Culture of Sensitivity: Black Canadian Women's Reproductive Health in Western Canada

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In the early evening on a hot summer day, I begin preparing for my interview with a participant. I switch into casual yet comfortable clothing and I wrapped my natural hair into a low bun with some curly frail strands framing my face. I light a small candle in my room, turn on the fairy lights that are strung up behind me while I line up my face directly with the camera view. My room is lightly lit but just enough to see my face. With my small notebook in hand, I anxiously wait for my participant to enter the online room.

Once I get a chance to check my audio and camera set up, I click accept. I immediately notice that she is also in comfortable clothing. Her natural hair is evenly parted in four braids, equally placed on each side of her head. She fidgets in her chair, and we engage in small talk for some time. I set my pen down onto my notepad and give her my undivided attention. Her shoulders relax, and she sits up as she explains her background. She almost expects me to start with the hard questions, but I reassure her that she can explain her story in her own words however she would like to. An hour passes, and we are laughing and talking in great detail about her labour and delivery story. After a while, I sense that her body language has changed. She tenses her body and looks to the ground. How she was treated still affects and disheartens her. She is stoic and apprehensive about retelling her painful ordeal. Her chest heaves as she places herself back in the operation room and fiddles with her softly coiled hair. I make a note to her that she doesn't have to go into great detail if she does not feel comfortable. I mirror her movements over Zoom while maintaining eye contact and reassuring her as she continues.

This interview, like the many others I conducted this past summer, helped me ethically interact with participants in an online environment. Although COVID-19 prevented researchers from interacting with participants in person, Zoom facilitated a safe space that allowed participants to maintain a level of comfort while remaining in their homes. Some participants had children and required Zoom's flexibility to disclose their experiences and tend to their children. The women I spoke to, although unique in their individual experiences, expressed similar fears and concerns about the stigma they experience as Black women with their reproductive health in Canada. I gained insights and perspectives from Black women living in British Columbia, Ontario, and Winnipeg. The women I interacted with recall having to manoeuvre around the healthcare system to avoid experiencing "obstetric racism" (Davis, 2019).

This past summer, I conducted my Undergraduate Research Award Project exploring *Black Canadian women's experiences with reproductive health.* Dr. Deana Simonetto supervised my project, which specifically examined Black Canadian women's experiences with pregnancy, labour, and delivery. I analyzed whether "obstetric racism" played a critical role in the access, care, and treatment methods Black women experienced (Davis, 2019). "Obstetric racism" emerges in the interactions healthcare providers have with Black and marginalized women with regards to their reproductive health and obstetric care. I situate my research in a larger climate of discourse about the mistreatment, violence, and oppression Black women experience within medical settings, which stems from legacies of colonial violence. As a result, Black women often have to advocate and make extreme choices to protect themselves and their

loved ones from potential violence they experience from medical staff. To establish and maintain a rapport with participants, I considered three key ideas: maintaining trust, creating a safe space, and ensuring ethics of care.

Trust

My research methods were a massive component of my research and solidified my relationship with my participants. By establishing a rapport with each of the fifteen participants I interviewed, I created a space and culture of comfort. This rapport allowed for snowball sampling and increased my access to a larger participant pool. I felt it was vital to make other Black women feel comfortable.This comfort contributed to a culture of visibility and care to minimize overt and covert racism within medical spaces. I incorporated questions like: "What were your experiences with pregnancy, labour, and delivery explained however you would like? Explain in your own words." Questions like these made my participants feel empowered when speaking about their experiences, which shifted the narrative from shame and trauma into empowerment and strength. Participants are also more likely to trust that I have their best interests in mind, for example, disclaiming that all interviews are confidential while refraining from excessively probing into their personal lives. Each interview was unique and required some improvising depending on how the participant reacted to certain questions. So, the trust had to be built earlier in each interview to allow for the depth of their explanations about how participants' experiences with racism and discrimination affected them.

Safe Spaces

Space, place, and mutual respect were crucial parts of the methods I employed in my research. Trauma-informed intersectional feminist research approaches account for equal power dynamics in the field and mitigate the role of the researcher and participant to amplify participants' stories, insights, and perspectives (Crenshaw, 1991; Kokokyi, 2021). In my case, I used Zoom to my advantage. I interacted with participants in a one–on–one interview to create an intimate, supportive environment where participants felt safe and did not need to minimize or sift out any information to make room for any competing or dominating conversations. The questions I asked also acted as a guide that allowed participants to open up and disclose things that a rigid survey may not have allowed. Overall, the URA project identifies how critical intersectionality and accounting for multiple social locations inform research practices and participants' insights (Crenshaw, 1991). Although participants expressed not feeling heard by medical professionals and staff, I practiced ethics of care and support to the Black women that overcame and continue to overcome so much. For example, actively listening, and checking in with participants after our interviews.

Ethics of Care

Ethics of care in my research project meant actively listening and presenting a transparent self, allowing participants to open up about their most intimate and private lives. As a Black woman, I felt overwhelmed by the harsh realities of how medical institutions produce and reproduce racism. I found that the racism the participants experienced is not an abstract idea; rather, it

comes into being through the fears and anxieties they have when they put their trust in the Canadian medical system. Similarly, without ethics of care and reciprocity between each participant, I would not have been able to identify how "obstetric racism" manifests in the interactions Black women have with healthcare providers (Davis, 2019).

Reflection

After interviews, I reflected on the lives, perspectives, and direct violence Black women experience within medical spaces. What is supposed to be a joyous experience in their lives is instead fraught with hardship, complications, and dismissal from health care providers. In the field, I believe ethics of care is critical to building relationships with participants and ensuring trust, safety, and rapport. Since conducting this project, I believe now more than ever Black women must work to support, love, advocate, and cherish their voices at all times.

Acknowledgment

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References

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