various initial concerns, such as contraception, infections, abortion, and surgical procedures.

I analyzed the data with Nvivo qualitative coding software using a grounded theory approach (Glaser and Strauss 1967). I developed analytical and theoretical codes that were used to code interviews and field notes. During my analysis, I wrote analytical memos about my themes, created categories, and mapped the connection of concepts and themes. Once I identified the differences in how social networks operated for women, leading to more open or closed approaches to challenging gendered norms, I considered whether these differences mapped onto any other factors – and found class to be associated with these differences.

Findings

Undertaking Reproductive Journeys

Every woman was on their own reproductive journey. Some stayed for more extended periods than they initially planned, while others went home immediately after treatment. Women journeyed to New York for long-term and short-term procedures, such as abortion, contraception, surgeries, treatment for infections, fibroids, and heavy bleeding. There was very little difference in the treatments that middle and low-income women sought, which shows that reproductive health care is challenging for women across various socioeconomic statuses. They also encountered the same reproductive barriers in Trinidad and Guyana stemming from the global economic system's health and economic disparities – despite differences in legal access to abortion in these two countries. Both low-income and middle-income women experienced familial barriers, legal barriers, poor treatment from doctors, and gendered expectations of motherhood. Traveling far distances to get quality treatment was exacerbated for low-income women. Middle-income women encountered these barriers as well.

Sexism in their home countries reflects gendered assumptions in the health care system and community. Rhonda talks about how these institutions intersect to shape her experiences of obtaining reproductive health care in Guyana:

It is not easy to be a woman in Guyana. I want to take care of myself, but the culture allows men to have control over you. If I want to go to the doctor, my husband knows my business and I can't make decisions for myself. He always wants to play a role in the decision making. And when I go to the doctor's office, there is another man that wants to control my reproductive health. Like one time, I asked to get birth control and the doctor looked at me like I was crazy and told me that I needed to make more children. I guess we are only supposed to be mothers and nothing else.

These sexist experiences with the health care system stem from gendered expectations that women should fulfill, such as being a mother and caregiver. Such

sexism can take away autonomy from women's decision-making within their households and doctors' offices and dissuade them from going to their doctors for services.

All the treatment women sought in New York was tied to challenging sexism, including treatments for infections, heavy bleeding, and fibroids. Doctors neglected the care of these conditions, even as these health issues prevented women from becoming mothers. Throughout interviews, women noted that doctors prioritized the care of women who wanted to become pregnant. Faced with these assumptions during their doctor's visits, women felt ashamed when they did not want to become mothers or get pregnant again. The stigma created a sense of isolation and led some women to go abroad to access services (Pennings 2002). Veronica, who journeyed for contraception, discusses how restrictive laws and legislation heighten this isolation:

Aside from traveling hours to the nearest women's clinic to get a check-up, well there are clinics nearby, but if you want the good ones you must go far. You also gotta deal with the attitudes of them doctors. . . If I ask them for some birth control, they will tell me about the law and what others will think about me. I am a mother of three kids, and I love it. . . The laws in Trinidad make it hard for women like me to get help and you got these people who want to run their mouths and tell women that they need to make more children, and this does not change anything.

Veronica highlights the experiences that both low-income and middle-income women experience, such as traveling far for the nearest high-quality clinics and the legal barriers that prevent access to reproductive health care. Even though contraception is legal in Trinidad, doctors can use the illegality of other services, such as abortion, to influence their decisions. Restrictive legislation in home countries forces people to journey abroad to obtain reproductive services (Inhorn 2015). Laws can create stigma and support sexist ideologies that serve as a justification to refuse reproductive health care to

patients (Calavita 2006) and protect the state's interest to continue the subjugation of women (Jolly 2016).

Veronica and Rhonda discuss the inaccessibility of reproductive health care in Guyana through their experiences of gendered expectations in doctor visits, communities, and laws. Another important factor that shapes their experiences in their home country is the cost of treatment. Devi talks about this experience:

The hard part for me is the bills that come with the visits. . .I don't have a job. My husband is the only one working and I have two children to take care of. I can't afford the care here and the things I can afford, well you do not even want to go into those hospitals. . .The cost of the bills for a private hospital for many visits is more than the cost of taking a plane ride to New York and get proper treatment for free.

Living with her in-laws and her family, Devi needs ongoing medical treatment. Women's partners are usually the breadwinners in the household, making it challenging to gain access to money for costly treatment without alerting their partners. For women from low-income communities, access to employment and resources is even more limited. The immense cost of treatment can outweigh the cost of a plane ticket to New York to seek treatment, making this a central factor in shaping women's journey to New York for reproductive health services.

New York's healthcare coverage is a driving force for reproductive journeys because new migrants and green card holders are automatically enrolled in Medicaid. Pregnant women in New York are also automatically enrolled in Medicaid. Medicaid covers all costs for family planning care and pregnancy-related care without copayments and out-of-pocket expenses (Guttmacher Institute, 2017). Social networks also help with financial assistance in New York, especially for women that journeyed to New York

through tourist visas. Like Inhorn's (2015) exploration of surrogacy in an IVF clinic in Dubai, the women in my study expressed having no other choice—they had to travel abroad to access effective treatment, legal care, and control of their reproductive decisions. For some, their journey abroad was not a voluntary choice; it was a necessity. Guyana and Trinidad's health care system pushes women to engage in transnational body projects (Casanova and Sutton 2013). Queens became a destination for body transformation that is out of reach at home.

Challenging Gendered Barriers in Secretive Ways

As women journeyed to New York to obtain reproductive health care, social networks and grassroots organizations were a key source of social capital. Social networks and grassroots organizations consisted of Indo-Caribbean women who lived in New York as well as friends in Guyana and Trinidad. They were connected through social media, such as Facebook and virtual meetings and events occurred on Zoom for those who attended events and workshops. Most of their communication occurred through Facebook Messenger and Whatsapp. Women in Guyana and Trinidad frequently spoke with family and friends who live in New York. Women who received treatment and went back to their home countries also introduced other women in Guyana and Trinidad to their families and friends in New York who assisted their journeys. These networks encouraged women to journey or migrate to Richmond Hill and provided resources and information on reproductive health services. Social networks and grassroots organizations become more than transmitters of information; networks served to challenge or reinforce “cultural forms of organization, particularly gender relations” (Curran and Saguy, 2001:71). Women's friends challenged gender relations and

limitations from the very start—from writing letters to their partners to writing fake doctor's notes for families back home to allow women's journeys.

Thirty-four of the fifty-three women who journeyed kept their reproductive journeys a secret from the very start, while nineteen of the fifty-three women told friends and families about their journeys. Women who were already part of the networks in Guyana and Trinidad influenced women to journey abroad for reproductive health services. They also encouraged women to keep their journey a secret to prevent obstacles that others may create if they found out about these journeys. These networks also helped look after children when needed and offered to help families during women's absence. Some women told their families about their journeys after their treatment, while others did not tell their families.

Lisha reflects on one of the most prevalent reasons for this: "I think I want to tell my family after it is all over. They might try to convince me to have more children." Lisha underwent the procedure for an intrauterine device. Women believed that procedures such as abortions, hysterectomies, and contraceptives would strip them of their womanhood amongst friends and family. Therefore, they were more likely to keep their procedures a secret compared to women who had long-term complications, such as heavy bleeding. However, long-term complications like heavy bleeding were still a concern amongst women because there was a possibility that they would not be able to get pregnant and fulfill motherhood. Lisha believed that her community's traditional expectations of gender could prevent her from undertaking her journey to New York. Becoming good mothers and wives permeated some Indo-Caribbean communities where women lived (Warikoo 2005). Women did not want to risk their journeys by telling

family members who might prevent them from obtaining treatment or convince them to have “more children.”

Respondents brainstormed possible ways to take secret journeys to Richmond Hill and get the support they needed to obtain reproductive health services. Lisha talks about how her social network facilitated her reproductive journey:

I didn't know what to tell people, like how can I just pick up and leave. I knew my family back home wouldn't let me unless it was serious. My friends (in Richmond Hill) wrote a fake letter to show my family. The letter spoke about my mother's health and that she needed someone to care for her. I had my visa, but I also didn't have any travel money. I had some, but not enough. Everyone pooled money together for my ticket and that is how I got to come to Richmond Hill. And they even let me stay with them while I was seeing the doctor.

Lisha's secret journey to New York started with the fake letters that women's networks wrote to her family about her mother's health in New York. Hondagneu-Sotelo (1992) similarly found that women networks of Mexican migrants also facilitated their journeys by writing fake letters to husbands to convince them to let their wives travel to the United States. Women's networks provided a way out of home countries for women, such as providing women with a place to stay and financial support. Expectations of being a caretaker in their families made it challenging for partners and family to approve of their journeys abroad. This became especially important for women from low-income households because they did not have the resources to journey abroad without financial assistance for a plane ticket and a place to stay. Providing resources and information about doctors, jobs, and health insurance became another essential role for women's networks.

Once participants arrived in Richmond Hill, the second phase of their journey began. During this phase, they directly challenge gendered norms, such as expectations around motherhood and other familial responsibilities. Mala talks about the support of her social network once she arrived:

When I got here, I felt a little lost. I remember going to my friend's house, and I kept wondering, what is next. The next morning my friend took me to a health insurance truck on Liberty avenue, and just like that, I got health insurance. I kept thinking in my mind: is this really free? My friend and some of her friends then helped me call up different doctors in the neighborhood to see if they take my health insurance...Then she even drove me to the doctor office and stayed with me. She even went into the room with me because I was a little scared. You know when you are in a new country, you have no idea what to expect...I don't think any of this would have been possible without her support.

Mala's husband passed away a few years ago. She currently lives with her uncle and aunt in Guyana, but she would not have access to reproductive health without her friends. Once women arrived in New York, they stayed with their networks. Social networks help women challenge gender norms by providing emotional support and ensuring that they receive the proper reproductive care they need. Challenging norms around motherhood was also easier for women in Queens because health care providers assisted women with health insurance. In Mala's case, she obtained her reproductive health care for free after getting health insurance. The prevalence of health insurance providers in the Richmond Hill community can be seen on almost every street on Liberty Avenue in Richmond Hill, which also contains cultural shops and eateries.

Access to health care information is an important resource that grassroots organizations in Queens implement in their programming. An excerpt from my field

notes from an essential items pantry that Queens Women's Empowerment organized discusses this,

They organized their tables at their pantry to include resources and essential items to share with community members. At the first table, there were two representatives from a health insurance company called, "Emblem Health." As the first table, they were giving out bags and brochures with information to obtain health insurance. As people arrived at the table, the representatives were telling them that they can help them sign up for health insurance on the spot regardless of immigration status. The unique positioning of this table as the first encourages many community members to stop here before accessing other resources and items.

During many of the programs at Queens Women's Empowerment, representatives from health insurance companies are tabling. While serving as a connector to health insurance and increasing women's familiarity with the US healthcare system, representatives also disrupt common myths that serve as a barrier to access care, such as immigration status. Immigration status remains a common barrier to access care, however social support, such as grassroots organizations can be key determinants of accessing and using health care services among new and undocumented immigrants (Nandi et al. 2008). Such access to information and providers makes it easier to access reproductive health care.

After obtaining health insurance or securing funds from social networks to undergo treatment, women visited suggested doctors from social networks. Women from their networks accompanied women to their doctor visits and served as a support system. Doctors also played an important role in educating and providing information for women during their reproductive journeys. Afeza, who journeyed to New York for heavy bleeding that was caused by fibroids, states, "My doctor was so attentive and listened to my experiences. I told her about my abdominal pain and severe bleeding. Then she told

me about my options to treat my fibroids and took her time to explain each option to me. . .For the first time, I felt educated about what was happening to me and acknowledged.” Women like Afeza expressed that doctors in home countries often neglected reproductive health issues that were barriers to becoming pregnant.

Women who are becoming mothers are more prioritized during doctor visits than women who are experiencing problems that may hinder them from becoming mothers. Most women that journeyed did not experience such neglect from doctors regarding such treatments during their stay in New York. After the diagnosis from doctors, women then discussed with social networks and doctors what the next step in their reproductive journey would be. Questions about where they will stay during their journey, how long the treatment will take, and upcoming appointments were then scheduled during the next stages.

During this process, women’s networks and grassroots organizations in New York exposed the women to a wider array of values and norms regarding marital relationships and reproductive choice. Activist Sabita with Indo-Caribbean Women’s Empowerment states that, “These organizations foster critical spaces for Indo-Caribbean’s to challenge gender injustice within their communities and families, share stories and create dialogue with each other, and create solutions together, not just for the United States, but the Indo-Caribbean diaspora as well.”

As a result, these networks and organizations encouraged more equality in economic decision-making, sharing household practices, and becoming property owners (Ramadar 2007). Social networks become important in this transnational process to influence gender consciousness-raising and challenge gender injustice. As women stretch

resources across borders to care for their bodies, their transnational body projects also encourage gender reformation as their values, expectations, and practices of gender change.

While challenging motherhood was part of the travel to Richmond Hill, many women continued to challenge gender norms when they returned to their home countries – sometimes secretly. Women who lived in low-income households were more likely than women from middle-income households to challenge motherhood in secretive ways when they returned home. Some women hid their birth control medication or intrauterine devices and did not tell their families after they arrived home. Social networks still provided support for them during this time. Nadia reflects on this experience:

I brought back a year's supply of birth control. My friends told me to hide it from my husband until I am ready to tell him. . . I hid my birth control in the ceiling of my roof because I don't want anyone to find it. I keep a few pills hidden in my clothes drawers.

Fourteen of the twenty-two low-income women who journeyed back home kept their journeys a secret, and Nadia was one of them. Hiding contraceptives became one of the ways women maintain their secrets and challenge motherhood. Even though they do not publicly share their journey, they still ensure that they gain access to their birth control and other medical devices. This shows the duality of gender as women secretly challenge motherhood while conforming to the other gendered practices within their families, such as caretaking and household duties. It becomes one of the only ways that low-income women ensure the continuance of their treatment in their home countries. Like other low-income women, Nadia does not have the resources to travel back to New York within a year to obtain more medication, so the fear of losing access to birth control

influences women to hide their medication in less accessible places, like the ceiling of their roof.

Similarly, Emily hides her birth control in one of her bags. She states: “I have a ripped pocket in my bag, and I just put my pills in there. It goes to the bottom of the bag, and no one will know it’s there. . .I gotta do what I gotta do.” Even though low-income women were more likely to practice secretive ways to challenge reproductive health care access, some middle-income women, like Emily, also kept their choices a secret. Five out of the nineteen middle-income women who journeyed back home challenged expectations for motherhood secretly. Middle-income women who lived with extended family members in home countries like Emily also tended to become more secretive because they did not want their extended families to know about their treatment.

Even though women challenged gendered norms such as motherhood, caretaking, and duties as wives, they are still maintaining gendered structures that reinforce motherhood (West and Zimmerman 2009) by keeping these challenges a secret. Accountability structures such as family and societal expectations remain as they continue to perform these practices. At the same time, they evade and un-do gender (West and Zimmerman, 1987) –producing a gendered duality. At times, the norms within home countries and New York clashed as women traveled back home after obtaining reproductive healthcare. Upon return, they noted that their gender is still under negotiation, with womanhood still identified primarily through motherhood.

Challenging Gendered Barriers in Outward Ways

Although many women challenged gendered barriers in secretive ways, some outwardly challenged barriers when they returned home by telling their partners and

families about their reproductive journeys in New York. Others made changes in their lives by changing their relationships. Talking to families and partners about reproductive health journeys and treatment was a difficult task. Sonya reflects on this:

I was so nervous to tell my family about my procedure. My mom had hope that she will have another grandchild and my husband also had hope that he will get a son. . . When I told my husband, at first, he did not say anything, you could see the sadness in his eyes. I felt bad, but I know to myself it was the right thing for me. He did not talk to me for a few days because I went behind his back to do this. . . I think my relationship suffered a bit because he was acting distant from me.

Sonya's partner is a lawyer, and she has two children. Women who chose to tell their families about their reproductive journeys had difficult conversations and risked some of their relationships with family members. Partners became distant, did not talk to the women, and often grew angry and sad about their journeys.

Like Sonya, the relationship of two other women in my study also "suffered." However, they gained independence and did not need to rely on partners for support as they wanted to achieve their goals. Telling partners about their reproductive journeys was somewhat easier for women that lived in middle-income households because they had savings and more resources available to obtain employment or go back to school. Thus, fourteen of the nineteen middle-income women who returned home challenged gender norms outwardly. Abigail also spoke about the importance of having this conversation with her family:

Once you get rid of your reproductive organs, people will think that you aren't a woman anymore. I knew if I didn't say something then this will always be the case for all the other women. . . We will all continue to be afraid.

She wanted to tell her family about her procedure because she wanted others in her family and community to discuss their reproductive health issues. Abigail refers to the ongoing stigma that some Indo-Caribbean women experience if they undergo procedures that permanently prevent them from giving birth or experience problems that prevent pregnancy, such as heavy bleeding, urinary tract infections, and fibroids. The narrative that womanhood is associated with biological reproduction leads to the cultural and social construction of what constitutes a woman through norms and ideologies (Moore & Currah 2015:75). At first, Abigail was, like Sonya, afraid to have these conversations with their family, but they helped break gendered norms in important ways. Empowering other women in their families and communities became a driving force to speak up about procedures and treatments during reproductive journeys.

Social networks were also there for women when they had these conversations with family members. For example, Neesha stated that: “When I had this conversation with him at first, I had my phone on and one of my friends was on the other line just in case something happens when I told him, but he was just really angry.” Even though women from middle-income households were more likely to challenge gendered norms outwardly when they returned home, eight of the twenty-two women from low-income households also challenged norms outwardly. Low-income women who challenged gendered norms outwardly were more likely to have substantial support from social networks. Low-income women who had a long-term visa to journey to New York were also more likely to stand up against family norms.

Others wanted to challenge gendered tasks in their home in outward ways by transforming their relationships and economic freedom. Some women became more

vocal about their feelings and things that they wanted to do with their life. Lina reflects on the changes in her relationship:

It is no longer a one-sided relationship in my view, in fact, I keep thinking back, that I actually got on that plane to get what I wanted. Now, I feel more comfortable to talk about how I feel and what I want. . . It's different now, I feel like we are a team.

Reproductive journeys became an empowering journey for women as they connected with other Indo-Caribbean women in the diaspora and learned new ways of changing their relationships to ensure equality. Women changed their understanding of their gender practices within their relationship by adapting some values learned from their friendship networks in New York (Ramadar 2007), reinventing their values. Thus, women's decisions were influenced by how women in their networks were also challenging gender (Smith-Lovin and McPherson 1993). Women wanted to claim the space to voice their feelings and make their own choices like their women networks. Importantly, creating dialogue and equality within relationships reduces the stigma within communities and families for reproductive health care, leading to greater change.

Seeking employment and education became an important way that women challenged motherhood and caretaking outwardly. The women in my study reported that they loved being mothers, but they wanted to do so with many other things in their lives, such as obtaining an education or getting their dream job. With the support of their social networks, this became possible. Versa, from a middle-income family in Guyana, discusses what this was like for her:

For me, it was more than taking me to the doctor's office or giving me the tools to get my treatments. It was the way my friends over here talked to me and encouraged me to do much better with my life. We had conversations about school, jobs, my passion, my interests, you know some of these things I never thought about

before. And no one never asked me these questions...My passion is to become a hairdresser...I finally feel like I am in control of my destiny and the woman who I am.

The journey for reproductive health care was one way that Versa challenged the gendered barriers she had encountered in her life. Twenty-eight of the thirty women linked looking for economic opportunities to their reproductive journeys. Seeking economic opportunities can create a more balanced relationship within their marriages, and women conveyed wanting this (Hirsh 2003; Hondagneu-Sotelo 1994). They tried to gain more equality within their household and more power to make their own choices due to economic opportunities—reinventing their own ways of challenging gender norms (Grasmuck and Pessar 1991).

Moreover, the activism in New York encouraged women to form their own organizations in their home countries to challenge gender injustices. Melanie who journeyed from Guyana started her own grassroots organization as a result of her journey to New York, she states,

I remember asking myself at my first Indo Caribbean Women's Empowerment event if work was being done in Guyana around these issues. . .I wanted to create spaces to talk about the issues and violence in Guyana but also make connections and build networks with people to address gender injustice and other issues that fuel it, like environmental justice. . .Seeing the organizers do it in New York and seeing the impact added momentum to start an organization.

Today, Melanie's organization has thousands of followers across the Indo-Caribbean diaspora. She hosted several events and held many discussions on her social media platform to bring awareness about the intersection of environmental justice and women's empowerment, gender-based violence, sexual and reproductive health, and community solidarity. These discussions invite women to share their stories, develop

solutions to address gender inequities, and cultivate spaces to involve women in advocacy projects. As women become active in grassroots organizations, they assume a gender consciousness that leads them to reflect on their gender identities and experience personal and social changes as they gain empowerment and self-esteem and become more sensitive to issues women experience in their communities (Padilla 2004).

The dialectical relationship between gender influencing their journeys, and the reformation of their gender during journeys shows the flexibility and mutability of gender. These women's narratives illustrate the linkages between shifting gender identities and reproductive journeys. Transnational networks craft and construct (Ortner, 1996) new meanings of womanhood by consciousness-raising. Among friends, the purpose of womanhood became not just motherhood, but the ability to make your own bodily choices, support yourself economically by leaving the household, and to stand up against husbands' demands. Gender expectations from home countries shifted based on women's experiences. Not only were their bodies transformed through this process, but their consciousness-raising became important to the transnational body projects as they navigate the disparities in home countries.

Conclusion

Indo-Caribbean women continue to navigate restrictions and institutions as they try to obtain reproductive health care. Gendered limitations within families and communities, lack of treatment from doctor visits in home countries, and the legal restrictions influence women to journey abroad. Regardless of these limitations, women in Guyana and Trinidad find their way around the oppressive systems of healthcare and family by relying on their women networks and grassroots organizations. These networks

facilitated and assisted in journeys by providing information, resources, and finance and actively challenged gendered norms and limitations—creating gendered consciousness-raising. Women realized the possibilities of obtaining a job and going back to school to earn an education and realizing these possibilities led to the transformation of gender relations within their families. Women also become changemakers upon returning to their home countries by starting their own advocacy groups and networks of women in their communities. Accessing reproductive health services abroad became a direct way of challenging the gendered norms of motherhood within their families and communities in home countries through the encouragement of women's social networks. Thus, gender becomes a constitutive element of migration or movement (Hondagneu-Sotelo 2003).

While social networks became important during journeys, women's class became another constitutive element in movement and choices. Women living in low-income households were more likely to challenge norms in less open ways, while women living in middle-income households were more likely to challenge gender norms in outward ways. Women living in low-income households were more afraid than those in middle-income households to talk about their reproductive journey because they are more dependent on their partners. Some middle-income women developed financial independence and could easily access resources, though some maintain hidden choices.

These choices become a representation of the oppressive systems in place as the family, and health care systems force women to choose between reproductive autonomy or having a family. The oppressive systems are shaped by the global economy and further influence women's journeys to western states to access health care. Reproductive journeys abroad become one example of the inequities that persist globally as bodies are

marginalized through class and gender entangled within the health care systems. The globalization of information, services, information, and procedures further encourage bodily and consciousness transformation. Women's networks became part of this process as they, too, underwent these journeys on their own.

Despite challenging motherhood, caretaking, and reforming their relationships with partners through their journeys, they are still caught between these systems as they try to navigate it secretly or outwardly. I further discuss in chapter 4 how these systems were created through colonialism and pose many challenges. However, women still express their agency. Undertaking reproductive journeys abroad becomes one step in the process of standing up against patriarchal norms. However, this fight continues as women are faced with difficult choices that can undermine the stability of their relationships and subject them to heightened stigma within their communities. As they try to evade gendered norms, women continue to perform traditional practices within their families. This duality of gender produces autonomy but creates tensions and guilt for some of the women. As women journey back home or remain in New York, their networks with other women strengthen. They gain more connection with women back home to disrupt their feelings of isolation before coming to New York, and they gain more support to continue this fight against gendered systems. Reproductive journeys became gendered movements.

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CHAPTER 4

INDO-CARIBBEAN WOMEN JOURNEYING FOR REPRODUCTIVE HEALTH CARE: THE INTERSECTIONS OF REPRODUCTIVE JUSTICE AND INTIMATE PARTNER VIOLENCE

Introduction

Intimate partner violence (IPV) is a global issue that threatens the health and well-being of many. The Centers for Disease Control and Prevention (CDC) defines IPV as behaviors carried out by intimate partners aimed at establishing and maintaining control and power over a partner, such as physical and sexual violence, stalking, and psychological aggression. IPV is linked to many negative outcomes such as mental health consequences, economic instability, and physical health complications, including reproductive health (Hasstedt and Rowan 2016). IPV may restrict a person's reproductive autonomy and lead to increased risk for poor birth outcomes, pregnancy loss, and other complications—a critical focus in this paper (Moore and Miller 2012; Hasstedt and Rowan 2016). There are few studies that document these linkages between intimate partner violence and reproduction, especially in the context of the Caribbean (Han and Stewart 2013). In this paper, I analyze IPV in the Indo-Caribbean community from Guyana and Trinidad, to understand the intersections of intimate partner violence and access to reproductive health.

Previous studies that examined intimate partner violence in the Indo-Caribbean community shows that Indo-Caribbean women's experiences of IPV has been linked to issues of immigration, inter-generational disconnect, religion, cultural ties to IPV, such as the use of the cutlass (a large knife), and alcoholism (Baboolal 2016; Parsad 1999). While

many of these linkages are common amongst various cultures, I interrogate structural inequities that contribute to IPV and reproductive injustice in Indo-Caribbean communities. Moreover, while IPV is deeply rooted in the histories of slavery, plantation economies, and indentureship in Guyana and Trinidad and Tobago (Thornton 2015), colonial constructions of ethnicity, gender, and class continue to prevent effective intervention programs and policies in Guyana and Trinidad and Tobago. Thus, I expand on previous studies by arguing that relying on colonial assumptions of Indo-Caribbean women as inherently immoral and Indo-Caribbean men as violent (Pitt 2019) have led to little intervention and a lack of social support services to support survivors.

In this paper, I ask: (1) How do experiences of intimate partner violence among Indo-Caribbean women impact their reproductive autonomy and access to reproductive health services? (2) How do structural conditions impact women's experiences of IPV and access to reproductive health care? (3) How do these experiences and conditions ultimately influence women's journeys to seek care in New York? (4) How do grassroots organizations that support Indo-Caribbean communities in New York grapple with understandings of IPV and create dialogues that shift away from colonial and racist understandings of IPV? To answer these questions, I focus on a global community in Queens, New York, a destination for Indo-Caribbean women from Trinidad and Guyana seeking reproductive health care services. I conducted semi-structured interviews with 82 women who journeyed for reproductive health services to NY and women who could not journey to NY, as well as activists, to understand their perceptions of intimate partner violence and their experiences of reproductive injustice. I also conducted participant

observations at local women's empowerment events in Richmond Hill and South Ozone Park in Queens.

I ground Indo-Caribbean women's experiences within their economic and social realities in Trinidad and Guyana by shedding light on the structural conditions, such as lack of support services, distrust in the justice system, and inaccessible health care. Cultural explanations of violence often shift our gaze from these complex realities and prevent the development of the structural interventions needed to address IPV and improve reproductive health care access. I also argue that grassroots organizations and global diasporic networks play an important role in bringing these structural issues to light. Lastly, I show how the intersections of gender, ethnicity, and citizenship shape IPV and accessing reproductive health care through a reproductive justice lens.

Literature Review

The Context of Guyana and Trinidad and Tobago

This paper focuses on the experiences of Indo-Caribbeans from Guyana and Trinidad. Indo-Caribbeans have roots in India (Baboolal 2016). Indian indentured laborers were imported from India to Guyana and Trinidad in the 19th and early 20th centuries, after the emancipation of Africans from slavery under the British (Gooptar 2022). Guyana and Trinidad and Tobago were the recipients of the largest number of Indians, and thus Indo-Guyanese and Indo-Trinidadians make up a significant population in these countries. According to the 2012 census in Guyana, Indo-Guyanese make up 39.9% of the population, followed by the Afro-Guyanese population of 29.2%, mixed ethnic heritage at 19.9%, with other ethnic groups such as Amerindians and Europeans making up the rest of the population. The 2011 census in Trinidad also indicates that

Indo-Trinidadian and Tobagonians make up the largest ethnic group at 37.6%, Afro-Trinidadians and Tobagonians make up 36.3% of the population, followed by 24.4% of the population identifying as mixed ethnic heritage, and other ethnic groups such as the people of Amerindian and European descent making up the rest of the population.

Caribbean indentureship is often compared to slavery due to the similar material conditions and experiences of the enslaved and the indentured (Kempadoo 2017). Indian laborers were recruited under false pretenses with promises of a better life to replace enslaved Africans. However, some formerly enslaved Africans were also driven into indentureship to survive particularly in Guyana. The journeys of Indian indentured laborers in the Caribbean started with overcrowding, intimate partner violence, sexual violence, and inadequate food and water on ships (Bahadur 2014). Upon arrival to Trinidad and Guyana, immigrants experienced long working hours and low wages determined by the plantation owners and cost of sugar. They had no choice in their employer, could not negotiate their contracts, and could not move freely without consent of their employer—creating economic conditions that would create dependency on indentureship. While men were recruited for their labor, some women were recruited to tie men to the plantations to serve as companions, to marry, and provide care work (Kempadoo 2017). The indentured also did not have many social amenities as they lived in tenements or “logies,” which were previously occupied by slaves. These logies were barracks barely raised from the ground and were partitioned into small and unventilated spaces occupied by one family, however large, or a group of men (Bahadur 2014).

European colonial rulers and colonists exploited Guyanese and Trinidadian people to extract wealth and expand the globalization of capital. This left these countries

saddled with political, social, and economic struggles-contributing to direct violence and structural violence (Knight 2019). Farmer (2004) argues that structural violence is the natural expression of a political and economic conditions that is rooted in colonialism, slavery, indentureship, and racism. He states that this structural violence, “continues to play itself out in the daily lives and deaths” of people who continue to live in poverty and do not have access to medical services and resources (311).

While Guyana and Trinidad gained their independence, ties to their colonizers remained as part of the system of global capitalism, Britain and United States intervene in their political processes, and through economic enforcement of structural adjustment programs, which decrease social services, reduce living standards, destroy their environments, and increase levels of violence (Barriteau 1996). As a result, gender inequities have been exacerbated through cuts to education, health care system, food subsidies, transportation, and the privatization of resources. Importantly, the development of the two-tiered health care system of public and private facilities in Guyana and Trinidad due to cuts in health care produced facilities that have limited specialists and providers, inadequate equipment and technology, and unsafe conditions (Nunes 2012; Delph and Nunes 1997).

These colonial structures continue to produce current conditions (Medwinter and Rozario 2021) and contribute to the reproductive injustices and intimate partner violence people experience in Trinidad and Guyana. These conditions are also present in the United States as immigrants from colonized regions of the world have been historically and presently discriminated against, racialized, excluded from institutions (Omi and Winant 2014) and have access to medical services, such as reproductive health care

(Roberts 2014). Indo-Caribbean women continue to experience alarming rates of domestic, sexual, and intimate partner violence. Recent estimates suggest that one in every two women in Guyana has or will experience intimate partner violence in their lifetime (UN Women, 2019), one in three women suffer from domestic violence at the hands of their partners in Trinidad (Pemberton and Joseph 2018), and there is no publicly inclusive data on Indo-Caribbeans in the United States. Given this, I ground the experiences of Indo-Caribbeans within this historical context to understand the experiences and intersections of access to reproductive health and intimate partner violence.

Understanding Intimate Partner Violence

Sociological theory provides useful tools to understand how and why intimate partner violence occurs, and how gender operates to produce and sustain violence. Intimate partner violence (IPV) is a common form of gender-based violence (violence committed due to a person's gender) (Robinson 2004). IPV cannot be understood without including a lens of gender and power, underscoring how "hegemonic masculinities" and gender norms produce gender hierarchies and inequalities that justify violence (Lawson 2012; Dobash and Dobash 2003). . Gender serves as a social structure or institution that organizes social relations (Connell 1987; Risman 2009).

Pitt (2019) argues that interventions to intimate partner violence during colonialism in Trinidad and Guyana continue to influence how violence is perceived. Mohaptra's (1995) historical analysis of "wife murders" in Trinidad and Guyana British Guiana in the 1860s contends that the dominant explanation for IPV was due to the

imbalance of men and women.² This gender disparity led to competition among men—as well as jealousy and distrust of women, which served as a justification for intimate partner violence (Mohammed 2002). As a result, Mohapatra (1995) notes that the goals of the legislative responses were to curb the “immoral,” nature of the women and by [channeling] the violent instincts of men” (250). The colonial government relied on this gendered understanding of Indo-Caribbeans as immoral women and uncontrollable, violent men. This produces present forms of colonial violence by transferring these understandings onto marriage, families, and intimate partnerships (Medwinter and Rozario 2021).

Some research emphasizes cultural explanations for the relationship between gender and IPV in Trinidad and Guyana (Pitt 2019; Kempadoo 2017). For example, Parsad (1999) and Baboolal (2016) turn to cultural explanations to understand domestic violence in the Guyanese diaspora. Parsad (1999) argues that while Indians who migrated to Guyana adopted Guyanese-Creole values, they retained an Indian cultural identity that places value on gender norms around family and marriage. Similarly, Baboolal (2016) argues that intimate partner violence stems from the norms of family structures where divorce is stigmatized and IPV brings shame to their families. Expectations of women as obedient mothers, wives, and upholders of Indian mortality assumes that women are responsible for childcare and household duties (Choudhry 2001; Kallivayalil 2004), as seen in other cultures. These expectations and practices also show how culture becomes a product of colonial structures.

² From the beginning of indenture, the ratio of men to women was 100 to 3, and this increased to 25 women to 100 men by the end of indenture (Roopnarine 2015).

De Freitas (1999) argues that these colonial ideas of motherhood and womanhood are placed as fixed norms. As a result, colonial stereotypes of Indo-Guyanese and Trinidadian women as submissive to their partners are recirculated in their communities and contribute to their consciousness of familial norms (Trotz 2004), and ultimately affect their ideas about the world (Hosein 2013). These ideas are sanctioned within and outside the home through violence and solidified by the inequities produced through structural forces.

In this paper, I pay attention to the structural conditions that have an impact on intimate partner violence among Indo-Caribbean communities. The term structural violence emphasizes how structures and institutions can cause violence by preventing people from accessing and meeting their basic needs (Galtung 1969). Accessing these needs are further contoured by race, socio-economic status, gender, sexuality, and citizenship status, creating hierarchies (Galtung, 2004; Hardy and Laszloffy 2005). The intersection of gender inequities within existing structural conditions become especially harmful for women.

Structural gender inequities are present in Guyana and Trinidad as women experience less access to resources, higher rates of poverty, high rates of unemployment, as well as growing rates for maternal malnutrition (Trotz 2004; Lazarus-Black 2001). In our article on Caribbean womanism, Medwinter and I (2021) show how these conditions become a new form of the plantation colonial state and mirror the conditions Indo-Caribbean indentured servants experienced. These structural inequities have a significant influence on women's decisions on entering, staying in, and leaving abusive intimate relationships (Dunn and Powell-Williams 2007; Lambert & Firestone 2000). Jewkes'

(2002) review of the relationship between IPV and poverty also shows a strong correlation between poverty and rates of intimate partner violence. For example, Trinidadian women within the working class and lower middle socioeconomic classes are more likely to experience IPV and were less likely to have access to counseling and resources compared to upper-middle class women (Nagassar et al 2010). Resources such as counseling, financial support, housing, and resources to navigate their experiences become a barrier for women against leaving an abusive relationship in fear that they will not be able to support themselves and their families.

These conditions can exacerbate gender inequities and create little faith in obtaining protection from their abusers (Seepersad et al 2022). Modeste-James and Huggins (2022) shows that even though there are legal protections, many women are afraid to report IPV because it can exacerbate their vulnerability to violence. Many women are also not educated about their legal protections in Trinidad and Guyana. For example, Peake (2008) found that 67.5% of women in Georgetown, Guyana who were survivors of domestic violence did not know their legal protections. Wallace et al. (2019) also found that women are also afraid to report IPV because there is a distrust in police. In fact, Peake found that 78.9% of women who experienced domestic violence in Georgetown, Guyana (the capital city) did not report their cases to police. Another important factor in the Caribbean is the lack of mechanisms to receive alimony or consistent child support after leaving their abusers, which further discourages people from leaving (Huggins and Mungal-Bissessar 2022). Importantly, inaccessibility to health care produces health consequences such as injury, permanent disabilities, mental

health consequences, and sexual and reproductive health consequences as a result of IPV (Sinha et al., 2022).

Thus, in this paper I argue that associating violence with culture essentializes violence and prevents us from seeing the structural conditions that impact IPV. It is important to understand how experiences of IPV reflect cultural systems (Razack 2003). However conceiving violence only through this cultural lens makes it difficult to identify strategies to prevent and intervene in IPV, while also shifting our gaze away from the social, political, and economic factors that also shape IPV. Understanding IPV through this lens also allows an analysis of how structural conditions impact access to reproductive health care, as well as the intersections between IPV and reproductive health.

Reproductive Justice and Intimate Partner Violence

Reproductive justice is a global issue (Rozario 2020). SisterSong (1994) defines reproductive justice as the human right to power and resources to maintain personal bodily autonomy, deciding whether or not to have children, and to parent children in safe and sustainable communities. Reproductive justice is about access, not just choice. Even when abortion or other reproductive health services are available, marginalized communities may not have access to their nearest clinic or have the financial means to obtain services (Silliman et al., 2004). Reproductive justice activists also recognize that the fertility of women of color is undermined by systemic and structural obstacles (Price 2020). The reproductive justice framework helps us understand and identify the power systems circumscribing race, gender, and class that impact reproductive health services access. Ross and Solinger (2017) argues that what happens to our bodies is continuously

challenged by these power systems. The negotiations and constraints women experience must be located within the economic and social realities that shape their lives and ability to access a good life.

Intimate partner violence can prevent access to reproductive health care. Reproductive control can occur through IPV as partners use threats and violence to impose their control over their partners' reproductive autonomy, sabotage contraception, and coerce or pressure someone to have an abortion, become pregnant against their will, or carry a pregnancy to term (Moore and Miller 2012; Hasstedt and Rowan 2016). Scholars have shown that such violence can reduce sexual autonomy and increase risks for unintended pregnancies, abortions, miscarriages, sexually transmitted infections (STI) and HIV transmissions (Moore 1999; Sarkar 2008; Tenkorang 2019). An untreated STI can lead to many sexual and reproductive health complications, including pregnancy complications, infertility, cancer, and pelvic inflammatory disease. Adkikari and Wagle (2018) found that women experiencing at least one form of violence from their partners were 1.7 times more likely to obtain an abortion and 1.5 times more likely to experience pregnancy loss. Women who experience IPV were also less likely to use modern contraceptive methods, such as hormonal birth control and an intrauterine device (IUD) (Mai and Phyu 2019). Even when contraception is available, experiencing sexual violence can prevent consistent and correct use (Moore and Miller 2010). Such barriers and experiences impede a person's ability to control their own family planning and protective sexual behaviors.

Accessibility to a health care center and a delivery care provider also may be limited. Women who had been sexually abused were less likely to visit a prenatal care

provider (Rahman et al. 2012). When pregnant women do not receive prenatal and antenatal care, infants are more likely to have poor birth outcomes as they experience a greater risk for preterm labor, low-birth-weight infants, and neonatal death (Sarkar 2008). Mogos et al. (2016) also found that women experiencing IPV before labor are four times more likely to have a stillbirth. Rapid, repeat pregnancies is another risk for women experiencing IPV, since they cannot experience potential health benefits from spacing out their pregnancies (Hasstedt and Rowan 2016).

Intimate partner violence is thus a reproductive justice issue. Intimate partner violence disproportionately impacts Indo-Caribbean women of reproductive age. These women have less control their family planning and maintain their reproductive health and autonomy if they experience sexual violence and reproductive control from their partners. The reproductive justice framework can help understand the linkages between IPV and reproductive health in the Indo-Caribbean diaspora (Outar 2012). I draw on the reproductive justice framework to understand how intimate partner violence impedes women's access to care—grounding their economic and social realities of controlling their reproductive choice. I also draw on the reproductive justice framework to understand how intersections of gender, ethnicity, and citizenship status shapes the experiences of Indo-Caribbean women. Understanding these intersections are critical to better address the needs of this community and other groups.

Methods

This paper is part of a larger study that examines the transnational journeys of Indo-Caribbean women who journey from Guyana and Trinidad to New York for reproductive health care. Specifically, I focus on a community in Queens, New York,

which is now named “Little Guyana” and has the largest cluster of Indo-Caribbeans in the United States, with a population of 82,000 Trinidad and Tobagonian and Guyanese immigrants (Indo-Caribbean Alliance 2014, para. 4). To capture the multitude of experiences and ensure the inclusion of authentic experiences during their journeys, I used a community-based research approach.

Community-engaged research can improve health outcomes and the lives of people that your research affects. It is an approach to research that engages with partnerships with communities, such as community-based organizations so that researchers can gain critical insights into their research questions, methods, and makes recruitment of participants more efficient (Handley et al 2010). Importantly, the researcher incorporates insights from community members into their interview questions, centering the critical issues that a community experiences. Becoming aware of these issues can lead to the development of solutions, such as influencing policies and creating intervention and programs with community members that is relevant and culturally applicable (Irby et al 2021). Thus, in this project, dialogue and conversations with participants during the events and meetings informed my research questions as we collectively identified inequities in the Indo-Caribbean diaspora. I also developed initiatives by leading and creating workshops and resources on reproductive health care. This project focused on understanding the inequities and developing solutions collectively with the community.

As an Indo-Caribbean researcher going back into my community to collect data, I had to be mindful of my positionality and how I navigated my field sites. There has been distrust in the Indo-Caribbean community towards researchers who come to do research

in the community and leave after their research is complete. To ensure the experience of the Indo-Caribbean community was authentically represented, I worked alongside organizers to develop solutions to attaining reproductive justice. Hartman (2006) encourages us to remain reflexive by asking and developing questions in our field site to contextualize and center experiences of the participants. The community based research approach allowed questions to arise in the field and let participants themselves situate their locations and realities. This approach allowed me to capture the complexities and contradictions in the field through a reflexive and expansive mode of interrogation—despite my connection with the field.

First, I conducted interviews with 82 participants. I conducted interviews with 32 women who journeyed from Guyana and 21 women who journeyed from Trinidad for reproductive health care services in New York. I then conducted interviews with 14 women living in Guyana and 8 women living in Trinidad who did not have the resources to journey to New York. During these interviews, I also found that women who journeyed relied on their social networks in New York, Guyana and Trinidad, and grassroots organizations to help facilitate journeys and gain access to resources and information. Therefore, I also interviewed 7 activists. Experiences of intimate partner violence came up organically through interviews as I asked questions about access to reproductive health care. After seeing the prevalence in this theme, I added interview questions focusing on intimate partner violence. I asked about their experiences of IPV, how IPV restricted their reproductive health care access, and why they entered and stayed in their relationships to understand their economic and social realities of their experiences.

Interviewees were recruited through various strategies. I shared my recruitment flyer on my social media accounts, such as Instagram, Facebook, and Twitter, and I also encouraged my social networks to share. Instagram was my most successful outlet to gain participants as I connected with activists and Indo-Caribbean organizations. I also reached out to several grassroots organizations in Queens that served the Indo-Caribbean community to share with their membership and attendees of their workshops. One key gatekeeper was an Indo-Guyanese woman who attended women's empowerment events and introduced me to women from Guyana and Trinidad who journeyed for reproductive health care. I further recruited participants through respondent-driven sampling by asking participants if they knew of anyone that also shared a similar experience. Respondent-driven sampling was my most successful recruitment method.

Secondly, I conducted participant observations to understand the reproductive health care services, education, and resources women received when they arrived in New York. I conducted approximately 150 hours of participant observations from March 2020 to October 2021 (48 one-hour long meetings and 39 workshops and educational events that lasted between one and four hours). These meetings and events were hosted by two grassroots organizations that serve the Indo-Caribbean community, which I refer to as Queens Women's Empowerment and Indo-Caribbean Women Empowerment. I participated in these events, volunteering, becoming a facilitator for some of the workshops, and participating in conversations. I carried a notebook to make jottings of conversations and interactions. Organizers also allowed me to take photos of the events. I then wrote detailed analytical memos the same day after leaving the virtual or in-person events and meetings.

I created pseudonyms for all people and places. All participants identified as women or gender non-conforming and are over the age of 18. The age of the women ranged from 22-52 years old as shown in Table 1. There were various reasons for reproductive health journeys, both long-term and short-term procedures and treatment, such as abortion, contraception, fibroids, cervical cancer, and reproductive tract infections.

Respondents contacted me directly to participate in the interviews. The interviews lasted between 55 minutes and 110 minutes. Before the pandemic, I conducted interviews in person at the location of the participants' choice, such as restaurants, coffee and roti shops, and in the park. I also conducted interviews through Skype, Whatsapp, and Facebook messenger for women who already returned to Guyana and Trinidad. After the pandemic, I conducted video and phone interviews for all participants. All interview data was audio recorded and transcribed. I managed the data with Nvivo qualitative coding software using a grounded theory approach (Glaser and Strauss 1967). I developed analytical and theoretical codes that were used to code field notes and interviews. During my analysis, I mapped connections between concepts and themes, created categories, and wrote analytical memos about my themes. Once I identified how intimate partner violence shaped reproductive health care access, I considered if this association mapped onto other factors, such as class and geographical location.

Findings

Situating Intimate Partner Violence

How do we understand and situate experiences of intimate partner violence and how IPV connects with reproductive health? IPV is not exceptional to Indo-Caribbean

women but produced through structural circumstances. Colonial arguments about Indo-Caribbean men and women remain potent and serve as a justification for IPV and reproductive injustice. This can be seen through narratives around divorce, marriage, and motherhood.

Grassroots organizations in Queens often invite people in the Indo-Caribbean diaspora to have discussions about IPV and gendered stereotypes. Some people in these spaces recirculate these ideas. For example, a participant in a women's empowerment workshop described intimate partner violence as a "man and wife problem." Understanding violence as an individualized problem avoids exploring the structural conditions of such violence and results in the isolation of victims and survivors. Here, IPV is cast as an essential part of marriage that can silence women from coming forward regarding their abuse. Annmarie, a single mother from Trinidad who recently divorced her partner due to IPV experienced this, stating:

I was enduring the abuse for years. For the sake of my children and my family, I didn't want to bring a bad name to them. I didn't want them to feel the humiliation of what I was going through, so I had to make up my mind [to be] strong and deal with it.

Colonial discourses of gender that is perpetuated by the government through social services and policies can also affect how Indo-Caribbean women see themselves and each other. Policies are an aspect of our structures that socially controls behaviors and practices through the imposition of restraints and sanctions (Parsons 2017), which controls how we act and perceive our actions.

Trotz (2003) found that Indo-Caribbean women in Guyana recirculated colonial ideas of womanhood—regulating their behaviors to act consistently with their ethnic identity, such as being obedient wives and caretakers. Ultimately, this can also affect how

they respond to IPV and how others perceive their experiences. For example, Pitt (2019) found that Indo-Caribbean women in Trinidad experiencing IPV who seek help from social services are often seen through the cultural lens of submissiveness and shame. Social service providers who meet women like Annmarie who stay with their abusers accept that violence is part of the culture, rather than discussing the economic or spatial circumstances that influence women's responses to stay.

Intimate partner violence is also defined as a cultural problem in faith-based institutions. Women who identified as Hindu discussed how they were treated in their temple after a divorce, when they experienced marital issues, and coming forward about intimate partner violence.

Samantha who currently lives in Guyana, discusses her experience of going to her temple after she divorced her partner due to IPV,

When I left him, the entire temple looked down on me. They used to ask me to set up the temple for our prayers on Sunday, but they only gave married women those roles. And even some of these women stopped talking to me.

Kanhai (2012) argues that Hindu religious texts describe women as goddesses of communities and the home, however the power of goddesses was de-legitimized through colonial and post colonial processes, and in turn produced discrimination and disempowerment for women in faith-based institutions. Religious institutions relied on understanding of karma and the transmission of submissiveness among women, meaning that women must have done something bad in their past life to experience IPV in their current life to disempower women (Mohammed 2013). Positioning IPV through this understanding obscures the root causes of violence and positions us to attach such

transmission of submissiveness as a cultural norm (Kanhai 2012). This often leaves some women, like Samantha, feeling unsupported.

Faith-based institutions can also provide critical support for survivors and victims of intimate partner violence. Survivors of IPV often turn to their faith-based institutions as a source of strength, as well as religious or spiritual counseling. It is also a place where networks among women are formed for consciousness raising women's issues and across the Indo-Caribbean diaspora (Kanhai 2012). Some activists in New York work closely with faith-based institutions through helping faith leaders support victims and survivors of IPV and providing resources for faith leaders. One initiative that Queens Women Empowerment led was distributing toolkits, having conversations at various faith-based institutions with attendees, and talking with faith-leaders in temples. Their toolkit, "Inter-faith Toolkit to Combat Gender-Based Violence in our Communities," included spiritual reflection passages and art supporting gender equity and survivor healing centering Hindu, Islamic, Christian, Sikh, Buddhist, and Jewish ideas. It also included tools to address IPV, resources to share with survivors, and encouragement for faith leaders to advocate for policies that address IPV. Such initiatives on anti violence work have been instrumental, serving as an example to move away from essentializing narratives that associate violence as a culture among the Hindu Indo-Caribbean community.

I have shown how gendered colonial discourses continue to foreclose examinations of structural conditions that impact intimate partner violence. I will now show how structural conditions intersect with experiences of IPV. The historical impact of the economic crisis during the 1970s and 1980s in Guyana and Trinidad has had a long-lasting impact on women as disinvestment in social services and the labor force has

gendered consequences, such as high unemployment, privatization of education and career advancement resources, maternal malnutrition and infant mortality, and women's work in marginal jobs in the informal sector (Trotz and Peake 2001). Coping with such structural and economic conditions places a heavier burden on women, and ultimately impacts their experiences of intimate partner violence and reproductive health care, while also centering motherhood and duties as household managers (Trotz 2003).

Roshni who currently lives in Trinidad discusses why she entered and stayed in her relationship with her abuser,

It was hard to leave my marriage. . .my kids and I were very dependent on my husband, you know. He used to take them to school, pay the bills, and always bought anything the kids needed. . .I kept thinking where we would get this support from if I had left. I didn't have a job. I was just, you know, taking care of my kids at that time.

Roshni's economic dependency on her partner and fear that there will be no support influenced her to stay with her partner. According to Wallace et al. (2019), survivors of domestic violence can accrue substantial expense given their need for housing, legal services, and health care in Trinidad and Tobago (3). With a lack of employment, educational services, and social services to help survivors, women do not leave their abusers in fear that they will not find an alternative suitable living for themselves and their children. As a full-time mother, Roshni's recognition and the investment into motherhood is also invisible, and as Trotz (2003) argues, the devaluing of such work also constitutes why many women in Guyana and Trinidad remain economically dependent. Without support from the state, women tend to rely on other support systems such as their families and community, however Roshni also lacked this

support as most of her family migrated to New York and Toronto. Thus, the gendered violence of poverty and displacement enables the cycle of IPV.

Another important factor that contributes to the experience of IPV is distrust in the criminal justice system in Guyana and Trinidad. While both Guyana and Trinidad have a Domestic Violence Act on the books that offer protection to survivors and their children, Chouinard (2015) argues that there is a lack of implementation and infrastructure to ensure protection. Natasha who journeyed to New York for reproductive health services discusses her distrust in these systems in Guyana,

There is no support with the justice system at all. . .when the police come, they only listen to the story that the man has, and they do not have any sensitivity to abuse. And if you can file an order of protection with the court, you can experience costly and long hurdles like you have to keep going back to the court and you live in fear that he will come back to abuse you. What protection do you have if they come back?

The criminal justice system in Guyana and Trinidad are not able to support and enforce their Domestic Violence Acts. Instead, survivors are revictimized, their experience is trivialized, and the process of holding abusers accountable often leave women in fear of further violence. This long and costly process in Guyana and Trinidad is also only accessible to few women who can afford to attend court proceedings, and women have lost their jobs for taking time off (Lazarus-Black 2008). Counseling, welfare services, and resources are not intertwined in the criminal justice system, and thus it is not sensitive to the needs and experiences of survivors. Failure to center survivors results in a criminal justice system that does not see the broader systems in which IPV is sustained in the Caribbean (DeShong and Haynes 2016).

These experiences of intimate partner violence show the importance of emphasizing the structural conditions that constitute women's experiences as they

navigate their experiences of IPV, given systems that offer little or no protection. Further, failure to understand these experiences as grounded in the economic and social realities of women's lives underscores the gendered violence women endure as a result of poverty. These conditions that produce and maintain IPV also produce reproductive injustice. I will now turn to the intersections of IPV and access to reproductive health care.

Reproductive Control

Reproductive control occurs when a person uses threat, violence, or intimidation on their partner to assert control over their reproductive autonomy—regardless of if those intentions align with their partner's reproductive goals (Moore, Frohwirth, and Miller 2010). Such acts include contraceptive sabotage, coercing their partners to have an abortion or carry a pregnancy to term, sexual violence, and pressuring their partners to become pregnant. These behaviors impede on a person's ability to control their reproductive health choices and access the health care they need during their pregnancy. Experiences of reproductive control are also contoured by class status. In this study, I found that low-income women were also more likely to experience reproductive control and intimate partner violence. 76% of women who experienced IPV were low-income, compared to 24% middle-income women. Thus, social and economic status intersects with reproductive health care access and IPV.

Intimate partner violence was a driver for twenty-one of the fifty-three (40%) Indo-Caribbean women who journeyed to receive care and distance themselves from their abuser. This was particularly true for the women who kept their journeys to New York a secret. Due to class and citizenship barriers, eleven (six women living in Guyana and five women living in Trinidad) of the twenty-two (50%) women who stayed in their home

countries also experienced IPV. Three out of the six women living in Guyana and two women living in Trinidad that I interviewed also kept their reproductive journey a secret in obtaining care. Nadia, from a low-income family in Guyana reflects on the important of keeping her journey a secret:

My husband was forcing me to have another child. Every day he would ask me, why don't we have another child yet and then he talked about his own childhood of growing up in a big family. It was like he was playing with my emotions every day about having another child, but I did not want one. . . The only way I could have kept it a secret was to come to New York. People talk here [in Guyana]. I was like so nervous to see someone I knew at the hospital and then they would tell him.

Studies have shown that women who are experiencing intimate partner violence were less likely to tell their partners about the pregnancy (Jones, Moore, and Frohwirth, 2011) in fear of reproductive control and physical and emotional harm, thus they were less likely to involve their partners in the decision-making. For women like Nadia, reproductive control occurred through manipulation. Manipulation can lead women to isolate themselves from support networks and influence them to make unwanted decisions about their reproductive health (Tarzia et al. 2020). To avoid this, women journeyed to New York to distance themselves from their abusers and the families of their abusers who can also attempt to control reproductive health decisions (Gupta et al. 2012). This was also especially important for low-income women like Nadia since their income, livelihoods of their children and themselves, and their home are dependent upon their partner economically. They did not want their partners to know about their reproductive journeys.

Another form of reproductive control women experienced was contraceptive sabotage. Contraceptive sabotage may include withholding, destroying, hiding, or

removing oral contraceptives, contraceptive patches, intrauterine devices, and condoms (Silverman and Raj 2014). This can pressure people into pregnancy and compromise their choice to avoid a pregnancy. Dina from a low-income family in Trinidad discusses this:

He took my birth control and threw it off the veranda top and continuously told me that he did not want to see it (birth control) in his house...I was so scared that he was going to do something to me if I bring it in the house.

While some Indo-Caribbean women like Dina obtained oral contraceptives and implemented her own strategies to prevent pregnancies, her partner used threats of violence and threw away her birth control. Dina journeyed to New York to obtain a long-term contraception, an intrauterine device to prevent future pregnancies. However, this was not her first chosen method of contraception (oral contraceptives). Studies have shown that women who experienced IPV are less likely to use their chosen method of contraception (Kusunoki et al., 2018; Paul and Mondal 2021). Dina was also not informed about the other methods of contraception. Women who lived in rural areas, those without education, and low socio-economic in Trinidad and Guyana were less likely to know about or use long-acting reversible contraceptives which are often unavailable in public health facilities (Ugaz et al. 2016; Ponce de Leon et al. 2019). Thus, health care systems need to be accessible and equitable in educating and making all contraceptive methods widely available.

Coercing a person to carry their pregnancy to term is another form of reproductive control that can occur through intimate partner violence, Vanie from a middle-income family in Guyana discusses this,

I wanted an abortion, but my husband wouldn't even let me leave the house for a checkup...he kept threatening to hurt me...the only time I could visit the doctor was when he was available to go with me.

As a result of her partner's control over her pregnancy and doctor visits, Vanie was prevented from asserting control over her bodily autonomy. Vanie used her friend and family networks to journey to New York to create distance between her partner and obtained an abortion. Abortion patients who experienced IPV are less likely to tell their partners about the procedure in fear that it will lead to additional violence (Woo, Fine, and Goetzl 2005). In secret, obtaining an abortion was Vanie's way of escaping the abuse she was experiencing as she did not want a permanent connection with him. This strategy of seeking an abortion was also implemented by other patients who wanted to minimize their involvement with their abuser (Jones, Moore, and Frohwirth 2010). These choices and strategies also reflect class status. Vanie's middle-income status allowed her to journey to New York in the middle of her second trimester. While this journey to New York was possible for her, it remains impossible for many women in Guyana who are experiencing intimate partner violence.

Ensuring access for safe and accessible abortions for pregnant people like Vanie in the Indo-Caribbean diaspora is a priority for grassroots organizations in New York. This priority is reflected in the mutual aid work, workshops, teach-ins, grassroots advocacy, and lobbying that the organization, Indo-Caribbean Women Empowerment leads. In a healing justice circle for reproductive justice, the Co-Director states,

As a survivor led organization, we know that gender-based violence puts women, girls and gender expansive people at higher risk for unwanted pregnancy. Legal abortion must be available and affordable for survivors. This is a human right. When abortion care is unavailable, the harm falls hardest on those who already face significant barriers to health care like the working class and undocumented people in our community.

Grassroots organizations understand the intersections of intimate partner violence and accessing reproductive health care. In their work, they ground the economic and

social realities in the Indo-Caribbean diaspora by centering class, citizenship, legality of reproductive health services, and access to health care. During their workshops, they also discuss these barriers not only in New York, but also remain mindful of the structural conditions in Guyana and Trinidad that impact access to care. For example, she hosted an event called, “Abortion Access Teach In” to discuss how the Indo-Caribbean community is impacted by abortion restrictions in Guyana, Trinidad, and New York. This session was attended by activists and community members in these locations and created space to talk about their reproductive health experiences, alternative options to abortion, such as misoprostol and mifepristone, and educating attendees on the legal restrictions. These workshops become important to create support networks and share information that is often inaccessible in New York, Trinidad, and Guyana,

Rhianna, a mother of three children and from a low-income house in Guyana was not connected with social networks and grassroots organizations, a visa, or the financial means to journey to New York. She remained in Guyana and discussed her experience of intimate partner violence and her third pregnancy:

When I was pregnant, he used to come home and abuse me. He would start fights with me every night and talk very bad about me. He would tell me that he didn't want the baby. . . One night he came home. . . and hit my head against the wall. . . I was so scared. I called my mom and I told her what happened, and she told me to go over by her right away.

Even though Rhianna wanted to carry her pregnancy to term, her partner wanted her to terminate her pregnancy. Rhianna experienced IPV before and during her pregnancy, leading her to leave her house many times with her children to live with her mother temporarily. This form of intimate partner violence manifests as a pressure to terminate pregnancies, when women like Rhianna do not want to do so (Moore,

Frohworth, and Miller 2010). Her story also represents the lack of economic and social support services for pregnant people and people who are experiencing IPV as staying with her mother was the only way out to assert her control over her reproductive health. The lack of reproductive health services and education, maternal health programs, counseling, and economic opportunities and unpaid labor is associated with the experience of IPV during pregnancies for women in Guyana (Miller and Contreras-Urbina 2021) and the prevalence of reproductive injustice.

Maternal Health

Women experiencing intimate partner violence were less likely to obtain reproductive health care services before, during, and after their pregnancy. This increases the risks of poor maternal and infant health outcomes. As I will show, intimate partner violence has a negative impact during pregnancy and postpartum. Class and citizenship status made it difficult for women to leave their abusive partners. Access to journeys to New York helped women control their family planning and alternative reproductive health options. Shaneeza who was currently living in Guyana at the time of our interview spoke to me about her experiences of intimate partner violence and reproductive health:

For the first part of my pregnancy, to be honest I didn't even know when I was pregnant. I was carrying on like everything was normal. It wasn't until I started to feel sick, that was when I took a test. When I found out I was pregnant, I asked my husband to take me to the doctor and I wanted to go to Georgetown. It didn't seem like he cared because he didn't even want to go with me, and he kept telling me to wait until my belly got bigger.

Throughout our interview, Shaneeza discussed the emotional and physical abuse she endured, which exacerbated her emotional distress during her first trimester as she was constantly worried about her pregnancy. Her exposure to IPV prevented her from

receiving prenatal care during her first trimester. Similar studies have found that such exposure to IPV is associated with lower use of reproductive health services before, during, and after pregnancies, which lead to risks such as maternal and child mortality, low weight at birth, and premature pregnancy (Rahman et al. 2012; Mogos et al., 2016; Kavanaugh and Anderson 2013; Cha and Masho 2014). Given that Guyana has one of the highest maternal mortality and child death rates *and* intimate partner violence in the Caribbean and Latin America, it is critical to understand the structural issues that are driving this intersection. The lack of clinics, resources, and education around reproductive health in Shaneeza's community made her reliant on her partner to drive her hours away to the capital of Guyana, Georgetown to obtain care. She also did not have the support from her partner on whom she was economically dependent. These structural challenges contributed to her experiences of IPV, and ultimately limited her access to prenatal care.

Another risk to maternal health is rapid repeat pregnancies (RRPs). Kimmy who journeyed to New York to obtain an intrauterine device describes this experience:

He used to force me to do it [have sex] without protection. . . I had three pregnancies back-to-back. The last one was the worst one because I was in and out of the hospital for weeks. They kept telling me that my iron was low. . . I couldn't feel my body. I just couldn't take it anymore. I felt so weak, and no one ever spoke to me about the risks of back-to-back pregnancies. . . I got the IUD in New York because I knew my body couldn't take it anymore.

Kimmy discusses her experience of repeated pregnancies as a result of sexual abuse. Rapid repeat pregnancies can limit the health benefits of spacing pregnancies and make it especially difficult for women to plan pregnancies (Mogos et al., 2016; Fisher et al., 2005). Closely spaced pregnancies can lead to many health risks, such as low birth

weight, stillbirths, preterm delivery, and nutritional deficits—as Kimmy experienced.

This can put the pregnant person’s health at risk as well as the fetal development. RRP’s indicate the disadvantages some Indo-Caribbean women experience in their health care systems in Trinidad and Tobago in Guyana, particularly poor quality and access to reproductive health care, such as contraception. As a result, Kimmy journeyed to New York to obtain a long-acting contraception.

Another maternal health risk that is linked with IPV is postpartum depression (Beydoun 2012). Sharon who was living in Trinidad at the time of our interview discusses this:

After my pregnancy, I was so sad, and I didn't want to do anything. I just felt a lack of motivation to do anything, even to be a mom. My husband and his family kept saying that I was running mad. . .My husband did not let me leave the house to go to the doctor, and I truly felt something was wrong with me. I came to find out later that it was postpartum depression from a friend.

After her second pregnancy, Sharon was experiencing postpartum depression—however during this time she did not attribute her emotional and behavioral changes to this. Her mental health issues were attributed to a common Caribbean trope of *running mad*, which minimized her experience and made her feel ashamed. Studies have also shown that women with a history of abuse or sexual coercion are also more likely to experience depression during their pregnancy, and depression increases if the abuse was very frequent (Martin et al., 2006; Rodriguez et al., 2008). A recent study also found that Guyanese women who lived in rural communities and did not have family support were more likely to have suicidal ideation during their pregnancies as a result of IPV (Miller and Contreras-Urbina 2021). Sharon, who also lived in a rural community did not have access to mental health resources and services and did not have family or social support.

Access to social networks among friends and family in Guyana and Trinidad became critical for many of the women in my study to talk about their experiences and resources. Without these networks, accessibility to mental health and reproductive health services becomes even harder to obtain in rural communities.

Women who experienced IPV during their pregnancies were less likely to obtain reproductive health care services and experienced reproductive health complications and mental health issues. Intimate partner violence can have a severe impact on maternal health outcomes as well as access to reproductive health care. These experiences further reflect class, citizenship status, and geography. Sharon and Shaneeza could not journey to New York because they did not have a visa and did not have the financial means to journey to New York. Kimmy, who comes from a middle-income household, had access to a visa, and she journeyed to New York for long-term contraception. For the women who remained in their home countries and could not journey, intimate partner violence continues to impact their health.

Conclusion

Overall, this chapter discusses one part of the puzzle of why Indo-Caribbean women journey to New York for reproductive health services. Intimate partner violence is a driver for many women to obtain services abroad for various reasons, such as creating distance with their abusers, keeping their pregnancy and reproductive health procedures a secret, obtaining their desired method of contraception, maintaining their maternal health, and avoiding rapid, repeat pregnancies. IPV led to reproductive controls as women's partners used violence, threats, and intimidation to assert their control over their partners reproductive autonomy. As a result of intimate partner violence, women could not access

reproductive health care, and thus impacted their ability to family plan and maintain their reproductive autonomy.

Importantly, to understand these women's experiences and choices to journey to New York and the intersection of IPV and reproductive health care, we also need to think about the economic and social contexts for these women. Previous scholarship examining IPV in Indo-Caribbean communities has emphasized culture as explaining high rates. However as I argue this forecloses examinations of structural conditions. It is important to understand how colonial constructions of gender, class, and ethnicity remain embedded in understandings of violence as cultural, especially in preventions and intervention services. A structural analysis identifies other factors – and provides approaches for how to reduce IPV.

This paper examines how economic and social inequalities intersect in women's experiences with IPV and reproductive health care. Women discuss their economic dependency to their abusers due to their lack of employment, the inaccessibility of quality reproductive health care and services, limitations in the criminal justice system, and a lack of support and financial services, such as housing and counseling that would allow women to leave their abusers. Women who were from low-income households were more likely to experience IPV and reproductive health abuses than women in middle-income households. They also found it much harder to navigate their abuses because their livelihoods were dependent on their partners. Women with a visa to journey to New York were more likely to be able to create distance from their abusers and obtain the care that they need, with the help of social networks. These realities reflect the structural conditions that contribute to IPV and reproductive injustice.

However, women still resist to obtain their desired methods of reproductive health care by journeying to New York for care and enacting everyday resistance in their lives in New York, Guyana, and Trinidad. Indo-Caribbeans in New York are also challenging and resisting inequities, but they are not leaving their communities in Guyana and Trinidad behind. Networks may leverage their access to resources and health care and power to transfer information and help. As a result, women in Guyana and Trinidad are also sharing this information with their friends and family, and becoming activists themselves. Grassroots organizations in New York also helped facilitate these reproductive journeys, while also participating in dismantling and interrogating social and economic inequities across the Indo-Caribbean diaspora. They also played a role in information sharing and helping women contextualize their experiences of IPV and reproductive injustice. This enabled women to understand their experiences and reject self-blame. Thus, grassroots organizational support plays an immense role to advocate for change, while also providing immediate support for Indo-Caribbean women.

The results of this chapter suggest that we can improve reproductive health care access by: (1) Interrogating the social and economic realities that contribute to IPV and reproductive injustice, (2) Investing in local grassroots organizations to enhance their resources and services to increase access to reproductive health care, (3) Ensuring effective health care facilities, social services, and economic opportunities in Guyana and Trinidad and Tobago, (4) Reviewing and modifying legal frameworks that prevent access to reproductive health care and revictimize survivors, and (5) Fostering global diasporic communities to foster networks and information sharing.

This study fills a critical gap in the literature to understand the linkages between IPV and reproductive health, especially in the context of the Caribbean and Caribbean diaspora. The reproductive justice framework situates the economic and social realities in connection with gender, class, and citizenship to understand the various negotiations and constraints people experience to obtain reproductive health care. In this case, some Indo-Caribbean women had to navigate their experiences of IPV and structural conditions that offered little or no support. Indo-Caribbean women are still experiencing IPV at alarming rates today. Understanding these intersections is critical to address the needs of these communities.

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CHAPTER 5

CONCLUSION

“It was simply a journey for me. Going to New York was a journey. My experience there was a journey. And even when I came back to Guyana, my journey continued.”

-Lisha

When I began this dissertation in 2018, I thought about my personal experiences, the experiences of my mom, and the experiences of many Indo-Caribbeans accessing reproductive health care. In every story, there was a journey. Each journey was unique. Some journeys did not end as women settled in New York, and many transformed the lives of Indo-Caribbean women. As I approached this project, I wanted to capture these diverse experiences, share unspoken stories in the Indo-Caribbean community, and interrogate why every experience has its unique journeys.

As I centered women’s experiences, I uncovered a puzzle regarding why Indo-Caribbean women journey to New York for reproductive health care services, given that immigrants, people of color, and communities that are economically disadvantaged usually have less access and experience discrimination in receiving health care in the U.S. (Ross et al. 2006). Each chapter has focused on reasons why women journeyed, such as receiving support from social networks and grassroots organizations, making efforts to obtain quality and affordable care, relying on diasporic networks, appreciating the medical culture in New York, journeying away from intimate partner violence, and challenging gender norms around motherhood and marriage. Women also experienced hardships during their journeys, such as financial struggles, isolation, moving numerous

times in New York, challenges obtaining a job and permanent living, and leaving their families behind in their home countries.

I used the term *reproductive journey* to describe these multidimensional experiences of people who seek to obtain reproductive health services abroad to capture the full scope of these experiences. Terms such as cross-border reproductive care, reproductive exile, and reproductive tourism draw from experiences obtaining assisted reproductive technologies and surrogacy (Connell 2013; Pennings 2002; Rudrappa 2015; Inhorn and Patrizo 2009). Yet access to basic reproductive health care such as check-ups, contraception, treatment for infections, abortions, and reproductive health surgeries also influence people to journey for care. When I asked my participants how they would describe their experiences, many described it as a journey. It was a journey that started in their home countries, and for women who could not journey abroad, their journeys remained in their home countries. Their experiences in New York were also a journey; for many, their journeys did not end even after they returned to their home countries. Thus, understanding their experiences through this framework captures those complexities and the ongoing impact of accessing reproductive health care in their lives. These journeys became stories of resistance, diasporic activism, and global inequities in health care.

Resistance

Women's journeys to New York for reproductive health care is a movement of resistance. Resistance for Indo-Caribbean women took many forms in both visible and invisible ways. They challenged gender norms through consciousness-raising among networks and grassroots organizing and ultimately reformed their relationships with their

families and communities. These choices were contoured by their access to resources, class, citizenship status, and global inequities in accessing health care. As a result, these movements were “simultaneously bound and free, coerced and constrained, victims and agents” (Kempadoo 2004: 65). Women’s access to care was reinforced through colonialism, global capitalism, their economic conditions, and gendered boundaries in their communities, families, and legal institutions. As they navigated these conditions, they experienced constraints and negotiation, while simultaneously resisting and navigating these systems of inequalities.

Their home countries of Guyana and Trinidad and Tobago experienced a history of exploitation by European colonial powers, which impacted the economic, political, and social growth that contributed to the structural violence that women experienced (Knight 2019). In addition, structural adjustment programs privatized health care and limited access to reproductive health care services and resources, decreased social support services, destroyed their environments, and increased the level of violence—exacerbating gender inequities. While women experienced reproductive injustice, they were also experiencing intimate partner violence, limited access to jobs and education, and a lack of social support. While navigating these realities, their pathways to obtain care became a journey that resisted the structural violence and gender norms around motherhood that prevented their access to care.

Their everyday forms of resistance during their journeys and after they returned home took many forms. Social networks and grassroots organizations organized and facilitated journeys by providing information, finance, and resources. They also contributed to the gendered consciousness-raising of women by encouraging them to

actively challenge gender norms and empowering them regarding obtaining a job and going back to school—transforming their economic growth and relations in their families. As a result, after returning to their home countries, women sought ways to maintain their reproductive health, such as hiding their contraception and sharing their stories with their communities. They also became changemakers as they formulated their own networks and advocacy groups in their home countries to continue sharing information and resources. As a result, they hope to transform their communities where reproductive health is no longer a stigmatizing topic. Many women also challenged motherhood and marriage expectations by seeking their own financial independence.

These forms of resistance were contoured by class, as women from low-income households were more likely to resist in less visible ways. In contrast, women from middle-income households were more likely to resist outwardly. Thus, reproductive journeys became a direct resistance to the economic and social realities they experience and reformed their understanding of gender. These transnational journeys constructed new meanings of womanhood through gendered consciousness-raising. They expanded their definition of womanhood to include self-care, making their own bodily choices, standing up together as a community, and obtaining opportunities to fulfill their dreams.

Such transnational movements are complex and consist of multiple pathways. Throughout this journey, women navigated gendered practices within their relationships and families differently due to their ethnicity, immigration status, and class. These journeys were hard, and not every woman benefited through resisting. This dissertation attempts to challenge dominant narratives of Indo-Caribbean gender by showing that even though larger structures of colonialism and capitalism bound women's experiences

and realities, women resist and create their networks to challenge and transform these systems, health inequities, and gender. Grassroots organizations' negotiations and strategizing in their local communities in New York transcended the global, sometimes transforming women's understanding of self and their collective identities. These journeys make their agency visible, even while they also highlight the structural inequalities they face.

From Local to Global Activism for Reproductive Justice

The reproductive justice movement focuses on maintaining the right to personal bodily autonomy, not to have children, to have children, and to parent children in safe and sustainable communities (SisterSong 1997). Reproductive justice organizing is intersectional and centers the economic and social realities that shape access to reproductive health care. Even when reproductive health care is legal, many communities of color cannot afford it or cannot travel to the nearest clinic. Ensuring that communities are safe and sustainable to maintain healthy reproductive lives was critical for the grassroots organizations in Queens, New York. Advocacy is an important aspect of the work among community-based organizations in New York to ensure that Indo-Caribbeans have access to reproductive health care, as well as interrogating systems that prevent such access.

The work of grassroots organizing in the Indo-Caribbean community in Queens, New York, centers community and care to facilitate these journeys and support women while they are here in NY. As I explored the reproductive health care journeys of Indo-Caribbean women, these values were present through and through their lived experiences, community, and their understanding of attaining reproductive justice. During a

reproductive justice rally in Queens, New York, in October of 2020, activists and community members gathered to rally about abortion care and how communities can stand in solidarity with each other and support each other, one Indo-Caribbean activist during the rally stated,

“And who are the ones that are mostly impacted by these restrictions?

It’s our very own communities...its women of color, immigrants, queer and trans people, and working-class people. These restrictions place a burden on our lives. Women are traveling far for reproductive health care, having little or no funding to obtain care, and not allowing them to create their own reproductive choices.

We need all hands-on deck in this fight. This is a fight against white supremacy, patriarchy, gender and race inequality, and normalized violence against our bodies. All these systems work together to uphold inequality. Eradicating these systems that continue to reinforce these laws and understanding the multiple oppressions that impacts us and our communities is key in this movement, because as Audre Lorde said, “There is no such thing as a single-issue struggle because we do not live single-issue lives.”

Activists are constantly thinking about the lived experiences, priorities, values, and concerns of Indo-Caribbeans with specific knowledge of their context. In their advocacy, they also explore the interplay among oppressive structures, agency, and negotiations around survival. Women, alongside their communities, are fighting for the liberation of their communities against all forms of oppression. They understand reproductive injustice as an issue that impacts the Indo-Caribbean community as a whole, and they continue to center the community through their programming. As a result, ensuring access to reproductive health care became a priority for activists for people not only in New York but in their homelands. The diasporic ties to their communities fostered global diasporic communities that supported each other.

This activism by Indo-Caribbean women to obtain reproductive justice shows that a movement that centers community, self-care, and love can increase access to health care. These diasporic communities became an important contributor to the reproductive health journeys in New York and provided information and resources for people who could not journey. They also fostered virtual spaces for people to connect and share their stories. During their workshops, people joined through Zoom and their phones and even followed up with organizers for more information. They were connected to grassroots organizations through social media. As a result, these organizations were bridging their social capital, transforming community spaces into thriving learning hubs to increase social capital, create the trust that promotes collective action, and serve as a bridge of social capital in the Indo-Caribbean diaspora.

These diasporic communities formulated a network of activists, social networks, and health care providers. Women worked with each other, activists, healers, organizers, health care professionals for mutual support while they pursued their own objects of reproductive justice. This created a community which fostered spaces for storytelling, dialogue, and activism grounded in solidarity and siblinghood—and enabled them to challenge the status quo transnationally. Such dialogue and storytelling challenged the stigma and shame they were experiencing in the community, while transforming norms that can be harmful and contribute to reproductive inequalities. These activists embodied a determination of improving the lives of women individually, collectively, and transnationally across the Indo-Caribbean diaspora.

What happened to journeys during the Covid-19 Pandemic?

When I started the research for this dissertation, women were journeying from Guyana and Trinidad and Tobago to New York for reproductive health care services. During COVID-19, these countries implemented travel restrictions, which decreased access to visas and affected the countries socially and economically. According to the United Nations Development Program (2020) assessment of the socioeconomic impacts of the pandemic in Guyana, respondents could not access health care, and limited healthcare facilities led to overcrowding, they did not have adequate access to food, experienced reduced work, and households needed essential items, such as period products. Trinidad and Tobago also experienced these challenges with an overwhelming healthcare system and the loss of jobs, especially in the tourism industry, as tourism accounts for the country's second-largest income source (Borden Project 2021). These challenges exacerbated the inequities experienced in this dissertation for many families while limiting the reproductive journeys to New York.

The Covid-19 pandemic also created awareness about health inequities in Guyana, Trinidad and Tobago as governments and ministries of health developed rapid plans to increase access to health care and access to facilities that did not exist before the pandemic (Hunte 2020). For example, Trinidad and Tobago created separate medical facilities to care for Covid-19 patients, which became a parallel health care system to avoid spreading the virus and ensure less overcrowding in healthcare facilities (Hunte 2020). This also led to the creation of education and training for people to obtain jobs in the health care sector. Importantly, gaps such as the limited access to pharmaceutical and medical supplies were brought to light as essential health care facilities did not have essential medication to support their communities, such as contraception. As a result, the

Ministry of Health in Guyana has prioritized ensuring essential medications are available at health facilities (Pan American Health Organization 2021). These examples prove that the government in Guyana and Trinidad and Tobago can respond to the limited access to reproductive health care, maternal mortality, and reproductive and sexual health education.

The Covid-19 pandemic also impacted how health care systems and grassroots organizations responded to help communities in New York. As shown in my dissertation, community-based organizations prioritized access to health care by inviting health care providers to workshops and events, creating virtual spaces that are accessible to the Indo-Caribbean diaspora, and providing essential resources for communities to thrive, such as access to food, period supplies, PPE, and clothing. For example, Indo-Caribbean Women Empowerment and Queens Women Empowerment provided workshops on safety planning in abusive households, educational and professional development, self-care, and health education. Local elected officials worked alongside these organizations to ensure access to resources, funds, and essential items while providing a space for communities to voice their concerns. As a result, the Covid-19 pandemic created and expanded collaborations across many sectors (Zenooz 2021). Thus, while Covid-19 restricted movement, it presented ways to increase access to health care, such as reproductive health.

The Matter of Reproductive Health Care

Overall, my research contributes to the field of health, sociology, and feminist and womanist studies by uncovering the constraints, choices, and access to reproductive health care for Indo-Caribbean women. I expand on the sociological theories of gender,

gender-based violence, medical tourism, migration, and grassroots organizing.

Importantly, I show the importance of understanding reproductive health experiences through a reproductive justice lens. I center the work of black and brown feminists and womanists in my study, as well as drawing from their methodological tools to carry out this research. I also show the importance of community-engaged research in the field of sociology to bridge the divide between academia and communities. As shown, such an approach to research can develop meaningful solutions with communities and promote public health.

My research sheds light on the current reproductive health climate in Guyana and Trinidad and countries with similar reproductive health policies as their neighbors in the Caribbean and South America. Today, advocates in Trinidad and Tobago and Guyana are calling for more access to reproductive health care, such as the legalization of abortion, more access to modern forms of contraception, sexual and reproductive health education in schools, elimination of waiting periods for abortions, medical equipment, and more health facilities and professionals to increase access to care. As I have shown, these changes are bound to the histories of Guyana and Trinidad. However, it is not impossible. As these health care systems transformed during the Covid-19 pandemic, it has shown some critical ways we can also increase reproductive health care access in Guyana, Trinidad and Tobago, and New York, such as:

- 1) Fostering global communities that connects resources, education, and builds networks to increase access to health care;
- 2) Investing in grassroots organizations the support the development of local communities, immigrants, and people of color;

- 3) Developing health care clinics in communities that do not have access to care, such as rural communities;
- 4) Strengthening primary health care services, such as prenatal, postnatal, and child care services should be a priority;
- 5) Engaging in cross-sector collaborations, such as partnerships between grassroots organizations and policy makers to bring about change;
- 6) Recognizing the social and economic inequities that prevents access to reproductive health care.

For community members who want to support, there are also action steps:

- 1) Supporting reproductive health funds and providers;
- 2) Asking yourself: what can your position offer this movement right now? Make those connections and add to the movement;
- 3) Supporting reproductive health patients: volunteering at a clinic, signing up to be an escort, offering childcare and financial support and checking up on them;
- 4) Centering and amplifying the voices and needs of people most impacted by abortion and reproductive health restrictions;
- 5) Normalizing conversations around reproductive health to reduce stigma
- 6) Showing up and organizing to advance reproductive justice.

This project has shown that community support, grassroots organizations, situating economic and social realities in connection with gender, class, and citizenship to understand the various negotiations and constraints people experience to obtain reproductive health care, and understanding the intersections of critical issues, such as

reproductive health care and intimate partner violence are all important to public health. These stories are the realities of people's sacrifices to access basic health care. These stories represent the hardships, such as leaving families behind, journeying with little financial resources, and for some, starting over life in a new country for long-term treatment. These stories represent agency and resistance within various boundaries. Yet, these journeys are filled with care, love, and hope.

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