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Reproductive Journeys: Indo-Caribbean Women Challenging Gendered Norms

A Thesis 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

MASTER OF ARTS

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Sociology

Reproductive Journeys: Indo-Caribbean Women Challenging Gendered Norms

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ABSTRACT

REPRODUCTIVE JOURNEYS: INDO-CARIBBEAN

WOMEN CHALLENGING GENDERED NORMS

FEBRUARY 2020

TANNUJA ROZARIO, B.A., JOHN JAY COLLEGE OF CRIMINAL JUSTICE

M.A., UNIVERSITY OF MASSACHUSETTS AMHERST

Directed by: Professor Joya Misra

Little is known about the factors that influence people from the Caribbean to seek reproductive health services in the United States. In this paper, I focus on Indo-Caribbean women from Guyana and Trinidad who undertake reproductive journeys to New York. I ask: (1) What influences Indo-Caribbean women to begin their reproductive journeys to Richmond Hill, New York? (2) How do Indo-Caribbean women challenge gender norms during their reproductive journeys? (3) How does women's class inform their decision making in challenging gendered norms? After conducting 30 in-depth interviews with Indo-Caribbean women from Guyana and Trinidad who seek reproductive health services in New York, I find that Indo-Caribbean women's reproductive journeys are influenced by sexism experienced within households, communities, and doctors' offices, lack of proper care, legal restrictions, and unaffordable treatment. Another driver is support from women networks. Social networks helped women challenge gendered norms around motherhood that are present within communities in home countries. As women receive support from their networks, they challenge gender norms varied by their class. Women from middle-income households are more likely to challenge gender norms outwardly. Obtaining reproductive health care abroad becomes a journey with multidimensional experiences of gendered negotiations and constraints.

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CHAPTER I

INTRODUCTION

Feminist scholars have long theorized why people travel to specific locations to obtain reproductive health services. Scholars refer to "reproductive tourism (Bergmann 2010; Blyth and Farrand 2005; Ikemoto 2009; Pennings 2002 and 2005)," "reproductive exile (Matorras 2005; Inhorn and Patrizio 2009)," and "reproductive care cross-border travel" (Whittaker and Speicer 2010 to represent these experiences. I use the term *reproductive journey* to describe the multidimensional experiences of women who seek to obtain reproductive health services abroad, to capture the full scope of these experiences. Much research on reproductive journeys documents the barriers people encounter in home countries, the hardships people experience in host countries, and the booming industry of fertility treatments (Inhorn 2015; Shenfield et al., 2010; Blyth and Farrand 2005). However, we know little about the gendered negotiations and constraints people experience, and how their class informs these negotiations. Reproductive journeys can help women directly challenge gendered norms, practices, and institutions. As the Indo-Caribbean women in my study journey to New York for reproductive health services, they challenged gendered norms and practices transforming their traditional gender roles. In these ways, their reproductive journeys became gendered movements.

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? 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, class, and citizenship.

Through conducting 30 semi-structured in-depth interviews with Indo-Caribbean women from Guyana and Trinidad who seek reproductive health services in Richmond Hill (Queens), New York, I find that sexism experienced within households, communities, and doctors' offices, lack of proper care, legal restrictions, and unaffordable treatment influence women's journeys to obtain services and ultimately travel to New York for continued access to resources. These barriers stem from ideologies that Indo-Caribbean women are expected to uphold "Indian" morality through motherhood and to be obedient women to their partners (Choudhry 2001; Kallivayalil 2004; Naidu 2009).

Another driver for seeking reproductive health services is the encouragement and support provided by women networks in New York. Social networks transfer valuable information about reproductive services available in New York and help women challenge gendered norms around motherhood that are present within communities in home countries. For most, women's networks support and help women challenge gender norms and redefine their roles and identities. Much literature on social networks focuses on social ties for economic opportunities and migration, but less research shows how these networks serve to challenge cultural norms and provide resources, such as health opportunities to overcome obstacles within home countries (Hanefeld et al., 2015). As women receive support from women's networks, they challenge gender norms in both visible and guarded ways, varying primarily based on their class. Women from middle-

income households are more likely to challenge gender norms outwardly during their reproductive journey, while women from low-income households are more likely to challenge gender norms in more guarded ways.

Mohammad (2002) and Mehta (2004) argue that women within the Indo-Caribbean diaspora are constantly making gendered moves that challenges gender norms and ideologies as they travel from one location to the next, from India to the Caribbean, and other parts of the world. This transforms their ideologies and practices of gender (Snorton 2017; Butler 1990, 1999) as they encounter new values and experiences and renegotiate patriarchal values and perceptions of power as they reconstruct their identities. As women challenge gender roles directly through reproductive journeys and after their journeys, they develop new expectations, roles, relationship dynamics and gender identities. This translates into new understandings of selves and goals they want to accomplish after journeys.

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. Their negotiations and resources from social networks usually remain invisible to their families even though they rely on families for citizenship. This gendered duality reinforces their autonomy, although they outwardly appear to conform to roles of the wife and the mother. This duality is informed by class as some women circumvent gender norms, and challenge and renegotiate their spaces and roles outwardly, while others still circumvent gender roles secretly when they cannot directly challenge norms. The stigma they experience from social systems, family

economy, and their own desires continues to shape these experiences throughout their journey.

As social networks facilitate these journeys, reproductive journeys can become gendered movements. I first show the barriers women experience in their home countries that prevent access to reproductive health services and their desires and goals after reproductive journeys. I then show how class and gender shape women's experiences in challenging gendered norms during their reproductive journeys. I then further show how these social networks facilitate reproductive journeys by providing resources, information, and support.

CHAPTER II

BACKGROUND

A. Reproductive Journeys

Medical tourism is an umbrella term referring to traveling to another country to seek treatment aimed at improving health (Connell, 2013). Connell further argues that definitions of medical tourism is limited, because it is difficult to identify who and how many medical tourists exist. An 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; Nowicka, 1996; Serrano Gil and García Casado, 1992).

Gilmartin and White (2011) furthers our understanding of health and reproductive tourism more broadly in terms of mobility for women to travel across borders, showing that not all medical tourism emerges from agency, choice, and possibility (Cresswell, 2010). Women in Ireland that are not Irish, undocumented, and at the bottom of the socioeconomic hierarchy experience transnational mobility in different ways. Mobility rights and reproductive autonomy (Oakley 1985) are thus contingent on one's nationality, class, and race. However, feminist scholars like Inhorn et al., (2009) disagrees 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.

I argue that framing women's experiences as reproductive journeys captures the various decisions, pathways, and reasons in seeking reproductive health care. By understanding women's reproductive health experiences in my study as multidimensional, I became attuned to the way's women were challenging gendered norms differently. Terms, such as reproductive tourism (Bergmann 2010; Blyth 2006; Blyth and Farrand 2005; Ikemoto 2009; Pennings 2002 and 2004; Smith et al., 2009), reproductive exile (Matorras 2005; Inhorn 2009), and cross-border reproductive care' (CBRC) (Whittaker and Speicer 2010; Pennings 2005) are all used to describe the diverse experiences of reproductive health seekers. However, these terms do not capture the multidimensional experiences of reproductive health seekers as they undergo journeys for different reasons and encounter various experiences in different host locations.

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 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 Speicer 2010). However, this term is primarily associated with patients receiving treatment through assisted technologies. Reproductive experiences abroad go

beyond obtaining assisted reproductive technologies. Questions about abortion access, contraception, and other reproductive health services also play a role.

Therefore, I suggest the term reproductive journeys. I asked my participants about 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 merely an experience of "travel." Their journeys began with the many barriers in their home countries that led them to seek reproductive health services abroad. Also, their experiences varied in terms of the level of hardships and pleasure they faced once they arrived in New York. Reproductive health seekers may face various constraints and negotiations, some may not face hardships in their host destinations, some will go back to their home countries, and others may want to stay in their host destinations. The term, reproductive journey represents the various outcomes and experiences, while acknowledging their choices and constraints in home countries and their journey to their choice of location to seek reproductive health. For the women in this study, their journey started with their social networks. Their social networks encouraged them to seek reproductive health services in Queens , NY. Their journeys end with their challenging of gendered norms within their families and communities in various ways, depending on their agency to do so. Thus, reproductive journeys can become gendered movements through a multitude of experiences.

B. Gender Transformation and Social Networks

Gender is an organizing force within our institutions, practices, and policies. Gender expression can be further complicated by race, ethnicity, sexuality, and class (Hill Collins and Bilge 2016; Crenshaw 1990; Lorde 2012; Barriteau 1992). Access to jobs,

social positions, and resources are thus shaped by all these factors that shape norms and ideologies. We are constantly engaging in practices of 'doing gender' (West and Zimmerman 1987). The re-doing, un-doing, and doing gender can lead to the maintenance of gendered structures (West and Zimmerman, 1987; Mojola 2014; Alfrey and Twine 2016) or it can challenge gendered hierarchies and positions. Feminist scholars have regularly shown this instability of gender (Snorton 2017; Butler 1990, 1999, 2011; Spade 2015; Ferguson 1993). Butler claims that gendered acts and identity do not exist without each other; therefore, gender becomes an identity that is continually constituting itself.

For Butler, gender is not a stable identity (1999, 179). She states that "gender proves to be performative—that is constituting the identity it is purported to be…gender is always a doing" (Butler 1999, 33). Gender similarly is also seen as a "performance" for West and Zimmerman (1987) and Goffman (1979). Butler (2011) calls "being a man" and "being a woman" as "internally unstable affairs" (86). For Butler, gender is not consistent through historical contexts and time, nor is it coherent. Snorton (2017) uses the concept of transitivity to also show the instability to gender—as people are moving, their gender is transforming. Understanding that gender is always in motion produces many questions for scholars who study gender as they examine the impact of moving on gender performances.

Some feminists argue that traveling or migrating to another location leads to new freedoms to expand gender roles (Pessar 1999; Andrews 2014; 2018). While others 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 (Malhotra, Misra, and Leal 2016; Mahler and Pessar 2001; Pessar and Mahler 2003; Oishi 2005; Hondagneu-Sotelo 2011, 1994; Menjivar 1997; Gold 2005). 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. 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; Youssef 2011; Kanhai 2011; 1999). 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 migrate to the Caribbean in 1838. Through these waters, resistance to caste systems and gendered norms in India became a reality as Indo-Caribbean's seek to challenge these systems through their journey. This journey becomes a reflection of other journeys of migration after arrival in the Caribbean. Kanhai (2011; 1999) also argues that Indo-Caribbean women found empowerment and creativity through their development and exploration of 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*

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night represents a community of women coming together to challenge

gendered ideologies, 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 roles because they had to manage

the household and obtain jobs. Such transformation reveals the negotiations of gender

and power as women challenge conceptions of gendered expectations—disrupting

assumptions that Indo-Caribbean women are one-dimensional and highlighting that

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 become important journeys for Indo-Caribbean

women as they negotiate and resist gendered practices and norms.

An essential aspect of traveling and migrating to new locations is the role of

social networks. While studies on social networks have often been "gender-blind" and

"indifferent to gender" (Boyd 1989), others have shown how gender relations structure

social networks and in turn influence migration paths and processes (Curran and Saguy,

2001; Davis and Winters 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 (Menjivar 1997; Gold 2005). For

example, women craft letters to migrants' husbands to convince them to let their wives migrate, secure a smuggler to get them across the border, or even give them financial assistance (Hondagneu-Sotelo 1994).

Nawyn et al., (2009) argue that gender theory should be used to inform our understanding of the connection between the gender relations and roles and journeys/migrating to a new location. For many migrant women, it is the gendered institutions that shape their decisions and opportunities for migration and tourism. These institutions are their family (Grasmuck et al., 1991), global labor market (Portes and Rumbaut, 2006; Kingma, 2007; George, 2005), and the state (Massey 2002; George 2005; Cheng 2003). Many immigration studies 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 need to examine the power relations between genders by using gender theory.

C. Social Networks and Access to Medical Services

Much literature focuses on the influence of social networks on migration. Social networks encompass interrelations among individuals (Moren-Cross and Lin 2006). 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 that go beyond home countries. Migrant social networks contribute to the continuation of international migration through the maintenance of these social relationships and the exchange of information (Massey et al., 1993; Gurak and Caces, 1992).

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 of medical journeys. Some of their participants were seeking IVF, Intra-cytoplasmic sperm injection, egg donation, and sperm donation. Patients were more likely to travel to locations recommended through their networks and support groups. These networks were more likely to provide information and recommendations on various providers and clinics. 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; Hanefeld et al. 2015).

These networks become "collective care" networks (Parr 2002). These networks have readily available resources and information to manage care as well as guidebooks to support patients that are traveling abroad (Connell 2011; Snyder et al., 2011; Ormond and Sothern 2012). Moreover, these networks also become a facilitator in the medical journey process as they transfer information between patients seeking care and health care providers. Although Hanefeld et al. (2015) touch on the influence of social networks on patients seeking reproductive health care, we know little about these interactions and resources provided to patients to seek reproductive health care.

I uncover the barriers that women experience in their home countries and influencers to journey to New York, such as women 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. The decision to challenge gendered norms are further influenced by class positions. Movement for reproductive journeys therefore became a way to challenge gendered barriers through the use of social

networks. So, this prompts me to ask: (1) What influences Indo-Caribbean women to begin their 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 inform their decision making in challenging gendered norms? These questions help us further understand the underlying processes in reproductive journeys.

METHOD

This study is part of a larger project that aims to uncover why Indo-Caribbean women travel/migrate to Queens, New York for reproductive health services. I conducted 30 semi-structured in-depth interviews with Indo-Caribbean women from Trinidad and Guyana. During interviews, I ask 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. Women whose came to New York for reproductive health services were recruited through a gatekeeper within the social network who currently lives in New York and provides information and assistance regarding reproductive health services. I then recruited participants through respondent-driven sampling by asking participants if they know of anyone that shares a similar experience at the end of 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. 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).

Feminist methodologies guide my interviews. Although I share the same ethnic identity with the women I am interviewing, 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 a method from Gomez-Barris (2017) —engaging a submerged perspective. During interviews, I ask questions that go beneath the surface of the transnational phenomena that is occurring and think about the historical and social contexts that are complicit in the process. 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 of folks in your project (Hartman 2008), but considering issues of standpoint and inclusion are critical to my analyses.

All participants identified as Indo-Caribbean women and varied in terms of age and class (See Table 1). The age of the women ranged from 22-52 years. Seventeen women are from low-income households, while thirteen women are from middle-income households. These households were determined through participants self-classifications of their class. For both Trinidad and Guyana, women's household monthly income that was less than $415.00 USD classified themselves as low-income, whereas women from households that earned a monthly income between $600.00 to 810.00 USD classified themselves as middle income.

Twenty-three women are from Guyana and seven women are from Trinidad. All women traveled to Richmond Hill and South Ozone Park, New York to receive a check up for their reproductive health care with initial concerns, such as reproductive complications and contraception. Both Richmond Hill and South Ozone Park are neighboring communities.

Table 1. Demographic Characteristics and Reproductive Pathways of Respondents

Pseudonym	SES of Household	Age	Home Country	Reasons for Journey	Pathway
Rhoda	Low-income	32	Guyana	Contraception	Returned
Veronica	Low-income	33	Trinidad	Contraception	Returned
Devi	Low-income	29	Guyana	Heavy bleeding after giving birth to second child	Remained in New York
Vanie	Middle-income	26	Guyana	Abortion	Returned
Versa	Middle-income	42	Guyana	Hysterectomy	Returned
Christine	Middle-income	27	Guyana	Contraception	Returned
Lisha	Low-income	31	Guyana	Contraception	Returned
Rhadha	Low-income	36	Guyana	Abortion	Remained in New York
Amy	Middle-income	28	Guyana	Abortion	Returned
Shivana	Low-income	39	Guyana	Hysterectomy	Returned
Mala	Low-income	32	Guyana	Heavy bleeding treatment	Remained in New York
Nadia	Low-income	31	Trinidad	Contraception	Returned
Emily	Middle-income	26	Guyana	Contraception	Returned
Sonya	Middle-income	29	Guyana	Contraception	Returned
Manisha	Middle-income	52	Guyana	Constant Reproductive Tract Infections	Returned
Sandra	Low-income	34	Guyana	Abortion	Remained in New York
Abigail	Middle-income	43	Guyana	Hysterectomy	Returned
Neesha	Low-income	28	Trinidad	Contraception	Returned
Bibi	Low-income	22	Trinidad	Abortion	Returned
Lina	Middle-income	30	Trinidad	Abortion	Returned
Nanda	Middle-income	35	Guyana	Contraception	Returned
Ann	Middle-income	48	Guyana	Heavy bleeding/fibroid	Remained in New York
Seeta	Low-income	33	Guyana	Contraception	Returned
Alicia	Middle-income	37	Guyana	Contraception	Returned
Simone	Low-income	24	Trinidad	Abortion	Returned
Jessica	Middle-income	44	Guyana	Hysterectomy	Remained in New York
Lisa	Low-income	29	Guyana	Contraception	Returned
Sheleema	Low-income	25	Trinidad	Ongoing Reproductive Tract Infections	Remained in New York
Afeza	Low-income	39	Guyana	Fibroid	Returned
Ashely	Low-income	25	Guyana	Ongoing Reproductive Tract Infections	Returned

Interviews lasted between 55 minutes to 90 minutes. Some interviews were conducted in person for those who are in New York. In-person interviews took place in a location of the participants' choosing, such as coffee shops, restaurants, and in the park. Interviews were also conducted through Skype and Whatsapp for 12 respondents, who had already returned to Guyana or Trinidad after treatment. These interviews enabled me to explore in detail the experiences, opinions, and motives (Rubin & Rubin, 2012). 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 was 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 (Corbin and Strauss 2008; Glaser 1998). 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.

CHAPTER IV

CONTEXT

A. Journeys from Trinidad and Guyana to New York

The two-tiered health care system of public and private facilities in Guyana and Trinidad can create barriers to access reproductive health care. According to the US Department of State Crime and Safety Report (2019), public medical facilities care for minor medical conditions. There is a lack of trained specialists, poor sanitation, long waiting periods, poor equipment, and not enough 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; Ramsroop 2013). 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.

In Trinidad and Tobago, unsafe abortion is the leading cause of maternal mortality (Martin et al., 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 for saving the life of the person giving birth. Similarly, in Guyana, access to safe and effective abortion is limited by the inaccessibility of providers and information about abortion even though abortion is legal (International Campaign for Women's Right to Safe Abortion, 2019). According to

Medical Termination of Pregnancy Act in Guyana, abortions during the first eight weeks is legal for any reason and after eight weeks an abortion is legal if it is done by two medical practitioners. Moreover, access to contraception depends on one's socioeconomic status. 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 was the neglect of nurses and doctors (Letter 1995; Alexander 1994; Collins 2016; Rambarran and Simpson 2016). In Guyana, there are several cases of severe bleeding women experience after childbirth and disorders that lead to maternal deaths that were ignored by nurses and doctors (US Department of State, Country Report of Human Rights, 2013).

Access to services is 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; 70% of physicians to 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, and it is higher in 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 are in rural areas. Similarly, in Trinidad, health facilities located outside of urban areas also suffer from the lack of medical staff and equipment (Bahall, 2018). The TFR in Trinidad and Tobago is 1.6 children per woman (ICPD, 2014).

New York becomes a destination for the women in this study. Journeying to neighboring countries can become more costly than journeying to New York. Some countries in the Caribbean also have restrictions on reproductive health care and women cannot obtain abortions unless their life is threatened. Guyana and Barbados are the only two countries in the Caribbean that has progressive abortion laws, while other countries like Venezuela, Brazil and Trinidad restrict against abortion procedures (Guttmacher Institute, 2018). According to a report on Trends in US Health Travel (2015), people from the Caribbean make up one of the three largest travelers to the United States for medical services (44% of arrival). People from the Caribbean are journeying to the United States for better facilities, technologies, and affordable health care.

CHAPTER V

FINDINGS

Class, citizenship, and gendered barriers shape the reproductive journeys of Indo-Caribbean women. All of the women shared common gendered barriers in their home countries, such as the stigma related to obtaining reproductive health care and ideologies of motherhood within their families. Another commonality among the women were their desires and goals as a result of their reproductive journeys. Many women wanted to go back to school, become entrepreneurs, and seek various employment, but reproductive health care was important for this. Even though they shared common experiences, their class shaped their experiences differently. Women living in low-income households were more likely to challenge gender norms in less open ways, while women from middle-income households were more likely to challenge gender norms in outward ways. I argue that their reproductive journeys became more than obtaining reproductive health care abroad. Journeys became a gendered movement as women actively challenged barriers and redefined their roles within their communities and families. This leads to a dual practice of gender as women challenge gender norms in their own ways, while conforming to roles of mothers and wives.

A. Undertaking reproductive journeys

Every woman was on their own reproductive journey. Some stayed for longer periods than their initial stay, while others went home immediately after treatment. Women from Trinidad were more likely to obtain an abortion in New York due to the restrictive legislation called the "Offences Against the Person Act" in Trinidad. Women who needed long-term and expensive treatments, such as intrauterine devices, hysterectomy, fibroid

treatments, and treatments for ongoing infections were also more likely to journey to

New York, as these procedures became a necessity to save their lives and prevent future

pregnancies. Additionally, seven women migrated to New York as a result of their

journey. Seventy percent of women who needed ongoing treatment migrated to New

York to access health benefits and other services in New York.

Women from middle-income and low-income households received similar

treatment and encountered the same reproductive barriers in both Trinidad and Guyana.

Both low-income and middle-income women experienced familial barriers, legal barriers,

improper treatment from doctors, and gendered ideologies of motherhood. Many of these

barriers stemmed from what they described as sexism in their households, communities

and doctors' offices. While other barriers such as traveling far distances for care and lack

of finance to get proper treatment were exacerbated for low-income women, middle-

income women encountered these barriers as well. These conversations reflect the

gendered expectations within institutions that may influence them to journey abroad

(Donchin 2010). While this can also be the case in New York, these women argued that

their social networks and health care providers contributed to a different experience.

Sexism in home countries are reflected in health care and community relations. The

gendered expectations they face within the household, such as with husbands, parallel

their experiences with doctors or neighbors. 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

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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 comments embedded within the health care system stem from gendered ideologies that women should fulfill, such as being a mother and caregiver. Such sexist ideologies can take away autonomy from women's decision-making within their households and doctors' offices. Further, sexist expectations can dissuade and prevent people from going to their doctors for contraceptives, regular check-ups, abortion and other services. Faced with these assumptions during their doctor's visits, women felt ashamed when they did not want to become mothers or get pregnant again. This feeling of shame discouraged many women in this study from visiting doctors for their reproductive health care. This created a sense of isolation caused by the stigma women encountered and led some of the women to go abroad to access services (Pennings 2002; 2011). Veronica discusses how this isolation is heightened by restrictive laws and legislation:

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. They only want to make money and they don't care about you. 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. But when it comes to my health, I don't play. The laws in Trinidad makes 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 make their

decisions. Restrictive legislation in home countries forces people to journey abroad to

obtain reproductive services (Pande 2014; Rudrappa 2015; Inhorn 2015; Shenfield et al.,

2010; Blyth and Farrand 2005). Laws can create stigma and support sexist ideologies that

serve as a justification to refuse reproductive health care to patients (Briggs 2017;

Gutiérrez et al., 2004; Calavita 2006). Thus, restrictive laws can create barriers and

reinforce gendered norms that prevent access to treatment.

      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. In
> Guyana, there is no public health system and when you want good
> help, you have to pay money. 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. I come out more sick. It's
> hard because I can't even work to help my husband out with the
> bills. Sometimes I sew people's clothes to help out, but it is not
> much. 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 has been experiencing complications,

including pain and heavy bleeding, after she gave birth to her second child. This issue

prompts ongoing medical treatment, which five other women I spoke to also needed.

Long-term treatments ranged from two months to a year and required constant visits to

the doctor's office.

Women's partners are usually the breadwinners in the household, which can make it difficult to gain access to money for costly treatment without alerting their partners. Without a public health system, both low-income and middle-income women struggle to pay costly bills, especially for long-term treatment. For women from low-income communities, access to employment and resources is even more limited. To pay for costly bills, women perform other tasks, such as sewing within their community or taking care of household farms and animals. 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. Similar to 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. Their travel abroad was not a voluntary choice; it was a necessity.

Yet, networks with women friends allowed these women to access health care in New York, good doctors, and even employment. Through their journey and support from women's networks, women also began to challenge these barriers as their gender ideologies changed. Social networks provided the space for women to talk about issues and encouraged women to undertake the journey through their support and resources. Vanie, from a middle-income extended family in Guyana, reflects on the role of social networks:

> I could not talk about my family issues or anything with other women in Guyana. These women gave me the space I needed to tell them about what I was going through. We spoke through Facebook and Whatsapp mostly. I told them about how my husband treated me and my experiences at the doctors' offices when I went. They let me cry, they let me go on for hours, they let

me say what I wanted. There was like, no judgment. What made
my experiences different? It's these women. I was never
encouraged to travel elsewhere to seek treatment nor was I ever
encouraged to stand up to my husband. I bet this goes on
everywhere in the world. But without support, I do not think you
can challenge these things (norms).

The space social networks created for conversations and support influenced women to

journey to New York because women did not feel alone in their journeys. Five out of

thirty women were connected with people within these networks in their home countries.

However, as women underwent their journey's in New York, they became more

connected with other women in their home countries. Mehta argues, "Through

storytelling, women have tried to affirm their subjectivity, using these stories as sounding

boards to question issues of gender inequality, sexual oppression. . . marginalization and

invisibility" (137). Not everyone can travel to Queens to obtain reproductive health

treatments due to other barriers, such as immigration. However, conversations among

friends provided a space to discuss inequalities and marginalization, challenge gender

norms, and influence gender reformation. Vanie identifies that women face these issues

"everywhere in the world," but that having a support group makes an enormous

difference. These networks also offered support for women to fulfill their desires and

goals during their reproductive journeys, such as obtaining employment and going back

to school.

B. Impacts of Reproductive Journeys

Gaining reproductive freedom meant, for many women, that they were no

longer tied to household duties and motherhood. The promise of fulfilling hopes and

dreams after reproductive journeys became a driver for many journeys and served as an

encouragement for women in both low-income and middle-income households to

challenge gender norms and redefine their lives. Aside from the barriers they encountered in their home countries, they all shared hopes to redefine their lives by accomplishing their hopes and dreams after their reproductive journeys.

Even though some women migrated to Queens, especially if they needed long-term treatment, most women returned to their home countries and reinvented ways to challenge gendered norms. Grasmuck and Pessar (1991) for example, found that women migrants compared to men migrants did not want to return to their home countries, fearful that they would lose newfound freedoms and return to traditional gender roles within their families. Yet, these women tried to find ways to carry their new ideas about gender back home and continued to perform roles of mothers and wives. Seeking employment and education became one outward way that women challenged norms. 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 friends made me see that life is beyond the boundaries of my everyday experiences…My passion is to become a hair dresser. I want to go to school for it. And my friends even tell me that I can get financial aid for this cosmetic school I was looking at…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 of the ways Versa challenged the gendered barriers she had encountered in her life, but after getting her treatment, she

realized that this journey also encouraged her to fight gendered norms beyond health care. Twenty-eight of the thirty women linked looking for economic opportunities and their reproductive journeys. Seeking economic opportunities can create a more balanced power relationship within their marriages, and women conveyed wanting this (Hirsh 2003; Hondagneu-Sotelo 1994; Levitt 2001). They wanted to gain more equality within their household and more power to make their own choices as a result of economic opportunities.

Christine, from a middle-income family in Guyana, similarly discusses this experience as she reflects on how her visit to Queens changed her life:

> When I was in school there was no such thing as sex education or going to see your gynecologist yearly. As I started talking to these women, I realized how important it is to go. For me, I thought I had to live the rest of my life like this, but these women changed my life. When I came over to Queens, I realized that I did not live my life as a woman, I was a molded clay of what my husband wanted me to be. These women taught me that I can control my body, take no disrespect from my husband and his family, and most of all I did not have to carry another child. When I go back home, I am no longer afraid to face him and I even have a job now.

Like Versa, Christine broke down the barriers around reproductive health that influenced her to journey to New York, yet this journey further opened her eyes to the economic freedoms. Both women benefited from the advice of their friends and health care providers, which led them to work towards fulfilling their own career goals. Health care providers provided resources and information on sex and reproductive health education to help women understand choices and procedures to make their lives better. Women networks and health providers became educators of health, economic opportunities, and empowerment. As a result, women imagined what they could do with their lives, even though some of these opportunities seemed distant beforehand. Similarly, Andrews

(2014; 2018) found that migrant women from San Miguel who returned home from the United States developed alternatives ways of living by participating in local politics, gaining development funding from the state, and developing new "productive projects" within their communities. They began to challenge the corruption within the community and ensured that funding was being distributed amongst the community. The women took on new roles based on their experiences in the U.S. The women in my study who returned to Guyana and Trinidad also challenged their relationships and attempted to take on new roles based on their own goals and passions.

After obtaining reproductive services in Queens, many of the women did not continue to assume that they will need to focus on childcare, allowing them to work outside the household. Women learned to do gender differently by reforming their relationships, maintaining and protecting their access to reproductive health devices and contraception, and fulfilling goals beyond the household that disrupted the practices of culturally perceived norms of masculinity and femininity (Butler 1990, 1999).

C. Challenging Gendered Barriers in Secretive Ways

As women journeyed to New York to obtain reproductive health care, social networks became a source of social capital. These networks encouraged women to visit or migrate to Richmond Hill and provided resources and information on reproductive health services. Thus, social networks 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. Social

networks often helped women maintain secrecy in their reproductive journeys. Twenty-five of thirty women kept their reproductive journeys a secret from the very start. They did not tell any friends or families in their home countries about what they were doing and did not share their choices with friends and relatives in New York who would not support their choices.

However, five of the thirty women told their friends who were already part of these networks. Women who were already part of 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 about these journeys. These networks also helped look after children when needed and offered to help families during women's absence. Even though many women gained their visas through family status and have family members in Queens, they did not discuss their reproductive health issues with them; most of their key networks were composed of friends and friends of friends. Social networks also played an important role in providing a living space once women arrived in New York, providing financial and job assistance as well as resources and information about doctors and services to help keep journeys a secret. Some women told their families about their journeys after their treatment, while others did not tell their families at all.

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 will strip them of their womanhood amongst friends and family, therefor they were more likely to keep their

procedures a secret in comparison to women who had long-term complications, such as heavy bleeding. Lisha believed that people's gender ideologies of womanhood would prevent her from undertaking her journey to New York. Ideologies of becoming good mothers and wives permeated through 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." Amy also reflects on how she challenged ideologies of motherhood by not telling her family about her journey:

> I didn't want to tell my family in New York because I was
> afraid word would get out to others in Guyana and plus my
> mother will freak out. She always asks me when I'm going to
> have another child, and I think it will break her heart if I tell her
> that I don't want any more kids.

Stigma became another driving force that prevented women from telling their family and community members. The stigma around abortion and reproductive health services within communities reinforced the norm that women should be defined through motherhood. Such stigma can lead to the fear of going to doctors' offices and to further disempowerment to obtain healthcare. Women did not feel the same way about the health care providers in New York. Conversations with health care providers were different because it focused on empowerment and education, rather than reproducing shame and stigma. During journeys, women also face inner conflicts because they feel guilty that they are lying to family members about the purpose of their journey. However, women like Shivana, realize that they should not feel guilty because their procedure and treatment does not define who they are: "I know they will feel sad for me if I tell them I'm getting a hysterectomy. They will think that I am no longer a woman or whatever,

even though deep down it changes nothing for me." Norms of womanhood are also attached to the type of procedures and treatments women receive. A hysterectomy is seen as the removal of womanhood, because she can no longer give birth. Thus, women who had procedures that permanently prevented them from giving birth were less likely to tell community members and families. Like others, Shivana did not let her surgery define her and her roles. She knew that she would continue to be herself after treatment.

Aside from the five women who connected with people within their networks in home countries, there was little reliance on families and community members. Thus, conversations develop within these friendship groups. Respondents brainstorm possible ways to undergo this secretive journey to Richmond Hill and the support they need 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 networks wrote to her family about her mother's health in New York. Hondageneu-Sotelo (1992), similarly found that women networks of Mexican migrants also facilitated their journeys by writing fake letters to husbands as a way to convince them to let their wives travel to the United States. Women networks challenged gendered norms and provided a way out of home countries for women, such as providing women with a place to stay and financial

support. This became especially important for women that live in 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 important role for women networks.

Once participants arrive in Richmond Hill, the second phase of their journey begins. This is where they directly challenge gendered norms, such as ideologies 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 been able to access reproductive health without her friends. Social networks help women challenge gender norms by providing emotional support and ensuring that women receive the proper reproductive care that they need. Challenging norms around motherhood was also easier for women in Queens because obtaining health insurance for free services was easy. Health care providers canvas neighborhoods and provide resources for people in the community. Doctors' were accessible and informative to patients as well than in their home countries, making it easier to challenge norms.

In addition, women felt comfortable challenging gender norms in Queens because they had a community of women that stood up for them. The networks of women in New York were exposed to U.S. values and norms regarding marital relationships and reproductive choice. As a result, these networks encouraged more equality in economic decision-making, sharing household roles, and becoming property owners (Roopnarine 1997; Ramadar 2007). Roopnarine (1997) notes that Indo-Caribbean women in the US are encouraged to work outside of their home to help meet the economic needs of the family, such as large mortgages.

While challenging gendered norms around 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 that lived in low-income households were more likely than those from middle-income households to challenge gender norms in secretive ways when they returned home. Some women hid their birth control medication and intrauterine device, 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.

Nadia is one of eleven low-income women that decided to keep her journey a secret after she returned home. Hiding contraceptives became one of the ways women maintain their secrets and challenge gender norms. Even though they do not share their journey publicly, they still ensure that they gain access to their birth control and other medical devices. This shows the duality of gender as women secretively challenge gender norms

while conforming to their roles within their family. It becomes one of the only ways that low-income women ensure the continuance of their treatment in home countries. Nadia, like other low-income women, 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 norms around reproductive health care, some middle-income women like Emily also kept their choices a secret. Three out of the thirteen middle-income women challenged gendered norms secretively. Middle-income women who lived with extended members of their families in home countries like Emily also tended to become more secretive because they did not want their extended families to know about their treatment.

Other women decided to keep their medical devices, such as intrauterine devices, a secret. Rhonda for example refused to tell her family about her intrauterine device: "Getting an IUD is changing my life. . .There is no way I'm going to mention it when I go back home. . .No one will never know anyway. After all it's not like someone can take it out of me." Rhonda challenged her role within her family by refusing future pregnancies. Devices implanted in women's bodies became a common secret, since no one could find out unless they told someone. These devices became powerful tools that empowered women to challenge gender roles within families and communities. This solution was

especially helpful to low-income women who did not want the continuous burden of hiding medication. Intrauterine devices also give women a sense of safety that no one can forcefully extract the device.

Even though women challenge gendered norms, they are still maintaining gendered structures (West and Zimmerman 2009) by keeping these challenges a secret. For many of the women who are challenging gendered norms secretively, they do so by taking control of their lives and standing up against ideologies around motherhood. However, women in low-income households are less likely to speak up about their issues because of limited finances and their dependence on other household members. Therefore, in some low-income communities and households, the very structures that force women to journey abroad for reproductive health remain intact. Accountability structures such as familial roles and societal expectations remain as they continue to perform these roles and 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 in New York clashed as women travelled back home after obtaining reproductive healthcare. Upon return, they noted that their gender is still under negotiation, with womanhood still identified primarily through motherhood. Women from low-income households practiced somewhat hidden ways of challenging gendered norms when they returned to home countries because they did not have access to resources such as the flexibility to leave their families again to journey back to New York for more treatment or medication. Withholding information about their treatment and medication became a way to ensure their ongoing access to contraception and relationships remained intact. Maintaining these relationships became important

while they sought their own independence through employment. The decision for reproductive journeys reinforces expectations of gender relations at a societal, familial, and individual level (Kanaiaupuni, 2000). Reproductive journeys, therefore, reflect gendered decisions that challenge the reproduction of household norms and ideologies (Grasmuck and Pessar 1991; Kanaiaupuni 1998), which in turn change as some women negotiate their social world in home countries and abroad.

D. Challenging Gendered Barriers in Outward Ways

While networks of sympathetic women provided resources and information to obtain reproductive health services in Queens, they also encouraged women to challenge gendered norms, which led to changes in women's gendered ideologies and practices. Many conversations among friendship groups focused challenging gendered barriers in their family relations, norms around motherhood, and gaining economic freedom by fulfilling their desires. Mehta (2004) discusses how Indo-Caribbean women can challenge gendered expectations and fight against patriarchal systems by traveling to new locations.

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 reforming 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 have 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 is also "suffered."

However, they gained independence as a result 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. Abigail also spoke about the importance of having this conversation

with her family:

Once you get rid of your reproductive organ, 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 talk about their own reproductive health issues. Empowering

other women in their families and communities became a driving force to speak up

about procedures and treatments during reproductive journeys. Abigail refers to the

ongoing stigma that some Indo-Caribbean women experience, such as the assumption

that womanhood is lost, if you undergo procedures that permanently prevents you from

giving birth. Four other women underwent the same procedure during their journey. The

narrative within women's communities that womanhood is associated with biological

reproduction was seen throughout interviews. The biological understanding of womanhood 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.

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 gender norms outwardly, six of the seventeen 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. Friends provided more support for these women, such as sending money for them and connecting them with other families and women in their home countries for support. When Neesha told her partner about her reproductive journey, her friend was listening to the conversation through Whatsapp to ensure her safety and give her the support she needed for this conversation. 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 norms in outward ways by transforming their relationships. 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 her gender

roles within their relationship by adapting some values learned from their friendship

networks in New York (Roopnarine 1997; Ramadar 2007), reinventing their own

values. Thus, as they interacted with women networks, their decisions and actions were

influenced through the ways women in their networks were also challenging gender

(Smith-Lovin and McPherson 1993). Women wanted to claim the space to voice their

feelings and wanted to make their own choices like their women networks.

Other women like Nadia also spoke about how her relationship is similar to

Lina's relationship: "We now have a more open dialogue between us and we are always

talking about how we feel, and even in decisions, we talk about what each other want. I

think for him, this was a wakeup call, and it was mine as well." Changing relationships

created an open dialogue to ensure equality within relationships, with more conversations

about feelings and more choice in decision making. Reproductive journeys became a

"wake up call" for the women in this study as they realized what they needed in their

relationships. Thus, their understanding of gender roles changed through their movement.

Importantly, creating dialogue and equality within relationships reduces the stigma within

communities and families for reproductive health care, leading to greater change.

Women during these journeys felt empowered through their journeys to further

challenge gender norms through their social networks and health care providers (Nawyn et

al., 2009). Women challenged gendered norms and fought for more autonomy after

their journeys around motherhood and family relations. Similarly, Hondageneu-Sotelo

(1992, 1994) found that traveling to a new location enabled women to challenge gendered

limitations within their family.

The dialectical relationship between gender influencing their journeys, and

journeys in turn shaping gender 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;

Kondo 1990; Stephen 1991) new meanings of womanhood. Among friends, the purpose

of womanhood became not just motherhood, but the ability to make your own bodily

choices, support yourself economically—leave the household and stand up to the

demands of husbands. The gender ideologies from home countries shifted based on

women's experiences.

CHAPTER VI

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. Women in Guyana and Trinidad journey to New York as a specific location to obtain reproductive healthcare because support networks facilitated and provided assistance for journeys. These social networks did not only provide information, resources, and finance but actively challenged gendered norms and limitations. Friends further played a role in changing women's gender ideologies. 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. Accessing reproductive health services abroad became a direct way of challenging the ideology of motherhood within their families and communities in home countries through the encouragement of social networks of women. Thus, gender becomes a constitutive element of migration or movement (Hondagneu-Sotelo 2003).

While social networks became important during decision making during journey's, women's class became another constitutive element in movement and choices in women's journeys. 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 to talk about their reproductive journey because they are more dependent on their partners. Some middle-income women developed financial independence, and could gain access to resources more easily, 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. Despite challenging gender norms through their journey's, they are still caught between these systems as they try to navigate it secretly or outwardly. Undertaking reproductive journey 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 roles within their family. 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 women networks increase. They gain more connection with women back home to disrupt their feelings of isolation prior to coming to New York and they gain more support to continue this fight against gendered systems.

There is a dialectical relationship between gender and their journeys—gender ideologies influence women to travel, which changes their consciousness of gender. Thus, this study shows the relationship between gender and transnational processes of reproductive journeys. Although much literature focuses on the relation between gender and migration, scholars interested in reproductive health care and reproductive tourism

must further explore how gender is intertwined within these movements. As the women in my study move to new locations their gender is moving along with them—gender is always in motion as their ideologies change.

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