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Episode 4: How to affirm and create conditions for health in order to honor bodily autonomy for all people

**Dr. Raegan McDonald-Mosley:**

Hello, and welcome to a new podcast series focused on advancing equity and family planning. This podcast is a partnership between Power to Decide and the Reproductive Health National Training Center with funding from the Office of Population Affairs and the Office on Women's Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA or HHS.

Throughout this series, we will explore tactics, programs, frameworks, and ideals to increase reproductive and sexual health equity in health centers across the country. Through this podcast, we hope to give Title X clinics, providers and staffers practical, easy to access, action-oriented training resources in order to advance health equity at family planning service sites.

My name is Dr. Raegan McDonald-Mosley. I am the CEO of Power to Decide, the national campaign to prevent unplanned pregnancy. I have over 20 years experience in this field, including as a practicing OB-GYN with the dedication and commitment to reproductive health and justice. Today, we have with us, Dr. Diana Carvajal. Dr. Carvajal is a family medicine doctor in Baltimore, Maryland, an assistant professor and director of the reproductive health education program, the RHEDI program, at the University of Maryland School of Medicine, Department of Family and Community Medicine. Dr. Carvajal focuses on understanding how and why people make decisions about their reproductive health, particularly contraception. Her research dives into how healthcare providers and the healthcare system can work to facilitate or impede contraceptive decision-making.

In this episode, we're going to discuss how to affirm and create conditions for health in order to honor bodily autonomy for all people. So let's dive in. So we're going to talk about bodily autonomy in this episode, and I want to start by centering the lives and experiences of transgender people in our communities. We know that transgender and gender non-binary people face discrimination and violence at higher rates, and that they also face higher rates of some mental health and physical health conditions. Sadly, the healthcare community is not exempt from making the lives of trans people more difficult. In fact, a 2018 study by the Center of American

Progress focused on a survey of LGBTQ people in our communities. On average, transgender people face more difficulties when attempting to receive care. This survey found that 29% of people encountered a provider who refused to see them, 23% had providers who would not recognize their family, 21% heard harsher abuse of language from a provider that was treating them, and 29% experience unwanted physical contact from a provider.

Gender or sexually diverse individuals can contract STIs, have an unplanned pregnancy or experience conditions of reproductive organs, such as endometriosis, ovarian or prostate cancer. All of these factors make it imperative that queer people and especially young people who identify as LGBTQ receive inclusive and comprehensive sexual and reproductive health care. Studies have found that when people have gender dysphoria or distress, when they receive gender-affirming medical care at a later stage, they have more mental health problems than those who received care earlier. It's also proven that individuals who received gender affirming care and care that honors their bodily autonomy have better mental health outcomes than those who do not. So Dr. Carvajal, bodily autonomy is a fundamental principle in sexual and reproductive health care. What does this mean in practice for someone to have bodily autonomy?

**Dr. Diana Carvajal:**

Yeah. So thank you for that question. I often hear choice, right? People have choice and that is what autonomy is, but I really think that bodily autonomy and sexual and reproductive health, it's more than just choice, right? Choice is important, whether it's one's fertility and that includes decisions about contraception, prenatal care, childbirth, postpartum care, and having the choice for that. For us in health care, it's really about supporting folks through their own decisions and providing options for folks and also answering all of their questions truthfully, but it's also about ensuring equitable environments in which to access care, I think. And so, as you mentioned, our SRH reality and really our national reality is that we live in a world of social inequities and injustices, and specifically the inequity of opportunities that folks have to control their own reproductive lives is really limited by our social and political context.

And so, I think we need to move past just respecting people's individual decision-making in thinking about bodily autonomy, but also to consider that we really need to fight and advocate for the social supports necessary for people to make those decisions to be optimally realized, and that's treating people fairly and equally, of course, but also recognizing people and who they are and listening to them, and recognizing that resources in terms of

access to healthcare for non-binary and trans folks and the LGBTQI community is really important, access to public education, access to equal income for equal work. So all of these really important social and economic and political contexts are important for people to have bodily autonomy, and us operating in that as healthcare providers and fighting for that, I think, is really important.

I mean, I think we talk about autonomy and health care for people's bodies when many folks are not living in an equitable world with equal access to resources, including healthcare that allow for and support bodily autonomy. I wouldn't say we have to go out and provide all resources for folks or even that we can, but certainly that we need to recognize that these are issues that interfere with bodily autonomy at every turn and really work to mitigate those oppressive factors, including us as oppressors in healthcare. And so, in practice, I personally think about focusing my efforts on, we hear this all the time, client or person-centered frameworks of taking care of people. A lot is written about this over the years.

Certainly, in SRH, we're talking about this a lot, but are we really doing it, right? Are we really using an approach to healthcare that, of course, includes access and quality care, but also trust building, listening and hearing what folks are telling us, letting them tell us who they are and what they need from us, right? It's bi-directional communication, but it's really led by the client or the patient. It's about refraining from our own judgment and our own imposition, our own values on patients and their decisions to really focus on what clients want. I think it's also rejecting our own paternalism. In healthcare, we often think we know what's better for patients and what's good or appropriate and needed for their own bodies and that's not true. We really need to let go of that and continuously support people, I think, through what they're telling us they need and want.

And so, I also think, the last thing I'll say about this and it's a long answer is that if we're going to apply this sort of framework, where we're really focusing on all folks and listening to what they want and need and providing equitable context for folks to access care, then I think we also really need to understand the contemporary and historic social and political systems that got us to where we are, right? I mean, I think it's really crucial to recognize and understand America's long-standing history of violence, abuse, and coercion against some bodies in SRH lane, namely non-white bodies and LGBTQ and non-binary folks bodies. It's a long-standing history and context of oppression and racism. If we're going to promote bodily autonomy, we really actually need to know how we got here to know how we're going to move forward. So we have to do the work to understand our history and understand that that goes a long way, frankly, and in avoiding paternalism coercion and to really uplift folks in what they need.

**Dr. Raegan McDonald-Mosley:**

Wow. That was really powerful. So, I love this sort of idea, this framework that you've provided, that choice is an ingredient, but it's not everything, right? Choice does not equal bodily autonomy. I mean, it's one important ingredient. We also have to make sure that there are social and structural supports to ensure bodily autonomy, and also really centering each person as an individual, not making assumptions about who they are and what they need, but allowing them to dictate and communicate that to us. That's a really helpful framework. Thinking more about the healthcare system specifically, what conditions would you say must exist for someone to experience bodily autonomy? I really want to focus for a minute on patients and members of our community who are LGBTQ and the barriers that they face within the healthcare system. How can we assure bodily autonomy for queer members of our community and trans members of our community?

**Dr. Diana Carvajal:**

Yeah. I mean, there are healthcare system factors that need to be in place to really support folks in their decisions. But then there are also those factors of when you, as a clinician or in the exam room or you're working with your team of folks, what is it that has to be in place? I really liked this idea of patient-led care, and that's not something I came up with. I heard it for the first time listening to SisterReach, Charise Scott, talking, but it's allowing patients to tell you what they want and what they need, and also who they are, right? So not making judgements about a person's gender or their wishes, or their wants, or their desires, or whether or not they should be pregnant or not be pregnant and how they plan to make those decisions.

And so, I think we really need to not only ask folks what they need and what they want and who they are, but we have to listen and we have to hear them and honor and support their preferences at the forefront. I think that's part of the problem. We're clearly not doing that. So some of the data that you gave us at the start of the podcast about people not listening, about folks getting harsh directive comments from providers or providers refusing to take care of them, that's problematic. A lot of that really has to do with not listening and not valuing folks, and we do that across health care. So SRH isn't particularly unique in that, but it is deeply embedded within our system that we know best.

And so, this paternalistic way of thinking that leads to the judgment of folks and to us not being able to listen to people. So, listening and hearing folks really allows us to not stereotype, not assume that we know about them and to let them lead their own care. We think we know more than people about their bodies, but we don't, right? And we never really have. And so, I think it's not as difficult as folks think if we are really focused on hearing people and honoring their wishes and honoring who they tell us they are.

**Dr. Raegan McDonald-Mosley:**

I love that. Your advice is to ask, listen, hear, and honor people's preferences. It sounds so simple and yet it's so challenging. I mean, more and more places, Title X health centers and clinics who have really focused over the years on providing information about people's lives and providing contraception, more and more of those places now are providing care to the LGBT community, including gender-affirming hormone therapy, right? It's so interesting to see folks who have stood up and said like, "People should have bodily autonomy to do whatever they want with their lives and decide when to get pregnant or not to get pregnant or which contraceptive device to use" sometimes prickle at the idea of people deciding what their body should look like and how their body should match how they see themselves.

And so, I think it's really interesting to just take a moment and do that values work inside to say like, "Hey, if we believe that people should be able to make these decisions in this context, why do we not believe, or why are we struggling to believe that they should be able to make those decisions around bodily autonomy in that context?" I think that we are exactly the right people to be doing this work. We counsel people all the time about the risks of contraception and hormones, right? So doing it in a different context. Definitely, we have to do the work to understand medically the risks and to understand culturally how to provide that care, but I think we are very experienced. It's doing this person-centered work, asking, listening, hearing, honoring people's preferences, and then the medical work of how to describe the risks and benefits of hormone therapy.

So, you spoke about reproductive coercion and oppression, especially among women of color and the fact that many women of color have really not had full bodily autonomy historically in our country. I want to just dive into it for a minute how this impacts the lives of black women and other women of color and how you address this with your residents, how do you incorporate this into their training so that they have an awareness of these issues so that we don't perpetuate these issues around reproductive coercion with the next generation of providers.

**Dr. Diana Carvajal:**

Yeah. And that's a great question. I started with figuring things out for myself and trying to do the work myself to understand how we got where we are. I never learned this in medical school or residency. So, I spent a lot of time deep diving into what the history actually is, which I think we definitely don't learn. I start with that with my residents. I mean, we have developed modules and we talk very clearly about understanding the history, even pre-inception of this nation, but for centuries and centuries, the history not only of coercion and abuse, but frankly, of violence that has been geared toward black women, again, since before this nation started

and indigenous women and immigrant women and other folks of color and LGBTQI and non-binary folks, where the violence and oppression that has been carried out really a reflection of the devaluing of their bodies and their reproduction, and their children, frankly.

And so, understanding that and how that has played out in contemporary times, where we know still that women of color, specifically black and Latino folks are being coerced to use methods that they don't want to use, specifically LARC methods, right? They're being targeted and focused on using these methods. We know that they're also the ones who are more likely to experience resistance to remove those LARCs. They're the ones most likely to be targeted in terms of grants that will place the LARCs, but then not remove the LARCs. And so, really understanding that our history has gotten us here, this deep seated devaluation of the bodies of non-white folks really, and how that has played out in contemporary times still this sort of perpetuating through our medical system and the way that we teach that some people shouldn't have children, right?

We think that somehow we know best, or you really shouldn't have a child because X, Y, and Z. And that goes back to bodily autonomy, not really hearing and listening to what people want and supporting them through that the best way that we can. So, we start with some history and then we bring it to contemporary times. As I mentioned, what we know is still being denied to folks of color. I think one of the best examples of what is happening in SRH related to our current system of inequity and injustice is what we're seeing in black maternal mortality. And so, it's not just contraception, but it's also in birth justice, in prenatal care, in postpartum care, how we know that black maternal mortality is still high. We know that some intrinsic biologic cause for the high rates of maternal mortality and morbidity compared to white women simply does not explain the disparity, right?

It's not some intrinsic biological factor. What is it? How many times do we have to hear reports of black women voicing concerns about their pregnancies, their bodies, and not being heard, right? And it ends up in bad outcomes. So we have a long-standing history, but we're in the thick of it. We're in the middle of it right now, and teaching what's happening, I think, is really important and also teaching that race as a biologic construct simply isn't a thing, right? It's the cause and the root of... The inequity is not race, but racism, right? And so, I think incorporating that into all the teaching that we do from this larger human rights perspective, where SRH fits squarely into that is how we start to teach folks how to provide this care in an equitable and just way.

**Dr. Raegan McDonald-Mosley:**

Yeah, that's super powerful. I was confronted with this issue of reproductive coercion when I first moved to Baltimore and started practicing over a

decade ago and this was in the heyday of LARC, where we were all super excited to have a one-ride implant and there were more IUDs available and I'm a newly trained, newly minted family planning specialist and excited to counsel patients about these options. I faced a lot of pushback from people in the Baltimore community. I had to do my own research and my own digging and talking to people in the community and learned about a project that happened here in Baltimore decades ago to increase the Norplant, which was the contraceptive implant available at the time for a young woman, mostly black women with low incomes in Baltimore City and even through the school systems here.

Dr. Dorothy Roberts wrote very eloquently about this project in her book, Killing the Black Body. But the legacy of this project, which had hundreds of women who had implants when they had bleeding issues or wanted it out, they had a really hard time finding providers who would do that. I've taken implants out decades later recently for women who were effectively sterilized for decades, having these implants in their arms. And so, this was obviously a very real tangible introduction for myself to reproductive coercion that has really allowed me to do some further reading and digging on this issue. I think it's critically important that all people who provide contraception, sterilization, abortion, family planning services understand that this is not just theoretical and this is not just historical. It is those things and it is also today, and that we have to really work hard every day to counteract this history and to ensure that our patients feel like they have the full decision-making power over their bodies.

**Dr. Diana Carvajal:**

Absolutely. Absolutely. I mean, I often hear from my residents things like, "This person came in and they really don't want to use contraception, even though they don't want to be pregnant because they're afraid that it's going to cause infertility." That's a myth. And so, I tried to dispel that myth or that misconception. And so, we actually have to stop and think about, "So, what's at the root of that, right? Why would someone think that a birth control pill or any birth control method would lead to infertility, right? Is there some kind of historical precedence for this? Were people actually sterilized against will? Were implants placed and then never removed, right? Were IUDs placed postpartum without folks really understanding what was happening, especially when we're talking about immigrants and folks who don't speak the language and who are being consented as, say, varieties during labor, which has happened in Baltimore City, not that long ago, right?"

We're talking about five, six, seven, maybe 10 years ago. So, we really get to the root of this. You can call it a myth, you could call it a misconception, or you can call it rooted in historical fact in terms of what actually happens. I mean, these conversations are ongoing, particularly with our residents.

They're probably sick of me saying it, but every chance I get, we start talking about what might be at the root cause of things. When folks come in and say, "I don't want to learn, because I don't want anything in my body that I can't control," that makes plenty of sense to me understanding the history of what's been happening historically, but also in not that far away contemporary times.

**Dr. Raegan McDonald-Mosley:**

Yeah. So we have to do the work of training the next generation of doctors, and we also have to do the work of repairing the relationships with the communities that we serve. And so, I'm grateful to you, Dr. Carvajal, for the work that you're doing right here in Baltimore, where I also live and work. The work that you're doing is critically important with training the next generation of family medicine doctors and ensuring that they have an awareness about these issues in addition to all of the technical medical expertise to provide reproductive health care. What about action items for our listeners? What can we advise them or encourage them to do in their own environments to ensure that they're centering bodily autonomy, and then repairing these relationships with the communities that they serve?

**Dr. Diana Carvajal:**

Yeah. I often tell folks... I think after, in my own teaching and my own practice, knowing the history of what's happened, it could feel so heavy, right? This weight of how do we do this and not mess it up and do it right? I often tell my residents, "Think about yourself and the kind of thing that you would like to have when you go in to talk about something that's deeply personal, which is your reproduction and your childbearing and having a family or not having a family, think about the things that you would want." As healthcare providers, it's communication with patients. It's having normal regular conversations with them, and that often means that we don't do all the talking, which I think in healthcare we're really, really used to.

I mean, in family medicine, we take care of so many different issues and so many problems within the context of people's health and wellbeing that we often find ourselves, we have to educate people, we have to talk, we have to tell them this and that. In this case, we really need to listen first, ask folks about themselves and what they want and their preferences, and actually hear what they have to say, right? Sometimes repeating back to people, "Okay. This is what I heard you say, and this is what we're going to focus on. Is that right?" In the case of LGBTQ folks, non-binary folks, everybody, asking them how they want us to address them, right? "How would you like me to address you? How should I refer to you today?" Right? So that you know who people are and what they want, and then honoring, supporting their preferences.

I'm doing a lot of work now with providers, particularly in the Latino, Latinx community about contraceptive counseling and I often hear folks say to me,

providers, "Yes, I do patient-centered care. I focus on people's preferences. Anytime I counsel though, I always start with the most effective methods first." And so, there's a little bit of disconnect there in what we hear in the healthcare system, what we've been trained to do, right? We want to get them the most effective method because it's the best and it will do the job at preventing pregnancy when that may not be what a person wants. Preventing pregnancy at all costs may not be the value that a person brings to the table in the case of contraception, but that extends to all aspects of SRH, listening, providing information in response to what folks tell you, being truthful about that information, right?

When I think of contraception, not downplaying, let's say for instance, what the side effects might be or not giving them the full side effects profile, which I hear as a complaint all the time. Not stereotyping folks and assuming what's right like, "Here comes this immigrant Latina who doesn't speak English. She's definitely poor. She just had a baby a year ago, so she doesn't need to have another one. Her and her family just can't afford that." That's a stereotype, that's a value judgment, and I hear that all the time, not doing that kind of thing. Letting folks make their own decisions and leaving those decisions, I think, is really important. These are concrete things that you can do and that you have to think to yourself, "I'm not going to speak right now. I'm going to listen, and I'm going to provide the support, not just today, but continuously, when they come back, if this method doesn't work, if they want a different method, if they want to get pregnant, if they don't want to be pregnant, if they have questions about their health in general, for them, their families, their communities."

I think providing that continuous support for folks, not judging them or feeling like we know better than them was better for them and their families. So, I think that's really important. It's also about the language that you use with people, so think clearly about language, particularly with non-binary and LGBTQ folks. Again, ask them how they want to be addressed and what their pronouns are so that folks already know in the beginning, "Okay. This person is trying to hear me and trying to listen to who I am." I think that that goes a really long way in building trust. We probably will not do it right every time right away, but laying the groundwork for trust building goes a long way in improving people's health and we have a lot of evidence to support that.

**Dr. Raegan McDonald-Mosley:**

I love it. Dr. Carvajal, you've given me so many amazing nuggets and for our listeners to think about. I'm just going to reiterate a couple of the key ones that I'm taking away today. I'm sure that listeners have received many more, but I really love just centering on, again, asking and listening and hearing and honoring the preferences of our patients, allowing people to tell us who they are, how they want to be referred to, how they want to their

body parts to be talked about, what kind of sex they're having so that we can adequately take care of them and really using a person-led care, centering person-led care per the SisterReach model and really using informed decision-making when talking to people, but really it all starts with listening.

**Dr. Diana Carvajal:**

One more thing I'll add is that it extends also into our exams and how we're physically touching people or not touching people and also listening to them in terms of what is the most comfortable for them and what is actually necessary in terms of the exams that we're doing or not doing. I think face-to-face interactions is important and looking people in the face is important and creating that environment, but we also do a lot of not evidence-based touching that isn't necessarily comfortable for folks and really thinking about that and asking people before we touch them, right? I always do exams, "I'm ready to begin now, but I'm going to wait until you tell me you're ready and moving forward." Right? We do a lot of that in our teaching as well in terms of patient-centered exams. So we can do patient-centered visits that include patient-centered exams that really let the patient, once again, lead the exam to the degree that they're comfortable, which I think is also really important.

**Dr. Raegan McDonald-Mosley:**

That's super helpful. All of this has been a really helpful and informative discussion. Thank you so much, Dr. Carvajal, for this discussion and that we hope our listeners walk away with not only a better understanding of how to advance equity and family planning, but also some actionable steps that you can enact today. To learn more about reproductive health training for family medicine residents, follow the RHEDI program at @RHEDIFamMed. That's R-H-E-D-I-F-A-M-M-E-D on Twitter. You can follow me at @DrRaegan on Twitter, and please stay connected with Power to Decide following us at, @PowertoDecide on all platforms. This podcast was produced as a partnership between Power to Decide and the Reproductive Health National Training Center. You can learn more at RHNTC.org. And thank you for tuning into our Advanced Health Equity and Family Planning Podcast.