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Michele Chen November 28th, 2021

Acquisition of Reproductive Health Knowledge: How girls in Georgia learn about their reproductive bodies

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An abstract of
a thesis submitted to the Faculty of Emory College of Arts and Sciences
of Emory University in partial fulfillment
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Bachelor of Science with Honors

Anthropology

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Abstract

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Over half of the Georgia's population experiences reproductive processes that occur to cis-women and nearly every individual in Georgia knows of someone who is experiencing it, however there are few formal discussions about this topic. Data has shown the damaging effects of American societal stigma of women's reproductive health on a woman's self-confidence as well as the influence of societal expectations of women on individual behavior, however not much data is collected investigating how girls and women navigate society to care for her reproductive bodies. This study uses a mixed method study to investigate, how, where and what types of information college aged girls from learn about their reproductive bodies. A survey asking questions regarding reproductive health knowledge and behavior related to school, religion, family, online searches, and overall confidence was collected, 11 semi-structured interviews were held. It was found that to care for their bodies, girls act alone in knowledge acquisition, but as they begin to be more comfortable with their bodies, they converse with their peers about their bodily functions. Throughout their entire reproductive health trajectory, girls adapt their bodies and their behaviors to fit what is expected of them from societal reinforcing the idea that being a woman is challenging stigma while meeting expectations. This research offers a unique perspective on how knowledge is different environments are set up to reinforce independent and social methods of knowledge acquisition, the changing meanings of womanhood, and provides an insight in how knowledge is acquired, and stigma is acted on.

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Acknowledgements

This thesis would not have been possible without the support and encouragement of a multitude of people whom I cannot begin to express my thanks to. This research project has shown me the importance of community in academia, the strength of women, and the necessary interpersonal skills required for qualitative research that I will carry with me for the rest of my life. First, I am extremely grateful to Dr. John Lindo for agreeing to be my adviser and for staying patient as I juggled between ideas and methods and for believing in my ability to plan and conduct research. Thank you for having more confidence in my research skills than I did and for encouraging me to go through with what I think is best. All your emails reassuring me that I was on track brought with it a sigh of relief and eased my anxiety tremendously every time. I know that cultural anthropology and women's health research is not your specialty, but thank you for making it these two fields yours to better support me for the past year. Next, I owe a huge thank you to Dr. Devon Goss for all your time to not only give me detailed feedback on my chapter drafts which were quite rusty when you first got them, but also for giving recommendations on how to alter the wording to improve clarity, tone, and ensure my message came across. Thank you for helping me find articles to incorporate in my paper. I must also thank Dr. Alicia DeNicola for getting my foot in the door of anthropology research, specifically in qualitative data collection, coding, and analysis in you Anthropology of Gender course. I credit a lot of my passion for the social sciences to you so thank you for shaping my trajectory in becoming a researcher. Other professors whose lessons I used throughout my research and in this paper are Dr. Pat Del Rey who sparked a passion to fill the void of women's research in the world of academia, Dr. Peter Brown who introduced me to the world of medical anthropology and gave me a starting point of prominent medical anthropologists studying women's health, and Dr. Melvin Konner who gave advice throughout the project on directions, expectations, and reminding me that there is a future in academia for me. I would like to recognize the invaluable contribution of all the survey participants and interview participants for sharing their stories and giving permission for me to share them with other people. I hope you know your strength and the incredible work you have done and the incredible work you will do for all the women around you. Next, I want to thank Dr. Debra Vidali and Ms. Heather Carpenter for guiding me through the entire honors journey and making sure my deadlines were met. Ms. Carpenter, thank you especially for answering my panicked 3am emails telling me that I can complete an honors thesis to which you were right about. Lastly, thank you to my family and friends for all your support. To my family, thank you for having faith in me. To Ryan, thank you for making time to read through hundreds of pages of drafts, printing out all the drafts, and reminding me nearly every day that I can do it. To Georgia, thank you for being such a pivotal part of my reproductive health journey, inspiring this project in the first place, and running practice interviews with me. So many other people not listed here have been crucial to getting me to where I am now and I will never be able to express my immense gratitude. Thank you.

Table of Contents

Tables

INTRODUCTION

"Michele: Do you feel like talking and doing about reproductive health has gotten easier since college?

Julie: yeah … I feel like teachers were more understanding like it was kind of on you. Like if you want to leave class early, you're more than welcome. People won't say anything to you, and I think that was such an important part and I think people stopped caring, you know what I mane? If you're going to change a tampon, nobody in college is going to be like, oh look at that person and there's 300 other people who are you really going to look at? That one person leaving or the instructor talking? … it was the freedom to like, you know, choose your own schedule because I know my mornings are generally worse than my evenings so I could generally choose my schedule around that and also, I could choose to not attend on day … I have the freedom to be like, well this is better for me which was never an option in high school… I feel like in college, you're more of an adult.

Beatrice: Oh, definitely. I think it's because there are more people that are willing to talk about it. I think my biggest concern is waiting for college is sometimes too late.

Lorraine: yes, I feel, yeah, I feel a lot of my friends, I feel like once you turn 18 and you're a little more autonomous, independent I guess, you have to make these decisions about reproductive health and I think yeah, people, once they reach that age here, they can talk about things without being cringey or whatever, I definitely say it's gotten easier.

These women aren't the only ones who feel that the environment college offers a space where they are comfortable talking about their bodies. It is no doubt that college is formatted in a way to promote growth of independence and critical thinking in an academic sense, but it also does this for women in regard to their reproductive bodies. This study looks at how college-aged women in Georgia learn about their reproductive bodies. College-aged women were selected because for those who choose to attend the traditional 4-year undergraduate college shortly after high school, this is typically the time of independence and personal growth since people are on their own for the first time. The responsibility of taking care of our reproductive body comes

with meeting societal expectations of physical attractiveness, empathy and kindness, and intelligence (Parker et al., 2017). Professors, educators, and individuals alike have confusions about the female body. In a letter address from Joseph M. Perry Jr., an educator at a Pennsylvania high school to the director of Indiana University in 1970, he writes, "Dear Sir, In February, I will be teaching a unit on Sex Education, and I would greatly appreciate any information you could me concerning the following: contraceptives, abortion, venereal disease, mental illness in children, developmental stages of pregnancy, infertility, care of the fetus and the newborn child. Thank you for your time and consideration" (Image 1). All the topics listed by Perry fall under reproductive health of women. After centuries of human existence, it seems like even those who are deemed the most educated are not entirely sure how the female body works because there is a lot of confusion about it. Even with the increased amounts of resources we have today, there remains to be enough confusion about the female body for rumors to sprout. In the midst of the COVID-19 pandemic and the push for the vaccine, there was a rumor taking hold stating that being near someone who had received the COVID-19 vaccine "could harm others, impacting fertility and the reproductive systems of women and also the development of children" hence the reason why a Miami private school is prohibiting their teachers from getting the vaccine (Aguirre, 2021). Rumors sprout from areas where there is a lack of knowledge and space for doubt. In this case, the lack of general knowledge about reproductive health and how menstrual cycles work help to explain why this rumor is beginning to be as widespread as it is. The only way to combat this is through improving knowledge about the women's body enough that the individual has confidence in her body and her capabilities.

According to the U.S. Census Bureau, as of July 2019 there were 166.6 million females 161.7 million males of all ages. The number of females in the U.S. has been greater than the

number of males in the U.S. for over two decades now (U.S. Census, 2021). The U.S. Census data from 2010 indicated that 10,097,332 out of 20,677,194 of 10- to 14-year-olds were female which is approximately the years when menstruation occurs, 10,736,677 out of 22,040,343 15- to 19-year-olds were female which is makes up the high school years, and 10,571,823 out of 21,585,999 20- to 25-year-olds were female which are the years most people start their undergraduate degrees (Howden & Meyer, 2011). Not all women attend college after graduating high school so their process of acquiring reproductive health information may be different from the experiences analyzed for this study. In our everyday discourse, "women's health" is used interchangeably with "reproductive health" which is also used in conjunction with "sexual health," but reproductive health is much more inclusive than our daily conversations indicate.

The World Health Organization (W.H.O.) defines reproductive health to be *a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes. Reproductive health implies that people are able to have a satisfying and safe sex and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.* For college-aged females, there is an emphasis on menstrual health, sexual health, and mental and physical health pertaining to body fluctuations regarding reproductive health. The U.S. does not use the W.H.O model of health to shape research and policy (Ruzek et al., 1997). Rather it takes a more biomedical approach which is diseases focused and leaves out the social forces and contexts that shapes women's lives (Ruzek et al. 1997).

Females in the United States learn about reproductive health from a variety of sources ranging from their peers, their family, school, the media, and more recently, through the internet. There are over 56 million students attending school, pressing the need for school health

programs to engage in conversations about reproductive health because it reduces the prevalence of health risk behaviors and have a positive effect on academic performance. Some elementary schools are teaching young girls about their menstrual cycle and thirty states, plus the District of Columbia require public schools to teach sex education. In addition to public education, there are a number of women's health clinics such as Planned Parenthood that offer family planning services which includes birth control, STD testing, abortions, breast cancer detection, among others. Due to his history and resources, Planned Parenthood is the largest family planning provider service, serving 41% of people under Title X in 2017. In Georgia, there are a total of 4 Planned Parenthoods. Some local clinics such as the Emory Health clinic in the greater Atlanta area also provides services. Many colleges in Georgia such as Emory University, Georgia Institute of Technology, and University of Georgia have a women's health center when a need arises.

In the United States, family planning services otherwise known as services that fall under Title X in the US Department of Health and Human Services, have become at the spotlight of debates about abortion. Title X, a federal grant program created in 1970 provides comprehensive and confidential family planning services and preventive health services such as contraception counseling, breast, and cervical cancer screening, testing and treatment for STI, pregnancy counseling and diagnosis, however despite the range of services offered, American politics focus on abortion. A former nurse at Planned Parenthood said "abortion, abortion, abortion – it's like waving red flags in front of a bull. We do so much else" (Green, 2019). Feldt, the former president of Planned Parenthood does not believe that Planned Parenthood should choose between being a healthcare provider and a political advocate (Green, 2019). As a result, the role of politics plays a role in the type of education females receive and the access to care that is

specific to a female's body. While this type of healthcare may sound niche, it is important to remember than half of the population of bodies these politics are dictating goes through these experiences.

In 2016 with the election of Donald J. Trump, the Gag Rule was reintroduced and became effective March of 2020 (PRH 2019, Rosenbaum et al. 2018, Planned Parenthood 2021). It prohibited healthcare providers receiving Title X funding from referring patients for abortion care even if the patient asked for it and prohibited doctors and nurses from giving people the full information about all their sexual and reproductive health care options across the board (Rosenbaum et al 2018, PRH, 2019). Not only that, but it would stop Planned Parenthood, an organization treating 41% of the 3.8 million patients served through title X from receiving government funding (Rosenbaum et al. 2018). The election of Joseph Biden removed the Gag rule on January 28th, 2021, but has yet to further improve reproductive health services. (Planned Parenthood 2021, Rhodes 2021) The symbolic meaning behind the Gag rule was to remind women that they should be controlled - what is done to their bodies, what resources they have, and what happens when they try to challenge the system. Rules such as these and regulations limit access to contraceptives and information, furthering silence what we know about the complexities of the female body. There is currently a variation of the gag rule called the global gag rule, also known as the Mexico policy, in place around the world that prevents foreign organizations receiving global health assistance from the U.S. from "providing information, referrals, or services for legal abortion or advocating abortion services in their country – even with their own money" (Planned Parenthood & Global Health Visions, 2018).

In addition to a political strain on the female body, there is a financial strain as well. The Pink Tax is the *extra amount that women pay daily as consumers for products and services that*

are similar or equal in merit to comparable men's products because the product or service is marketed towards women (Lafferty 2019). By extension, the Pink Tax also includes Tampon Tax because it is an economic obstacle woman face that men do not (Bennett 2017). It is present in a majority of states including Georgia because menstrual hygiene products are considered a "luxury item" and so a general sales tax is put on them (Bennett 2017). The costs of this tax on American women are approximately $3.1 billion each year (Bennett 2017). In one study, it was shown that 1 in 5 teens struggle to afford menstrual products. This has great effect on students' academic because in New York City, it was observed that at schools with free period products, the attendance increased by 2.4%. The pink tax in addition to gender wage gap puts women at a lower tier and strips them of having a full voice in shaping their lives. The gender wage gap refers to the difference between the salaries of women and men for the same job. As of 2018, women were earning an average of 82 cents for every $1 a man makes with Hispanic, or Latino make the largest with $0.54 for every $1 a White man makes. Poverty is a structure violence that limits the resources women have (Bleiweis, 2020). Since women in the United States spend more for products while also being compensated less for their work, they are more at risk of experiencing poverty. In 2012, the poverty rate was 14.5% for women and 11% for men (Entmacher et al. 2013). Socioeconomic status has been found to be the key factor in determining the quality of life for women in terms of access to education and opportunities, but it also makes women vulnerable to domestic and sexual violence, deepening the cycle of poor health and poverty. When it comes to physical health, low-income women have the lowest rates of mammography screenings, die of breast cancer, and are more likely to experience obesity. The effects of financial structural violence on top of gender violence on women's reproductive health have not been thoroughly investigated.

My interest in female reproductive health, specifically reproductive health discourse and reproductive health pedagogy stems from patterns of whispered conversations with close female friends about our bodies. As we have gotten older, conversations were less associated with flushed faces and situations that once catalyzed panic is now second nature. During my first two years of college, I worked part time at a middle school as a teacher's assistant where I developed close relationships with many of the students, particularly the girls. One day at the school, I needed to use the restroom badly. The student's bathroom is much closer to the library than the staff bathroom is, so I found myself in a middle school girl bathroom stall in the first time in 10 years. The smell of menstrual blood and the sight of menstrual pads rolled up messily, likely because the person was in a rush, brought me back to my middle school days when I didn't know much about the female body. Between this "aha" moment and revived whispered conversations about their changing bodies, I sought out to see how college-aged women from Georgia learn about reproductive health. Although I have attended public school all my life, my experience, and the knowledge I possess is specific to the school curriculum that I encountered in New York City. In the United States, there are varying reproductive health approaches between states and since Georgia has historically been in a different political environment than New York has, I have not experienced first-hand what growing up in Georgia is like.

This paper will focus on females and their reproductive health experience, but it is important to note that not all females menstruate and not all who menstruate are female. Other groups of individuals who menstruate also include transgender men, but these other groups will not be discussed here because their experiences are different from that of cis women. This paper will focus on cis college-aged menstruating identifying women in Georgia. As a female conducting research, I hope to challenge against the ideas in science about the

female body constructed by upper middle-class men by producing an analysis that is representative and specific to a particular population/community. This study was conducted using deductive reasoning because the scientific method and inductive reasoning only works if bodies are objectively analyzed with the assumption that all factors are the same. This is not the reality that female bodies live in; therefore, a mix qualitative and quantitative approaches were used here.

METHODS

This study used a mixed method qualitative and quantitative approach to answer the question; how do girls from Georgia learn and grow into their reproductive bodies? The quantitative data was collected in a survey format with a total of 22 questions touching 5 different categories: school, religion, family household, online searches, and overall confidence in knowledge. The format of the interview was a mix of check all that applies with an option of "other" and the participant to fill in information themselves, rate from 1 to 10, and multiple-choice questions (Appendix A). Throughout the course of 5 months, I collected 112 survey responses using Qualtrics. 25 participants did not consent to taking the survey, so their responses were removed before analysis. 1 participant indicated that she is a transwoman and left a comment asking why the survey was not inclusive of trans people. It is my error as a researcher for not clarifying that the questions of the survey were to address the experiences of cis women. Due to the varying experiences cis women feel from trans woman and as to not diminish any challenges either group feel, this study focuses specifically on the reproductive health of cis college-aged women from Georgia. Some of the experiences transwomen have that cis women do not include coming out to family and friends as transgender, finding the social and financial support to decide starting hormone therapy, feeling gender dysmorphia in social settings, getting surgery, and the list goes on (Frank & Dellaria, 2020). I would like to emphasize that the entire hormone therapy process transwomen go through is something cis women do not have to go through and that it is imperative that a study of this nature that looks at the reproductive body of women should include questions related to the hormone therapy process. Hormone therapy is often thought of as a second puberty because of physical, emotional, and sexual changes that happen in the body so that the levels of different hormones, proteins, and other things are equivalent to that of ciswomen (Harper et al., 2021; Deutsch, 2020). Transwomen are no doubt women and should be treated as such, but

keeping Kimberlè Crenshaw's *intersectionality* in mind, the discrimination and challenges transwomen go through is different than those cis women go through and to respect both groups of people, it is important to keep research objectives specific (Crenshaw, 1991). This is not to imply that there are not overlaps between the experiences of trans women and cis women and the nearly identical hormone levels in both groups, but for this study, a reproductive health process that does not encompass hormone therapy was investigated. For this reason, the survey data from the participant identifying as a transwoman was not included in the analysis. The qualitative portion of this study was collected through semi-structured interviews with college-aged females. There was a total of 6 structured questions asked to all interviewees (Appendix B) and depending on the response and engagement of the participant, follow up questions were asked to each answer. 11 interviews were held and recorded over Zoom with the shortest being 33 minutes long and the longest one approximately 1 hour and 15 minutes long. The women interviewed are currently attending college or had just graduated from a university in the United States. After transcribing the interviews by hand, the transcriptions were uploaded on MAXQDA and coded for. The codes used were Periods, Friends, Stigma, Birth Control, Sources of Information, Being a Woman, Challenges, Next Steps, Religion, Role of College, LGBTQIA+. Within each code listed 3 to 5 subcodes. The code "Religion" had a total of 8 codes in comparison to "Sources of Information" which contained 125 codes. Since not enough data was collected on religion, the role of religion on learning about reproductive health will not be analyzed here. The use of both quantitative and qualitative methodologies allowed for context to be provided for the statistics found and give numbers a story. At the beginning of the research, the focus was on the aspects of reproductive health related to the menstrual cycle and the stigma associated with it, but during the literature review spanning both the social and physical sciences, it became clear that reproductive cannot be grouped definitively into categories like "menstrual cycle" and "pregnancy" because both revolves around a healthy mind and body. After this, my research broadened to an understanding of all aspects of

reproductive health that are relevant to college students. This includes factors regarding the menstrual cycle, sexually transmitted diseases, and mental health.

The quantitative portion of the research shows the prevalence of different experiences, such as feelings of confusion about body processes and testing out new products, college women have. For those who have not experienced these emotions, thoughts, or behavior firsthand, it provides a sense of how common experiences such as turning to the internet for clarification is. For those who have experienced this firsthand, the numbers are here to show that your experiences are not alone. The qualitative portion of the research gives an inkling of an idea as to how vast the range of stories behind those numbers can look like. Overall, this research gives insight to how girls growing up in Georgia who are now in college have taken charge to put their health into their own hands and how they, as the next generation of scientists, educators, doctors, businesswomen, artists, and as most importantly women, are paving the path for women who come after them. Although this research focuses specifically on college-aged girls who had attended a Georgia public school, many of these experiences can be found in students in other parts of the United States.

The subject matter at hand is personal and when talked about, if at all, often occurs behind closed doors in whispers (Aizenman, 2015). For this reason and for the comfort of the participants, all survey questions as well as interview questions were made optional. As a result of this, the denominator for the quantitative portion of this study varies for each overall theme. At the end of the survey, the participant was asked if they would like to participate in the interview portion of this study. 33 number of participants had indicated interest in the interview portion of the study in their survey and 9 of them were interviewed. 2 more participants were recruited for the interview through social media postings and word of mouth using digital posters (Appendix C). Previous studies looking at the quality of qualitative research in relation to the number of interviews held found that when all one-on-one interviewees were asking a similar set of questions, data saturation,

occurred after analyzing 12 interviews (Guest et al., 2006). Although the number of interviews I have is on the smaller end, I feel that the overall themes and the patterns collected from 11 interviews can help add to conversations about acquiring reproductive health knowledge. Since there was no incentive other than to further improve on the information we know about reproductive health among women from Georgia, all the interviewees were very receptive about the questions posed. For a handful of participants, there were some areas that triggered more hesitation than others as indicated by a shorter answer response or a pause. Thankfully, due to the nature of semi-structured interviews, questions about the individual were asked until she appeared comfortable again before returning to the interview guide or less follow up questions were asked regarding the topic, she showed discomfort in. My priority was the participants' comfort. I am extremely grateful that the interview participants were open minded to the idea of talking about personal experiences and there was a lot of giggling and nodding our heads in shared agreement about specific incidences that were once so taboo.

Supplemental Data

To get an understanding of the material taught in schools, I planned for and received IRB approval from Emory University to conduct participation observation at a Georgia high school's sex education class either virtually or in person. After reaching out to all the public high schools in the greater high school area, a total of 16 schools, I was informed that IRB approval was needed from the Georgia Department of Education. After applying, I received a response stating that due to the COVID-19 pandemic and the in-person curriculum, I cannot conduct participation observations in schools. Luckily, I was able to have a virtual meeting with one of the principals at a public Georgia high school and got a chance to ask her questions about sex education and health education that she teaches at her school and that is expected of her to teach from the state of Georgia. In addition, I looked at the Georgia Standards, a document published by the Georgia Department of Education

with learning objectives for each grade, to get a sense of the topics set by the state to be taught in schools.

Positionality

My upbringing in the northeast of the United States, a region with cultural, political, and economic differences to Georgia put me at a disadvantage because I did not enter the research with a strong understanding of how the education system functions both internally and on paper. However, since I have started university at Oxford College and later at Emory College, I tutored at a Georgia public elementary school and middle school and worked alongside Georgia public high school students. I draw from this experience to get an idea of the basic academic structure of Georgia public schools. With the onset of the election which came at around the time I was preparing for my proposal, I started to learn about the history of reproductive rights in the Southeast region of the United States, specifically in Georgia. Throughout the course of my research, I maintained communication with a few of the people I conducted interviews with as well as other from Georgia which have been vital in understanding what a typical class, day, and year was structured. Their willingness to draw on their high school memories and share them was essential because I was not able to conduct participation observation due to the COVID-19 pandemic.

As expected with anthropological work, especially one that is only a year long, time is a constraint. As a stranger asking personal question to the interviewees, I may not have received the same responses as someone who has a close relationship with them. I conducted only one interview with each participant making it possible that some of the responses did not go as in depth as they would have if multiple interviews were conducted over a period of time. As someone who also identifies as a woman and is an undergraduate student, I mitigated this by spending the first couple of minutes of the interview with small talk where I showed my vulnerabilities and my experiences. Additionally, due to the COVID-19 pandemic, another limitation I experienced was an inability to

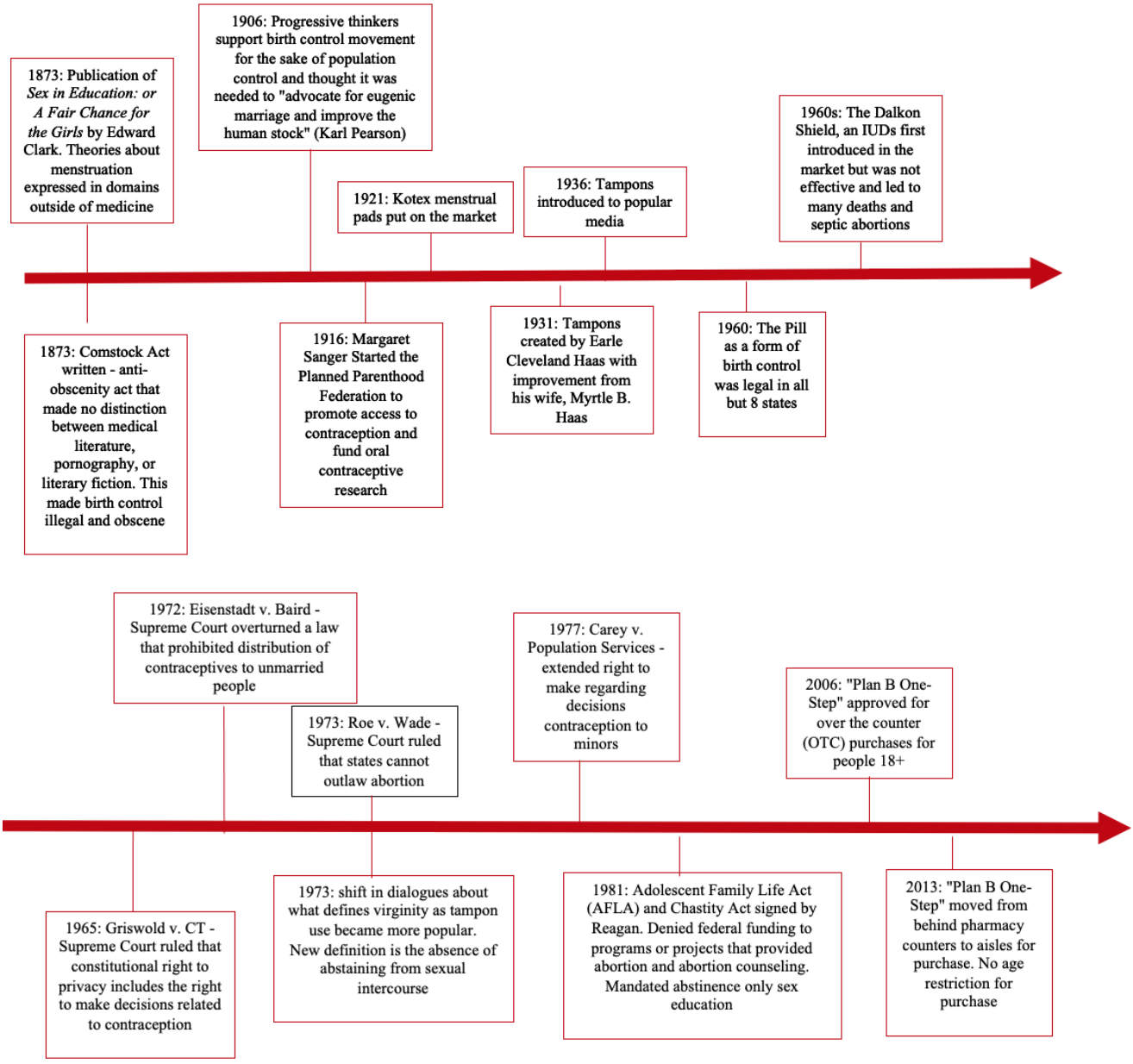
get an emic understanding of girl bathrooms and how the sex education curriculum is carried out in public schools in the metro-Atlanta area. I had to rely on my work experience as a tutor and ask description questions during the interviews to obtain a better image.

Research Challenges

The greatest challenge in this research was the presence of the pandemic and the limitations that came with it. Initially, I was hoping to visit at least two high schools in the greater Atlanta area and sit in on sex education classes, but due to the pandemic, it was difficult to obtain consent from Atlantic Public Schools' IRB committee. I reached out to 16 public schools and asked for a copy of their syllabus, the name of any books assigned to students, and the name of any videos they gave students to watch. This does not compensate for firsthand participation observation since I do not get to take note of how students are reacting to materials presented to them.

LITERATURE REVIEW

A Brief History of Menstruation and Reproductive Technology



The relevant literature on reproductive health falls under disciplines touching on etymology, reflexivity of the body-self, and power structures at various levels - government,

society, and within the body. Individuals, groups, and social institutions are all controlled by and have power to enforce certain behaviors (Ruzek, et al., 1997). The social dynamics at play has turned a natural, biological event into a social phenomenon impacting students' perceptions of themselves in the context of the environment she is in. Studying reproductive health from an anthropological perspective provides insight into the norms, shames, and types of information passed vertically between generations and horizontally between groups. This makes up culture. The definition of culture is widely contested. Ruth Benedict's definition of culture is "A culture, like an individual, is a more or less consistent pattern of thought and action" (Benedict, 1934). There is a push and pull between the individual and their culture where individuals learn, practice, modify, and teach different parts of their culture over time (Rutherford, 2013). Culture is the passing down of knowledge or a set of beliefs and the way reproductive health knowledge is shared in the United States is a modge-podge of different political beliefs, religious ideologies and varying education systems that need to be explored to see how they work with and against each other. An anthropological perspective will take into account the different factors influencing how knowledge is obtained and shared, specifically from who and of what.

A Brief History

Menstruation Medicalization

In the U.S. a century ago, women used rags and homemade sanitary cloth pads to catch menstrual discharge. When daughters began menarche, they turned to their mothers believing they were diseased and for the most part they were not wrong according to medicalization behaviors at the time. Medicalization is the process of defining a problem in medical terms, usually as an illness or disorder, or using a medical intervention to treat it (Brown & Closser,

2016). The result of medicalization is placing diagnostic labels on situations and while this is helpful, occasionally, it can be harmful. For example, in relation to women's health, "saggy breasts" or more medically, "breast ptosis," is considered a medical disorder among some people which is "treated" by plastic surgery (Martinez & Chung, 2021). For a large portion of the early 20th century, menstruation was viewed as a way to get rid of "bad blood" in the body (Freidenfeld, 2009).

Menstruation sources of information

When mothers were not a thorough source of information, girls turned to the library to find books about what was happening to their bodies (Freidenfeld, 2009). It was not until the 1930's that medical researchers agreed on the biological function of menstruation that attitudes towards menstruation as a disease changed (Freidenfelds, 2009). The newly accepted function of menstruation is to prepare for pregnancy. Part of the push towards better research was the introduction of Kimberly Clark's Kotex menstrual pads in the market in 1921 (Freidenfelds, 2009). Clark saw a need for reliable sources of information for menarcheal girls and began to publish pamphlets which contributed to a revolution in the availability and research about menstruation. Once the theory of menstruation having a reproductive purpose was widespread, progressive reformers used science as a rational to introduce mandatory public schooling about hygiene, manners, and sex education with a focus on abstinence. However, menstruation was still taught only at home through Kotex pamphlets. It was not until the 1940's that pre-menarcheal menstrual education began in public schools when Americans embraced a scientific explanation of menstruation over a religious one and believed that education should be standardized for all girls (Freidenfelds, 2009, Vostral, 2008). In addition to pamphlets, Clark worked with Disney to produce *The Story of Menstruation* in 1946 that provided illustrations of

the menstrual cycle, health, and hygiene advice (Freidenfeld, 2009). When tampons were introduced in 1936, women and physicians were concerned about the safety, the efficacy, and the sexual implications of the tampons. Some who had not yet adopted the scientific explanation for menstruation believed that tampons would stop the "bad blood" from drainage.

Birth Control

Following Kimberly Clark's successful distribution of Kotex pamphlets educating girls about menstruation was the repeal of the Comstock Act of 1873. The Comstock Act prevented the publication of medical literature by making no distinction between that and pornography (Ginsburg 1991). Margaret Sanger gathered public support to repeal this by taking a conservative approach to advocating for birth control by claim that it should only be used by married couples to "scientifically" space their children and that it should be heavily advertised in poor and communities of color. It was viewed that birth control is a form of population control and that contraceptives can be targeted to people of lower class and of color under the guise of "overpopulation" (Ginsburg 1991, Pies). During this time, eugenic ideas were spreading rapidly and birth control's close relation to the history of eugenics had lingering effects on the community. Some influential Black leaders like Marvin Davies, the president of the NAACP branch of Florida, rejected the idea of Black women using contraceptives because it was another form of government control on the body (Caron, 1998). Unfortunately, many people agreed with Sanger's logic, and she founded Planned Parenthood which is now working to apologize for their discriminatory history. Sterilization as a form of population control continues to exist in Georgia in the 21st century. In September 2020, it was discovered that immigrant women at an ICE detention center were coerced into hysterectomies under the guise that they were getting a treatment for something else (Chapin, 2020). Discussions about sterilization force us to look

back at the eugenic ideas throughout American history. The 1970's were supposedly great years for women autonomy about their health with the passing of Roe V. Wade in 1973 which allowed women, not the government to decide if she gets an abortion. However, during that same period, up to 50% of indigenous women were forcibly sterilized by Indian Health Services because the government wanted to halt the growth of the indigenous population and did not trust indigenous women to take birth control pills (Chapin, 2020). Reflecting on the opportunities contraceptives have given to college women also requires the acknowledgement of ways this technology has been abused.

Control of the Women's Body

The question of how a female goes from a girl to a woman has been touched on through seeking the answer to what a woman's body means/indicates. The social identities women hold, both the achieved and the ascribed are placed onto them through ritualistic processes. Within the category of women, there are different types of women – the sister, the daughter, the mother, the wife, and the list go on. The ritual processes which Davis-Floyd describes as, "a patterned, repetitive, and symbolic enactment of a cultural belief or value; its primary purpose is transformation" is described in further detail when she wrote of the ritualistic process of a woman becoming an American mother (Davis-Floyd, 2003). These identities are created, and the accustomed behavior determined through acts of biopower defined as "power that exerts a positive influence on life, that endeavors to administer, optimize, and multiply it, subjecting it to precis controls and comprehensive regulations" by Michel Foucault (Foucault, 1970). He also describes the opposite, juridico-discursive power whose "effects take the form of limit and lack" (Foucault, 1970). This idea is further elaborated in the connotations behind "politics" which anthropologists claim to be the central insight into looking how power is structured and enacted

in everyday activities "notably, in relations of kinship, marriage, and in inheritance patterns, rituals, and exchange systems" (Ginsburg & Rapp, 1991). These powers come from government and societal forces to dictate our actions and behaviors. In the United States health field, biopower emphasizes the values of men and emphasis of science and disease over the illness experience (Davis-Floyd 2003, Scheper-Hughes, Foucault 1970). The United States values of individualism, capitalism, and patriarchy is prevalent in how health is approaches, particularly when the female body, in particular, is in conversation (Davis-Floyd 2003). Within the area of the female body, biopower has led to the view of human bodies as a machine particularly because it assumes that like in a lab with controlled variables, all humans live nearly identical lives, but both history and individual experiences has shown us that this is not the case (Davis-Floyd, 2003; Martin, 1988). One proposed understanding of the body is that it is viewed from three perspectives – the individual body-self, the social body self, and the political body (Scheper-Hughes & Lock 1987). The individual body self is how people understand how different parts of their selves such as the mind, the body, and the soul, work together to make up the individual. The social body is the meanings a body absorbs in reference to nature, society, and culture. This includes how individuals work and interact with objects and other living objects around them. Lastly, the political body is closely related to what Foucault referred to as biopower and what eugenics has played out to be population control. This includes the regulation and control of bodies regarding how it reproduces, works, relaxes, and other activities humans delve in (Scheper-Hughes & Lock 1987). All the perspective of the body starts from the foundation of understanding the body as a machine. This becomes problematic because female's bodies, unlike men's body is not as predictable and therefore was viewed as abnormal to the point of pathological.

Biopower are experienced by women at a local level. For example, the hygiene handicap has made women out to be disabled for a period of time each month causing to the stigmatization of a natural phenomenon. Biopower extends to control of the body to how the individual converses and how the individual sees herself. Despite the increase in scientific knowledge regarding the reproductive body, the type of language used to describe menstruation has not changed because the production of knowledge was reflective of the thoughts at the time. This influences the access to resources we have and for the female body, this is including birth control and abortion. As the birth control and abortion became safer and more widely available, there was a great concern that it would encourage promiscuity, but Gage suggests that opposition to abortion and birth control is not that there is a disagreement about efficacy or safety, but rather because widespread access of contraceptives and abortion is linked to the increase in opportunities women have, or in other words and loss in the ability to control women (Ginsburg 1989; Martin, 1988).

Etymology of Control

There are multiple sources women learn about their reproductive health from. A theme continuously sprouting in anthropological studies are how women are encultured into their roles in society and figure out the social script that they belong in. The social script is specific to time and space and includes an interaction between the individual with the environment she is in. For most of history, females were seen not be a full body like male bodies were, particularly because women were limited to their bodily functions. For instance, in a political life, women were not given the right to vote until 1920, implying that women were not viewed to be citizens the way their male counterparts were. Male figures like Edward Clarke suggested that women should stay at home because of their "bodily function" in his influential *Sex in Education* (1873). He is

referring to menstruation which some male employers still support through creating a working environment that supports the predictable male body and the unpredictable female body. Another way physical structures are built for men, rather than women is looking at the temperature of office buildings. In a study looking at the effect of temperature on cognitive performance between men and women, it was found that women perform best in rooms between 70 and 80 degrees while men perform best in rooms at temperatures below 70 (Chang & Kajackaite, 2019). While this is true, many offices keep their thermostat on the lower end of this range despite many places now employing comparable numbers of male and female employees (Roy, 2019). Feminists such as Mary Putnam Jacobi conducted research showing that women work better and with much greater safety if given an appropriate working environment. However, studies conducted by women were not seen to be equated to evidence lacking hypothesis such as women are "swayed by the tides of their ovaries" as suggested by Robert T. Frank who continued to fight for this even when research showed that biochemical changes occurred in response to socially mediated changes (Martin, 2016).

It was not a coincidence that new theories from men about the limitations of the female body came after World War I, World War II, and the passing of gender discrimination laws. For example, ideas of premenstrual syndrome (PMS) had always existed, but the "explosion of interest in PMS" took place after the "second wave of feminism, stronger convictions about women's right to work, lower birth rates, legislative support barring sex discrimination, increasing urbanization, and growth in educational opportunities" (Martin, 2016). The effects of limiting women to their body functions had huge effects on how some women perceived themselves. One interviewee from Martin's study shared "I grew up thinking you shouldn't draw attention to your period, it makes you seem less capable to so certain kinds of work … then all of

a sudden recently I started hearing all this scientific information that shows women really do have a cycle that affects their mood … medical proof that women are less reliable" (Martin, 1988). There was an accepted notion that women's health problems are psychogenic and that it's "all in the head" (Ruzek, et al., 1997). The medicalization of the body contributes to the control of the female body. Anger is listed as a symptom of PMS which Marin argues is because PMS affects only women and, in our society, women who express anger are considered problematic since it contrasts the social script of women as a peace maker in their family (Martin, 1988).

Outside of institutions, communities of people, and our own selves also act as social police of sorts. Part of the social script includes acting as an individual who is not menstruating which is called *passing.* Passing is the ability to show the world an identity that is not the full truth which women do on a nearly monthly basis to avoid stigmatization of menstruation, another form of how girls learn control (Vostral, 2008). In the U.S., there is value placed on physical appearances that affect the type of treatment and attention girls receive which is why in order to get the attention that they want, girls must pass. Some theories about stigma of disability are relevant to stigma and menstruation such as the menstruation as an "invisible" condition which involves the dilemma of disclosure (Brown & Closser, 2016; Martin, 2016). Often, women are passing by choosing to utilize the technology available. Menstruating women also experience a double pass when they are, one, coming off to the world as non-menstruating and two, to themselves as non-menstruating. This indicates that not only are people holding each other accountable to conceal the act of menstruating, but the individual herself does that too.

Part of control includes alienation. In *Economic and Philosophic Manuscripts of 1844*, Karl Marx introduced the Theory of Alienation which argues that an individual loses the ability to determine his/her own life because of the way society alienates the individual from its

community and products. While his work is more focused on alienation in an economic sense, such as alienation of the worker from their product and the alienation of the worker from the act of production, the other two types of alienation can be more broadly applied to alienation women experience as they are going through puberty (Marx, 2007). The third type of alienation is, alienation of the worker from their species-essence, or in other words individuals lose opportunities for self-development because they must sell their labor-power to the market as a commodity (Marx, 1932). In reference to the female experience, by taking the time to figure out ways to best conceal a menstruation or other parts of puberty, women lose time they could have spent on themselves. Additionally, as young women are looking for ways to pass as individuals with predictable bodies to compete with others who are also overcoming the same challenge, they lose time for self-discovery and investments in themselves, thus leading to the need for to learn about themselves later in life. As shown through interview collections, this usually occurs in college because as women are stepping into new environments, feelings of alienation are undermined. The fourth is alienation of the worker from other workers which Marx explains to occur because workers compete against other workers in the market to create a competitive labor market (Marx, 1932). In regard to reproductive health, the fourth alienation is loosely related to how females often do not talk amongst each other at the beginning stages of their periods out of embarrassment.

Liminalities and Linguistics

For this paper, there will be varied ways I address individuals. For some situations I will use "girls," for others, "women," and a few, "female," but it is important to know that when a female goes from being a "girl" to a "woman," she is in a state of liminality. Victor Turner wrote, "liminal entities are neither here nor there; they are betwixt and between the positions

assigned and arrayed by law, custom, convention, and ceremonial" (Turner, 2019). Women beginning puberty for the first time are in a state of liminality where they are not quite a girl and yet not quite a woman yet. During this state of liminality, Turner argues that individuals submit to community beliefs, values, norms, attitudes, and sentiments (Turner, 2019). In other words, the language used influences how women are treated and how they perceive themselves (Brown, 2016). When sex education began in schools, many feminists noted the emphasis of abstinence and a lack of teachings on how to take care of the female body (Martin, 2016). They argued that the rationale behind this is because there is topics that pertain to both males and females are seen as "positive," but topic related to only females are viewed as "negative (Martin, 2016). As science developed, the terminology used to discuss women's reproductive health, especially the menstrual cycle can be paralleled to the language used to talk about machines. Menstruation taught in textbooks use a signal response metaphor such as "The hypothalamus receives signals from … the endometrium responds direction to stimulation … they influence, through feedback mechanisms … programmed by the hypothalamus" (Martin, 2016). With language such as this creating our foundational understanding of the reproductive body, it gave a space for men to repeatedly tell stories of how menstruation limits the cognitive effect of women, and a need for women such as Dr. Mary Jacobi to argue that menstruation has little effect on cognitive performance (Vostral, 2008, Ussher, 1992). It's important to note here that studies found no evidence of mood changes throughout a menstrual cycle, and some have found that there is a greater correlation between a woman's mood and her environment than there is between her mood and her menstrual cycle (Ussher, 1992, Martin, 2016). Despite current scientific evidence disagreeing with the accepted beliefs about PMS and the menstrual cycle, women's reproductive health continues to be pathologized, pressuring women to perform their assigned social script. In

the study of women's health with a medical anthropologist approach, it has been questioned time and time again if "good" women's health "the absence of disease or something more" and how "disease" is defined (Ruzek, et al., 1997).

The length of time and experiences of liminality varies across culture and environment. The first exposure women have towards menstruation and birth control is through their parents and even with the foundation reproductive health education women receive through institutions such as schools, social relations like mothers and girl friends continue to play an important role in enhancing reproductive health knowledge. Parent-child relationships, communications, and parental control have been found to be linked to adolescent sexual behavior, contraceptive use, and how adolescents make decisions for themselves (Frisco, 2005). In a longitudinal study, it was found that with every one unit increase of parental involvement, there was over double the odds of condom use, two and a half times increase of oral contraceptive use, and greater than three times increase of using multiple contractive methods (Frisco, 2005). These studies indicate that the greater access to conversations with individuals who have passed the stage of liminality a female has such as a mother, then the less time the individual spends in a liminal state because they are fed answers that shape how they think. Additionally, liminalities vary between groups because the interpretation of reproductive health differs across cultures. In the United States, differences across culture have led to varying access to reproductive health technology (Freidenfelds, 2009). For example, it was found that Chinese immigrants and U.S. born daughters disagree on tampon use because traditional Chinese approaches to health believes in the necessity of draining menstrual blood which is not possible with tampons and because many immigrants are not familiar with tampons until they arrive in the U.S. (Freidenfelds 2009). Regardless, the messages parents and friends pass on to the liminal entity is that menstruation is

seen as “messy” and that the entire process is unclean (Martin, 1988). There was also a focus on a narrow range of behaviors with “either/or” debates that did not account for the varied experiences and processes within a community of females (Ruzek, et al., 1997). Different access to resources, different culture preferences, and different comfort levels all affect how long a female stays in the liminal state as well as what Tucker describes as the “authoritative community” passes on to her. College students are in a state of liminality because they are both dependent and independents when it comes to learning about reproductive health too because for the first time, they are away from the influences of their mothers and grandmothers. As new social expectations are put onto college women, there is also a change in discourses that bind college students with one another and shapes our social construction of reality (Whisnant).

Despite all the ideas introduced to girls as they become women, women continue to “question, oppose, resist, reject, and reformulate things in which they live and the ways in which society might work” (Martin, 1988). Foucault writes about the relationship between institutions and the individual body where for institutions to remain in control, they must acknowledge the people they control to some extent (Foucault, 2014). Women continue to shape what reproductive health is not only because it’s a body process that occurs, but also because there is a consensus that “the primary positive feeling many women have about menstruation is that it defines them as a woman” (Martin, 1988). Women continue to share information about successfully passing and contraceptives to help each other escape the limitations of how their body as defined them. However, the political oppression women face continues to be a barrier on improving their collective lives because without access to political power and without a seat at the table, they can’t shape their destinies.

A framework for women's health research outlined by Chesney, Ozer, and Ruzek includes looking at diseases that are more common in women than men, leading causes of death among women, gender influences on health risk, societal influences, violence, healthcare policy, and lastly reproductive health which this paper aims to do. There is a great need to look at the spheres of influence which includes addressing the conditions causing behavior, not the behavior itself to better understand the competing ideas and discourses at play to shape our behavior (Ruzek et al. 1997, Curtis 2009, Whisnant).

CHAPTER ONE: GIRLS ARE LONE WOLVES

"I've always been on my own you know, like a lone dog type of thing."
– Mary, college senior

As the human brain evolved millions of years ago and language was developed, increased socialization occurred and with it came concepts of *ladylike* and stigma. Stigma comes from the Greek word referring to markings that are put onto the skin of criminal, slaves, and 'traitors' to make them as "blemished" individuals (Bologna et al., 2021). Throughout history and even today, biological processes experienced by women such as menstruation have become a marking which must be hidden to pass as an "unblemished" person.

Why are women lone wolves?

Nearly all the participants except for one expressed strong frustration at the way society is set up where it feels like women are encouraged to keep their reproductive health experience to themselves, or in other words, *lone wolves*. The term "lone wolf" is used to describe individuals who work or act alone either out of choice or because they must. Virginia said "I hate that it's supposed to be so hush hush. I don't go around broadcasting that I'm on my period, but yeah, if I'm not hanging out with my friends because I have cramps, I'll be like, Oh I have cramps… I have a friend right now whose having some problems. She's just constantly bleeding for weeks, and she talked to me about it … we were actually in a public setting talking about it very quietly." Later in the interview, she shared that she had a friend who was bleeding and didn't want to talk to

school about it both because she wasn't sure who to ask and because she was a little embarrassed. Virginia commented that when it comes to reproductive health, even the smallest thing can affect someone's confidence. To understand why Virginia and her friend lost a little bit of confidence, I looked at where the source of embarrassment is. In this case, like it often is, it is from a deviation from the norm, creating a stigma which Goffman viewed as a social construction of identity. Women's statuses are reflective of the structure and organization of kin groups (Lowes, 2020). In this case, Virginia and her friend understood that in their kin group, a Georgia public high school, it is stigmatized to reveal that you are menstruating, causing a need to hide it for the sake of their reputation. As Virginia got older and her kin group changed, stigma also changed. Talking about menstruation is not stigmatized in her college group which is why she is comfortable talking about it. According to Virginia, the event her friend experienced would be considered a social aberration because the aberration occurred in the environment of the individual. This interaction occurred after the Zoom recording had stopped and Virginia appeared to sit up a little less and began to open about stories that she had heard from others. While she was sharing the experiences she had heard of, especially this one, her facial expression indicated that she had secondhand embarrassment for her friend despite never having experienced this firsthand. The ability to experience secondhand embarrassment is two-fold. First, Virginia has a clear understanding of social expectations and realized how her friend had failed to meet those social expectations, and second, the anterior cingulate cortex and the left anterior insula allow humans to feel others' pain (Krach et. al, 2011). It is likely that the anterior cingulate cortex and the left anterior insula evolved to allow humans to learn from each other's experiences through stories.

Another type of aberration is a biological abnormality where a biological event that is outside of what is considered normal or what the individual is used to, occurs. Another way we can differentiate between the two is that social abnormality has more psychological side effects and a biological aberration may either be a one-time event or the symptom indicating the body has changed. When women were worried about judgement or wasn't sure who to turn to for advice about a biological abnormality issue, they turned to the internet. For some, the internet has been such a saving grace that it has made the awkward avoidable. When I asked one person what she believed has been the most difficult thing about understanding what her body needs is, she shared "I think that it's awkward to talk about so if something is wrong, if I feel like something is wrong, I have to google it or talk to my mom, but now that my mom's not here, I have to call her and I can't exactly send a picture and be like is this right so I think the fact that it's still a very private part of a woman's life." It's important to note how this participant used the word "private" to indicate that this is the part of being a woman where they are expected to navigate it on their own.

How can women be lone wolves?

Sometimes, women turned to the internet to feed a curiosity that had not been fulfilled by an outside source such as a parent or schools. Susie, who identifies as bisexual said, "I definitely learned about different types of sex online because all I had been introduced to was, males should wear condoms and then when you have sex, it's just penis and vagina sex and that's out so most of my learning was from internet searches like, how do different types of people have sex. I actually didn't know there was different types of sex

besides like penis and vagina sex until basically high school internet searches. I felt very inexperienced going into college. I'm going to meet all these people and I don't really know what I'm doing." This was expected. Only 13.4% of Georgia secondary schools provide students with information about HIV, STD, or pregnancy prevention information relevant to LGBTQIA+ youth (SIECUS, 2016). In addition to the lack of information provided to Beatrice in schools, it also seems like there was a lack of societal information about LGBTQIA+ sexual health she learned passively from people and media. Mary also did not learn much about sexualities outside of heterosexuality and, thus, she also resorted to internet searches to learn more. She shared, "I had to Google, um, there's a spectrum for asexuality so you can be like a-romantic, heterometric, homoromantic, biromantic, panromantic, demiromantic, all that stuff. I googled all that. I googled, more just nitty-gritty stuff about how you can be asexual and still want to you can still have sex." In order to learn about their identities, women are left on their own to explore whom they are based on the information the internet provides.

Women also turn to the internet when the explanation they received is not adequate. In the interviewed participants, two women shared that they have an IUD and what happened after getting one. Lorraine said, "post getting the IUD. I think for a couple of months, I had, not symptoms, but aftereffects. My periods were super heavy for a while and super long and I was like, what's happening. Did they put it in wrong? Am I not suited for this? A lot of googling. Things looked weird down there. I was scared." Similarly, Beatrice shared, "I use Reddit a lot to ask questions especially after I got my IUD. I was like, okay, is this discharge normal and this and that. What else did I google? I googled, oh can you get pregnant on an IUD."

I asked one participant what she would have done if the internet did not exist and she said, “I probably would have been very confused, and I probably would have hurt myself. Definitely. Thank god for Google. I also just wouldn’t be as knowledgeable as I was at the time because I was really interested in not only my own body, but also men’s bodies because I was like 8 or something so I didn’t deal with men or anything like that, but I wanted to know like, how does this work. I got to learn so much about the reproductive system that I would not have learned until way way older like college. I think it made me smarter and made me understand a bit more and also be able to tell when the adults were bullsh*tting me when they were talking about sex.” This participant conveys what all the participants have expressed. One, that they turn to the internet such as Google for a variety of reasons such as confusion, curiosity, worry and two, that the internet helps to provide women with anxiety relief and protects them from trying something new that may be harmful.

The quantitative data also shows that the internet plays a vital role in how women learn about reproduction. The survey asked how women used the internet and indicated for the participant to select all that applies. Over half of them (54%) indicated that they signed in and cleared the search history within a day after. About 51% indicated that they completed a search using Incognito Mode, about 16% made a search while signed in and cleared the history within a month after, and 2% used guest mode. Since at least half of the participants cleared their history or went incognito mode, with the intention of keeping their question a secret, we can hypothesize that women turn to the internet when they are presented a question that they are either embarrassed by, like Susie said or not sure who to go to like Beatrice. The survey also collected data on the type of information women googled for with

a select all that applies function. The most searched topic was about the menstrual cycle at 83%, second most was birth control pills at 76%, and third most was tied between the male reproductive anatomy and birth control implants at 67%. The least searched topics was safe sex between two females at 0%, second most tied between abstinence and abortion at 10% and lastly how to prevent STDS at 40% (Figure 1). For privacy reasons and to ensure the participant did not feel discomfort, the survey did not ask participants to indicate their sexuality so it may be possible that there were no LGBTQ females that participated in the study.

In a study looking at how digital technology is being used for sexual and reproductive health, researchers found that the benefit of digital communication is that messages about sexual and reproductive health can reach a wide audience. One change that was observed is almost a double the amount of STD tests and greater contraceptive use since it can be ordered online (Barth, et al., 2002). The existence of the internet it suggests that women are expected to learn things on their own because they have the means to.

Material Discussed	Participants who did an internet search about it	Participants who did not do an internet search about it
How sexually transmitted diseases are transmitted	40	43
How to prevent STDs	33	50
Safe sex between a female* and male*	34	49

Safe sex between two females*	0	83
Birth control pills	63	20
Birth control implants	56	27
Birth control condoms	34	49
Abstinence	8	75
Abortion	8	75
State laws related to reproductive health	45	38
Federal laws related to reproductive health	44	39
Health Centers	54	29
Female reproductive anatomy	55	28
Male reproductive anatomy	56	27
Menstrual hygiene	51	32

Menstrual cycle	69	14
Breast Cancer	44	39

Table 1: Internet search topics conducted by survey participants
* Females and Males in this table refer to biological females and males.

What are girls expected to learn in schools?

In the survey, participants were asked to "select all that applies" about what types of things they learned in health education classes in their high school. As a reminder, all participants attended a public high school in Georgia. The top 3 (better wording) things students learned were about abstinence (87%), abortion (87%), and how sexually transmitted diseases are transmitted (74%). It is important to note that because of the constraints of quantitative data, while we see that 87% of girls learned about abstinence and abortion respectively, we do not know exactly what about these two topics are taught. The topics that were least learned in school were birth control implants (3.5%), health centers (3.5%), state laws related to reproductive health (5.8%). We can use qualitative data to tell the story behind these numbers. It's interesting to elaborate here that while the survey indicated that they learned about these topics, we are not entirely sure what about them. However, we can extract from the interviews what these lessons may have been like. I asked Julie what her sex education was like in high school, and she shared, "We had this one seminar, and it was like, oh, you know, you should stay abstinent and that was the end of that story. Don't have sex until you get married ... I feel like we learned about condoms in middle school, and it never got past that. I don't remember ever like high school was more like when you get into a relationship, you should be more careful like, okay great, that was

the end of that story." She also took summer PE and said, "When we had summer PE, it was for 5 or 6 hours, and it was only for 3 weeks which is why it was so terrible. Half of the time, it wasn't even PE. It was a health book, it was like cheating, but it wasn't cheating because you were allowed to use the book on the test and every day, we would have a test and you could use your book for it because no one actually reads the book because people don't have time to read the book…if it was a question on the test, I read it and if it wasn't I didn't read it. That's how they did it at my school… It was an old ass textbook…The book was that old that it was wrong in the book and they were like, for this section, don't read the book, we'll just show you some PowerPoint type sh*t and y'all can test on it but don't listen to the book because the book is incorrect…They knew it was incorrect but nobody wants to go through the effort of, if somebody wants to read it, let me fix it, no like it's okay. It's good enough." With the same outrage and tone, Julie's experience was shared by Mary. She said, "9th grade, I started to realize, [sex education classes] are just really repetitive because I remember being in the nurse's office in high school and just looking around, glancing, and seeing pamphlets and I was like, how interesting. I had gotten to the point where I was like, this is weird, why don't we talk about this stuff? … I've always felt like it was useless. It became useless. I always have thought that as we got older, it should have gotten more explicit. They really should have gotten more explicit, but they didn't. they were just doing the same thing. It would've made sense by the time they got to high school, that's when they were really talking about how people of the same sex can have sex, how they can have safe sex, how there are other forms of birth control, all that stuff." Both answers also entailed several sighs out of frustration that something so logical to them was not shared by their teachers and those in higher positions at schools.

These two incidences demonstrate how many students in the interviews indicated that they felt their school education was lacking. A deeper dive into Georgia sex education curriculum history and development offered explanations and challenges to what many of the participants shared. In 2019, representative Jasmine Clark introduced House Bill 133 which would require schools to teach a medically accurate sex education and HIV/AIDS prevention, however this failed to pass in the state house. This is important to note because even though Georgia schools are required to teach sex education and AIDS prevention, it was not required to be medically accurate (SIECUS, 2016). It appears to be that by telling their students to skip a part of the textbook, Julie's teachers did more than they are required to on paper. It's important to note that the state sex education policies do not require schools to provide instruction on consent, but they do require schools to provide accurate information about sexual assault and sexual violence. One participant shared that she wishes her peers as well as herself learned more about consent. She says, "consent is a huge thing, especially in America, we have really bad … rape type stuff. It's fine if you're having safe sex, but you're raping someone? That's gross. That's absolutely unacceptable and you have to be put into jail, so we need to inform everyone about all the different branches of reproductive health. Kids need to be taught this so that when they become adults, they do not do stupid stuff that could hurt people." Rebecca's comment exemplifies how there does not seem to be a large enough emphasis on preventing people from being victims and perpetrators of violence. As of right now, there are two bills in the Georgia house pending for approval. One is the House Bill 54 which would require sex education to include information on the risk and benefits associated with tampons, and the other is House Bill 195 which requires sex education to be medically accurate.

Material Discussed	Participants who learned about it in school	Participants who did not learn about it in school
How sexually transmitted diseases are transmitted	64	22
How to prevent STDs	55	31
Safe sex between a female* and male*	53	33
Safe sex between two females*	2	84
Birth control pills	7	79
Birth control implants	3	83
Birth control condoms	44	42
Abstinence	75	11
Abortion	75	11
State laws related to reproductive health	5	81
Federal laws related to reproductive health	4	82

Health Centers	3	83
Female reproductive anatomy	61	25
Male reproductive anatomy	62	24
Menstrual hygiene	35	51
Menstrual cycle	15	71
Breast Cancer	11	75

Table 2. Proportion of students who learned the following topics in schools
* Females and Males in this table refer to biological females and males.

The Center of Disease Control (CDC) has listed 20 specific sexual health topics that are necessary for students to take care of themselves (Brener, et al., 2019). Some of these include how HIV and STDs are transmitted, methods of contraception other than condoms, sexual orientation, preventive care necessary to maintain reproductive and sexual health and many more. It was found from SIECUS that 19% of Georgia middle schools taught students all 20 critical sexual health topics and 33% of Georgia high schools taught all 20 health topics. Similarly, in the CDC analysis of Georgia sex education, they noted 4 things that are not included in law (CDC, 2017). One, "curriculum follows federal or national standards, guidelines, and/or recommendations," two, "curriculum is delivered by trained instructors," three, "curriculum is medically accurate," and lastly, "instruction is sequential across grade levels." The last observation was also noted by Mary when she expressed,

with her hands moving with her breath in an exasperated sigh, how she wished the health education curriculum at school were additive.

I was given the chance to speak to a public high school principal of an Atlanta public school to get an understanding of what things on the administrative end looked like. She was kind enough to direct me to the Georgia Department of Education's website where the curriculum is listed. The Georgia Standards is a list of educational checkpoints across all topics, math, social studies, science, English, and health education. The Georgia standards for health education regarding sexual and reproductive health are as follows. Here are snapshots taken straight from the Health Education High School (HEHS) Standards.

HEHS.1.i	Discuss the potential unintended consequences of sexual activity on personal health and well-being. See O.C.G.A 20-2-143.	Example • Physical • Mental • Social • Legal • Financial consequences

HEHS.1.o	Analyze the concept of consent to include a person's right of refusal to participate in undesired activities (drug use, bullying, sexual activity, criminal activity) and that such solicitation should be reported to a trusted adult. (See O.C.G.A 20-2-143 and O.C.G.A 16-6-3)	Example • Consent is a clearly communicated agreement • Consent is not assumed by appearance, body language, previous behavior, or silence • Sexual assault should be reported to a trusted adult or authority • Current Georgia code, the year 2020, sets the legal age of consent as related to sexual acts at 16 (O.C.G.A 16-6-3)
HEHS.5h	Justify the reasons for remaining sexually abstinent. See O.C.G.A 20-2-143; CODE IDB 160-4-2-.12	Example • Discuss the reason(s) abstinence from sexual activity is an effective method of preventing acquired immune deficiency syndrome and the only sure method of preventing pregnancy and sexually transmitted diseases. • Analyze the risks and consequences of early sexual involvement.

Fig. 1: Health education standards set by the Georgia Department of Education

As shown above, the Georgia Department of Education has made it clear that lessons on consent should be taught but based on the experiences of the interviews and the responses of the participants, this is not practiced. In alignment with Rebecca's and many others' experience, there seems to be an emphasis on abstinence and almost a fear mongering surrounding sex as noted by some participants. I was not able to find any guidelines for teaching students specifically about the menstrual cycle or how to take care of a woman's reproductive body. By looking at the curriculum and the legislations in place for sex education, we can turn to the theory of Environmentally Responsible Behavior to understand girls why girls turn to the internet and other sources for accurate and thorough information. ERB theory starts with knowledge which then move to attitudes, then

personal responsibility, then intention of acting, and lastly, environmentally responsible behavior (Akintunde, 2017). This put into the context of reproductive health for girls can be interpreted as, first girls need to acquire knowledge about their bodies which they do so through internet searches and whispered conversations. Next, based on their attitude towards the information about reproductive health practices such as using a tampon over a pad, the individual creates an intent to act on the knowledge. Last, if the action proves to be beneficial to the individual's life, she may adopt this behavior until additional knowledge is obtained.

Some schools are implementing a variety of initiatives to aim to change the type of education that students receive about their bodies. For the past 10 years, sex education was taught at the middle school level so that students can enter high school with a health credit under their belt, but over time, they realized that the information being taught in health classes are more appropriate for high school students than middle school students. In addition to answering questions about the curriculum, I also asked the principal if she could share details about how her school is formatted. She shared that at her school, the teachers who will be teaching the health curriculum will be the Physical Education teachers, but the science teachers are also certified to teach the course. It seems that at her school, she has taken the initiative to ensure that the curriculum is taught by a certified individual despite there being no legal requirement for this. She also shared that at her school, thanks to a senior project, the school is stocked with free pads and tampons for students to use. They receive donations from parents to keep this initiative going because the school itself is unable to due to costs. One last thing she shared with me about the

format of the school is that words of affirmation written on post-its line the bathroom mirror of the girls' restrooms.

Are women lone wolves because the health information they receive insufficient?

When women are confused, it's often because an explanation they received from an outside source was insufficient. These sources are usually a parent, schools, healthcare professionals, or from a friend. There is a wide-spread belief that the task of educating individual girls about their bodies rests squarely on the responsibility of school systems, but in reality, girls use a variety of sources as integral to providing information about their bodies. While schools have breadth, they don't have depth. Other sources of information such as the internet and older women can provide more depth.

A handful of interviews revealed close relationships between the participant and their mothers who are their go to people when they have a concern. Others, who are not as openly expressive about their reproductive health concerns to their mothers shared that while they know they can ask and they know that it would not be a big deal to ask, they still felt like it is awkward. As shown in Figure 2, in the 79 households where a mother is present, 69 of them discussed with their mothers about their reproductive bodies (79.74%). As for other family members, in the 73 households where a father was present, only 18 of them talked to their fathers about their health (24.66%). In the 35 households where a sister is present, 23 talked to their sisters (65.71%) and as for the 42 participants who has brothers at home, only 5 had discussions about their reproductive bodies with them (11.9%). In the interviews, I looked for reasons why someone might not speak to a male family member about this part of their lives and many of them responded, that they

didn't need to if they can go to their mothers. They also shared that if it came down to it, they would turn to their fathers. For example, Virginia shared that when she got her period for the first time, she called for her mother, however, when her sister got her period, she called for her dad. She said "I think he was the only one home when my sister started her period so. When I started, my mom was home, and I yelled for her… I'm sure if I'm home she would have called for me."

While 79.74% participants with mothers at home spoke to their mothers about their bodies, I wanted to investigate why this rate wasn't closer to 100. It seems like while women know that their mothers are repertoires of information and have likely experienced what they are right now, they still hesitate to turn to them. I investigated for a reason why and it returns to the idea that women fear being stigmatized. When one participant was diagnosed with STD, she said that her boyfriend was very nonjudgmental of what she was going through. She said, "With the way, he had responded to it, I had been told that everyone else would respond completely opposite. Even with my mom, she was telling me that. It was a lot because when she found out I wasn't a virgin, that's the reason why she found out because I was having symptoms that I needed to go to the doctor." One thing that surprised me from the survey data is that over twice as many people do not talk to their siblings as people who do. Based on my observations from the interview data, it appears that girls who are close to their siblings are more likely to talk to them about their reproductive health compared to those who are not close in age. Those who are not as close to their siblings were more likely to turn to their friends.

Family member	Number of participants

Mother	
Present	79
Discussed	69
Not Discussed	13
Absent	3
Father	
Present	73
Discussed	18
Not Discussed	64
Absent	8
Sister	
Present	35
Discussed	23
Not Discussed	59
Absent	23
Brother	
Present	42
Discussed	5
Not Discussed	77
Absent	37

Table 3. Family make-up of participants and if they discussed about reproductive health with them

Overall, due to stigma, an introductory knowledge, and sometimes even an absence of knowledge, women have no choice but to be lone wolves and fill in the gaps themselves. As the interviewees reflected on how they came to realize different things about their bodies, they expressed feeling like a lone wolf. This feeling of isolation is due to a myriad of factors that stem from how their environment teaches and silences conversations about women's reproductive health. Behavior that keeps reproductive health topics private and refrains girls from asking specific questions seems to be promoted through the stigmatization of reproductive health. Moreover, from the few formal conversations and settings they do learn about their bodies, they information they receive is inadequate, introductory, and sometimes even inaccurate. In the next chapter, we will look at how women are also social creatures.

CHAPTER TWO: WOMEN ARE SOCIAL ANIMALS

The previous chapter looked at how women are lone wolves in understanding reproductive health because of external factors such as the information they learn from parents, the material that are taught in schools, and the resources that they have access to from-healthcare providers. However, this is not always the case. College-aged women are also social animals, especially when it comes to talking with friends or other people their age. These social connections were present within the methodologies of the study because as a college student who identifies as a woman, I was able to use my experiences and imagine the stories shared during the interview. This allowed for me to connect with the interviewers and express that I've had similar experiences. Collaboration and relationships are what separate the human species from the Great apes. Through language, facial recognition and the development of social structures, the human advantage over other species in the Earth kingdom is our ability to work together and share knowledge. Women are lone wolves in many ways especially at the beginning of their reproductive health journey, but as they get accustomed to what is happening to them, they begin to find the confidence in themselves to open up. Women are social beings and give and receive advice to and from women around them.

The development of language led to the rise of storytelling and the transfer of knowledge. All the participants mentioned that they talked to a friend before about events that happened in their body because of puberty or questions they had. In social science research, there is a negative correlation between stigma and conversations. One study found that a person who lives in a community with a 20% or higher divorce rate has a lower risk of suicide despite divorce being a risk factor for suicide. This is because the person is surrounded by other people who

are like themselves (Pescasolido, 2019). In the context of reproductive health, the interviews in this study found that as people talked more about their reproductive bodies, over time, they started to destigmatize and even criticize the ideas many people have about reproductive health. When women start talking about their bodies openly, they seem to criticize and fault their bodies less for things like "bad discharge," "leaking," among other things. Women begin to feel at ease over the similarities of their experience with other people and the differences, are different – not in a worrisome way, but just different. The survey revealed the 3 most talked about topics between participants and their friends are birth control pills (88.16%), menstrual hygiene (88.16%), health centers (73.68%), and thirdly, tied between sex between a female and male, female reproductive anatomy, and the menstrual cycle at 71.08%. The three topics that are least talked about among the survey participants are tied between abstinence and abortion (36.84%), second, safe sex between two females (39.47%), and breast cancer (42.1%). The context these topics were talked about was not collected so it is uncertain if participants were talking about these topics in reference to their own bodies or in relation to the greater society. Overall, at least 50% of survey participants discussed with their friends about nearly every topic related to reproductive health. The only topics that saw a less than 50% discussion rate in the survey are safe sex between two biological females, abstinence, abortion, and breast cancer (Table 4). The high rate of conversation about birth control pills, implants, and condoms may have contributed to a 36.84% of participants having conversations about abstinence and abortion. Lastly, since the average age women in the US are diagnosed with breast cancer is 63 years old, (Susan G. Komen), it is not surprising that less than 50% of women talked to their friends about breast cancer (42%).

Material Discussed	Participants who discussed with friend	Participants who did not discuss with friends

How sexually transmitted diseases are transmitted	46	30
How to prevent STDs	38	38
Safe sex between a female* and male*	54	22
Safe sex between two females*	30	46
Birth control pills	67	9
Birth control implants	61	15
Birth control condoms	54	22
Abstinence	28	48
Abortion	28	48
State laws related to reproductive health	45	31
Federal laws related to reproductive health	41	35
Health Centers	56	20
Female reproductive anatomy	54	22
Male reproductive anatomy	54	22
Menstrual hygiene	67	9
Menstrual cycle	54	22
Breast Cancer	32	44

Table 4. Survey results of topics participants talk to their friends about
*biological female and biological male

Conversations with friends begin to occur in high school where girls open up more about their sexual health experiences with more people. It is uncertain if this is a result of girls getting older, but stigma seems to be removed as people get older and know more people who share their experiences. I asked Julie if she feels like talking about reproductive health has gotten easier since middle and high school and she shared, “yeah, I think also that the fact that you have more friends that you can talk about it and everybody’s kind of at that stage in life. I think in the middle school era, some people are there, some people aren’t there yet and so you can’t talk to every single person because they’ll be like those two people that have no clue what you’re

talking about. I think when you enter high school and college, everyone is in that same boat and so there isn't that shame where someone doesn't know what you're talking about. Everyone's kind of in that same boat and we're all going through it like, what the heck, we'll just talk about it, and I think that changes drastically even more in college. Everyone's living now so everyone's kind of has to talk about it, so I think it's definitely been easier to talk about since that moved on and I think TV commercials and stuff. I think they just made it more open and the world in general. It's not the fact that we grew older, but it's because the world's more accepting of it." Here, Julie describes the individual growth people experience in reference to their social environment and credits the change in how open people are to media like commercials. She also labels the "people who aren't there yet," or those who have not started their periods yet as sources of discomfort. Since talking about periods with people who do not know much about them makes a conversation awkward, this may be the reason why nearly all the interviewees expressed how it is much easier to talk to a girl than it is to talk to a guy, even if it is their fathers and brothers, about periods.

Deciding who to talk to periods about requires a high level of cognition that is commonly used in public health models such as the social cognitive theory model. The social cognitive theory takes into account personal cognitive factors such as the ability for women to analyze their experiences with periods, and socioenvironmental factors like the normative beliefs and social support surrounding periods to predict human health behaviors. When I asked Virginia when the first time, she told someone she is on her period was, she said, "It was very possibly not until high school. We realized it was dumb to hide it so probably the first time, if I had to give you an exact time was … when I needed a pad, so I asked someone for one, but I didn't go up to someone and say, 'I'm on my period.' It was more like *whispers* 'Do you have

a pad?' I started being aware of other people having their periods in middle school, but I don't think I really talked about it with anybody until at least high school." Both quotes indicate that women wait until they know that the person, they are conversing with likely has a similar experience before bringing up the stigmatized event to lower the risk of stigma. Women calculate the risk of stigma before sharing an experience and even as they are sharing an experience, there is a small fear that there will be judgement. As the interviewees opened up about a topic that is relevant to them, but also so heavily stigmatized, they are considering their ability to be vulnerable and what the person who they are sharing may think of them. Interviewees also had to decide during the interview which aspects of their reproductive health experience they were comfortable sharing with me. According to this model, the way the participants made the decision to share something was first deciding if they, themselves, were ready to be vulnerable and second trying to figure out if I would place judgement on them if they shared something.

When girls first start to talk about reproductive health topics and share their experiences, it seems to usually take place in the girls' bathroom at school. One person said, "girls, obviously when we're together, we would talk about it in the bathroom so yeah, they told me about it and we would share our differences and flow and you know, give each other pads and things like that." The role of the bathroom in the early stages of a girl's reproductive health journey is a breeding ground for conversation and it seems like there is a magic in girl's bathrooms that makes girls forget about the stigma outside of the bathroom door and ask people for pads with no fear of judgement. The girl's bathroom is a place of gathering, a place of no judgement, and a place where vulnerability is welcomed. Rebecca said, "I remember one time we were talking about periods, and she said sometimes, she has to, like after showering, she has to rinse

out all the clots in the tub, and I was like, I never thought that somebody else had to do that. When I was younger, I had a lot of clots in the tub, and I thought it was so weird and so crazy and I thought that I was like the only person to who that happened to and she was telling me about that and it made me feel so, I don't know, just so comfortable." The conversation between Rebecca and her friend occurred because her friend trusted her enough to share something personal and there may have been a part of her that was looking for reassurance that she is not weird for having clots. The benefits both Rebecca and her friend received is reassurance knowing that their experiences are not an abnormal which as a young girl, it sounds like Rebecca needed since she felt comfortable with this side of her after the conversation happened. It has been noted that during middle childhood, boys and girls of each culture form their own subcultures (Konner, 2010). It appears that during the time menarche begins to form, a sub-culture within girlhood temporarily exists. Since menarche begins at different ages for girls, those who have started their periods, such as Rebecca and her friend, form their own culture and those who have not yet started their periods form another group. Eventually, as everyone gets starts menstruation, this sub-culture disappears.

Talking about worries regarding reproductive health on a personal level is much easier said than done, but it is important that those interacting with young girls entering puberty find ways to encourage conversation because having social groups helps to increase confidence, impacting development. The Bronfenbrenner's Model of Human Development suggests that the fit between a person and the environment is based on 4 systems, the microsystem which is the immediate environment a person is in, the mesosystem which is the interaction of two microsystem environments, the exosystem which are environments that do not directly involve the individual but still affects her, and the macrosystem which is the larger cultural context

including culture values and expectations (DiClemente et al., 2019). Creating changes on the exosystem and macrosystem is difficult on a day-to-day scale, but girls set up microsystems and mesosystems every day everywhere they go. Many girls begin puberty in late elementary school or middle school which aligns with the years that girls need a great amount of social support. In 2018, the Confidence Code for Girls found that between the ages 8 and 14, confidence levels fall by 30% (Hough, 2019). A professor at Harvard surveyed 400,000 students in California found that self confidence among girls lags in 6th grade and only begins to increase starting from high school (Hough, 2019). There are many factors that could explain the delayed increase in confidence among girls until high school. Based on this study, one factor may be that girls in middle school are not yet comfortable talking about their changing body with their peers which lead to low self-confidence. As girls start high school and become more comfortable talking about themselves, they find out that they are not alone which fulfills a social need and builds confidence.

Social networks can play a huge role in protecting individuals against poor mental health and physical health because they play many functions including, but not limited to, social capital, social influence, companionship, and social support. Social capital includes bonding, which is related to trust, reciprocity and belonging and bridging between groups which gives greater access to public goods and services to girls. Regarding reproductive health, the importance of social capital is most clear when girls first talk to someone about something they are worried about because reassuring comments from the listener gives girls assure them that they still belong. Social support includes emotional support like empathy and love, instrumental support like tangible aid and services, informational support like advice and suggestions, and appraisal support like constructive feedback. In many of the interviews, it

was revealed that girls receive a lot of social support when they confide in someone about what is happening to their bodies. Some like Virginia received advice that improved their lives such as the advice she received to skip the placebo pills in the birth control pack where "instead of getting 3 packs in 3 months, I get 4 packs in 3 months and [she] highly recommend it. [She] like[s] not having a period" who she heard from her best friend. Others like Morgan who confided in her girlfriend the UTI symptoms she was experiencing received some advice on medication to help with that, and some like Rebecca received empathy from her boyfriend when she told him that she has an STI.

In addition to seeking for acceptance and people to relate to, girls look for social groups to learn with and to learn from. Social groups are a source of enculturation for girls. Enculturation is defined by Sandler to be *"*the process through which the individual acquires the culture of his group, class, segment, or society … the transmission of culture by cultural agents such as parents and teachers or the assimilation of it by the individual*"* (Shimahara, 1970). It's important to note that while both socialization and enculturation occur throughout a female's lifetime, but to socialize with her peers when it comes to reproductive health, a female must be encultured first. In this case, the enculturation includes getting a period and experiencing other puberty events that is typical for biological females. For example, Virginia shares that she learned from her friend to not wear white pants on her period. I asked her she became aware of what to wear and what not to wear on her period and she said, "definitely my friends helped me out especially going into high school. I didn't really care about fashion in middle school because whatever my mom bought me, I would wear, but in high school, it was definitely, don't wear white jeans. Don't really wear skirts. It was these rules of things not to wear. Don't wear things that make you feel uncomfortable kind of thing

so definitely talking with my friends and kind of internet searches too because I'm trying to figure out what materials are more susceptible to certain things." Julie did not get the same experience and had to learn about the rule of white bottoms through personal experience. She said "I think also the traumatic memories that stay with you like, I still remember wearing a white dress on my birthday in middle school and clearly I did not know my period was going to come, but it did, and my white dress turned red real quickly and I had to go home on my birthday. And I had to call my mom and be like, you have to pick me up like right now, right now…I was in a class, and nobody told me. Obviously, you can see red on white, but I had to go to the bathroom and be like, shoot cause nobody was like, 'hey you should go home or to the bathroom or something.'" As shown, Julie is disappointed in her classmates for not helping her out and suggesting that she visits the bathroom.

Conversations with friends are beneficial because sometimes girls are not exactly sure the types of questions they have or what exactly it is that they are confused about. Referring to a quote mentioned previously, Morgan mentioned some of the UTI symptoms to her girlfriend for reasons either because she didn't believe it was important enough to see a physician or bring it up to a parent about, she was uncomfortable talking about it to a parent, or it just happened to come up randomly during a conversation. Regardless of the reason, it was important that she shared the symptoms she was experiencing with her girlfriend, because her girlfriend was able to identify that Morgan might have a UTI and was able to help her find medication to bring her relief.

Friendships are formed through learning and growing together and with reproductive health, it is no difference. Julie learned how to put on a tampon with a friend. She said, "One day, in summer PE … it was for 5 or 6 hours, and it was only for 3 weeks which is why it was so

terrible. … We were both on our periods and we were like, well crap. Running on a track for 4 hours is kind of an issue so we were like you know, we have to figure this out, it can't be that complicated, and we had talked to some other people, and they were like, 'Oh, it makes your life so much easier.' So, in summer PE, during the health portion, we decided to watch tampon inserting videos instead of doing our readings that we were supposed to do and then we end up going to the bathroom we're like, you know what, we could probably figure this out and it was such a pain. We had no idea if we were doing it correctly or not and it just took a couple of trial and errors and people were like, 'Y'all got this, you can do it.'" It's not clear whether Julie would have decided to figure out how to use a tampon if she weren't with someone who was equally as confused as she was. It could also be possible that if she hadn't heard from other people how it makes their lives easier, she wouldn't try it for herself. Or even perhaps if she didn't have people cheering her on when she was trying to figure it out, she would not have been successful. Regardless of if it were just one of these reasons or a combination of all three, Julie had a social group to help her better care for her reproductive body.

The role of friends among the LGBTQIA+ community is the same as it is for heterosexual women, but there is a bigger focus on finding someone to relate to. Friendships about sexuality seems to focus more on providing guidance, reassurance, and education based on experience since there aren't many people that talk about it, especially not organizations and institutions like schools. I was curious about the emotional aspect of learning about sex and asked Morgan if the conversations she had navigating same-sex sex was uncomfortable in any way. She shared, "It was felt very embarrassing for me. It was like, 'Oh my gosh, you do what? You can have sex in the car? At Steak and Shake? Oh my gosh!' and she'll be like, 'yeah, and there are some fun ways to do it" and I was like, 'um, okay." Then with my girlfriend currently,

it was a very big learning curve. It felt unsuccessful for the first few times, felt awkward, felt clumsy, you know what's going on and I learned mostly through experience." Learning through experience and later getting reassurance is common. I asked Susie who shared that she felt "inexperienced" going into college if she has talked to more people about what sex feels like. She said, "yes, definitely talking to my friends. I have a lot of friends who are either pansexual or bisexual or lesbian and a few gay friends. I can't relate to my gay friends as much as my other friends, but we've definitely talked about, because I used to talk about sometimes when I have sex with men, I enjoyed it, but it was not my most favorite thing to do and it was kind of just like talking to them, like have you had similar experiences having sex, but not like truly enjoying it to your fullest potential. You were enjoying it in the moment, but you were kind of like, it wasn't the greatest thing ever like you were expecting it to be, and they were kind of helpful in the fact that sometimes it could be just the sexual experience in general and not necessarily good for the person or the action itself. Talking to them and talking about their sexual experiences help me realize one bad sexual experience doesn't define your entire sexual experience so kind of basically putting yourself out there and trying to go about sex in maybe different ways and trying to think of different positions or things like that." Here, Susie expresses gratitude for having a group of friends who she can confide her concerns with and receive reassurance that her experiences are not atypical.

In addition to pleasure, there is a need for hygiene. I asked Morgan how she learned about sex hygiene for gay sex since it was not covered in school and she shared, "I had a friend who's older than me and she's gay and she had a partner at the time and she would like tell me stuff and she was like, 'Okay, some good tips are like, um, she would tell me sex tips and stuff but she didn't get into the hygiene as much. Where I got hygiene stuff, it was mostly online, I

guess. You know those little infographics you see on Instagram, um, stuff like that and I don't know, I feel like I learn online from Tik Tok now." Social media platforms such as Instagram and Tik Tok appeared multiple times throughout the interviews as well as the survey response. Some, like Daria use social media as a starting point for conversation. Daria shared, "When it comes to my sister, most of the time, we'll see things on Instagram and we'll be like, did you know this?" Morgan agreed and said that "[Instagram] normalizes things so you don't feel like an alien." This indicates that the internet is playing the role of not only sharing information that is not commonly known but is normalizing things that many women worry is their own experience. In a study conducted in Philadelphia assessing health seeking content on social media among teenagers, it was found that both high and low frequency social media users turn to social media for health information (Plaisime et al, 2020). Many participants in the study indicated that they are on social media, some more frequently than others, and all that mentioned social media indicated they had learned something on it.

In recent years, social media platforms have become much more interactive between influencers and non-influencers. Interactions between influencers and their followers are in a way a type of social relationship. Parasocial relationships, defined as the audiences' illusory social experiences with people on media (Horton and Wohl 1956), have been formed as a result of the increased social media use has affected many people. Parasocial relationships of today are different than those 20 years ago because there is a way for influencers on Tik Tok and Instagram to interact with their audiences in the comment section of their content. Parasocial relationships are formed when there is a similarity between the influencer and the follower (Lou & Kim, 2019; Yuan & Lou, 2020). The parasocial relationships described in the interviews are not as extreme as some that are out there, but the role of the ones shared is to show their

audience that they are not alone. For example, one person said that the internet and social media "normalizes things so you don't feel like an alien." Similarly, Mary said, "[It wasn't until I] got to college, when I started to feel comfortable with that. Especially love, love, love Tik Tok because [it] makes me feel seen and welcomed because I love when I hear people on Tik Tok talk about periods and stuff like that and I really thought it was just me but there are thousands of people in the comments, it's not just me. That's great, it makes me feel so happy." Here, the relationship Mary describes is a semi-parasocial relationship because she feels connected with people who she hasn't met before, but unlike fully parasocial relationships, she is not actively following the people commenting or the creator of the post.

While there are many relationships formed between peers, especially at the college level to improve their reproductive health knowledge and confidence, there are many important social relationships formed between a female adult, such as a mother and the daughter. Human culture is unique because of the ratchet effect where there are modifications to culture over time as information is passed from generation to generation. Cooperation is what makes humans unique because it is a source of cultural transmission. Teaching is important for cultural conventions. In a study comparing how human children and chimpanzees learn, it was found that the cultural adaptation of humans has three processes that aren't found in other primates which are teaching, social imitation, and normativity (Tennie et. al, 2009). The idea that culture can be spread between generations and can be built over time is called the ratchet effect (Tennie et. al, 2009). Children learn from their parents how to act in different situations so that they can conform to the expectations that society has set up for them. This includes things like passing as a non-menstruating women or skills like removing blood stains as Mary's mother did for her. She shares, "My mom did show me how to wash off blood from my underwear."

When specific cultures are brought into ratchet effects, individuals have the choice to decide which parts of the culture they would like to keep. For example, Julie shares that her family drinks a lot of cranberry juice as a preventive effort for many reproductive health related problems such as UTIs. Julie has kept this knowledge; however, she drinks it after she gets a UTI to solve the problem. Cranberry has been a centuries long health aid for reproductive health for women, so it is interesting to think about how the ratchet effect has carried this knowledge through time and space and how individuals like Julie are taking this knowledge and making it work for their bodies.

Human species and many mammalian groups thrive because they evolved to rely on social groups to protect themselves and share resources. When it comes to reproductive health, women are no different. They turn to women with more experience than themselves for help and they acquire new knowledge with their peers. Throughout all the interviews it was seen that when women are talking amongst their friends, they are speaking as equals, and they are learning from each other and supporting one another. With the social cognitive theory in mind, it appears that it is difficult to find the confidence to talk about reproductive health experiences with older women and professionals because women are not sure how these individuals will react to their questions. Studies over the past couple of decades have indicated how physical maturation is a source of stress and how social support acts as a buffer to stress. The principal effect model suggests that social resources are helpful independent of the situation because they provide people with positive affect, sense of predictability, and acknowledge the individual's self-worth (Camara et al, 2014). The findings in this article support this model because many of the women shared a time when they opened up to a friend about an experience their friend did not also share or vice versa. In line with the principal effect model, women were

comfortable sharing something they knew might not be reciprocated because they predicted that they would get a positive response and be reassured. At different stages of a girl's life, there are new phenomena and women turn to their friends to help them get through it. Part of enculturation is innovation and the widespread use of it. In the next chapter, we well go into further how women learn how to adapt in new situation as different life events are thrown her way.

CHAPTER THREE: WOMEN ARE ADAPTIVE

"It is not the strongest of the species that survives, nor the most intelligent; it is the one most adaptable to change." – Charles Darwin

Our world is full of solutions, but at the same time it is also filled with issues. Sometimes the source of an issue can't be changed such as the genes coding for breast cancer, but some issues sprout from individual behaviors. In other words, the diagnoses of breast cancer can't be prevented because the root cause is biological, but the problem of women suffering from trauma after having their breasts removed is because of societal meanings attached to breasts. Since women cannot resolve the issue, they have no choice but to adapt to survive with the challenges that life throws at them. Adaptation is done through the process of assimilation and accommodation (Huitt & Hummel, 2003). Assimilation being understanding the environment to fit cognitive structures and accommodation being the process of changing cognitive structures to accept something from the environment. Women use a mix of assimilation and accommodation to find where and how they fit into their environments.

Adaptation through absorbing the environment passively both negatively and positively

Margaret Mead's works touch on the study of enculturation and socialization. Enculturation being "the process of learning a culture in all its uniqueness and particularity" and socialization being "the set of species wide requirements and exactions made on human beings by human societies." In the interviews, it was found that part of socialization involved absorbing these requirements in the world passively. This appeared

to influence how women wanted to portray themselves in order to fit into society. Take for example, Beatrice, a college freshman who was recapping the time she was first starting to shave. Through seeing a lack of hair on women in media and in people around her, it seems like Beatrice felt that in her society and in order to fit in to the label of "women," she too also had to be hairless. She says, "I think, there was this one time I remember, and it was picture day. My mom bought me this one shirt that didn't have like, basically, you have to shave for, and I remember I didn't, and I remember standing in line so embarrassed because I didn't want to raise my hand and so that day, I told my mom, if I could shave. She didn't let me do it, she had to do it herself." This was in 5th grade and prior to this incident, Beatrice had absorbed her environment enough to label this particular shirt as a shirt that she needed to alter her body to wear. To feel a part of her society, she felt that she needed to replicate that look, in this case a hairless look, in order to fit in and portray herself as a woman.

The impact of socialization was not just limited to grooming behavior. The desire to fit into the society was also observed as people were exploring their sexualities. When Susie was asked about her sexuality, she said, "I knew I was bisexual in high school, and I didn't really know how to put a label on it. I didn't come out with a label until within the last year so like college. I definitely learned about different types of sex online because all I had been introduced to was, males should wear condoms and then when you have sex, it's just penis and vagina sex and that's out so most of my learning was from internet searches like, how do different types of people have sex. I actually didn't know there was different types of sex besides penis and vagina sex until basically like high school internet searches. I felt very inexperienced going into college. I'm going to meet all these people and I don't

really know what I'm doing." Susie had grown up surrounded mainly by heterosexuality through looking at her own parents, consuming mixed media, and direct communication from her public school. Some anthropologists suggest "it is through socialization … that children … learn how to do gender in interaction and how to avoid sanctions for doing it" (West & Zimmerman, 1987). Part of reproductive knowledge is having the vocabulary to express what is happening to an individual's body, but because in the state of Georgia heterosexuality demands to be the norm by religious, traditional, or even perhaps political forces, women need to adapt and start to look on their own for resources to help them.

These two examples demonstrate the negative impacts with passive learning, but socialization is not always bad. Some young girls learn what to expect for puberty before they even begin it from older individuals. This includes seeing a box of tampons in the bathroom or seeing a mother's bra in the laundry. One participant said, "I started the summer before 5th grade. Since I have an older sister, it wasn't a foreign concept to me because she's 5 years older than me, so I like, saw her like have her period and like tampons and pads were a very familiar household sight so I knew where they were and that stuff. When I got it, I still remember, we were on our way to go somewhere and all a suddenly I was bleeding out of my vagina, and I wasn't freaking out." Mary made it clear that she was not "freaking out" because of previous exposure to what to expect. She was able to accommodate to the situation because she had previous knowledge to build on. It can be argued that it may have just been Mary's personality that resulted in a calm reaction and that may be part of it, but the other findings in the study shows that having exposure to events like a period help soften the shock of the initial experience.

This experience is contrary to another participant, Julie, who had no previous knowledge to build on. When she got her period for the first time, she said, "It was the summer of my 5th grade and I remember because that was kind of a very big thing for me and I remember it was the 4th of July when I first had my cycle and it was kind of a mess because I was not expecting it and I was hyperventilating and fireworks were going on and I kind of lost my mind. *laughter* It makes it very memorable." When I asked if she had been told anything about it, she expressed that while she was given a vague idea, she was never told explicitly about what was going to happen.

Socialization does not only come from older women. It can also come from general surroundings. It also comes from events like shopping or watching media. Morgan shared that she currently uses a menstrual cup when she is on her period, and I asked how she learned about it and how she made that decision. Morgan said, "I think maybe a year or two ago. I was in a store, and I was like, 'well, I use so many tampons and it's a hassle. Maybe I should get a diva cup because it's reusable and it's like fine if you clean it well. It works very well.' They have written stuff on the box about it – how it works, and I thought it was cool, so I got it and I was really excited, and it's been really helpful, better than other products… Maybe it was high school on social media or something. Maybe I saw it on Snapchat. I didn't have any friends who had them or anything." Another participant, Colleen shared that she had bought a vagina product because she had learned about it on Instagram and wanted to support a small Black owned business. Women take their surroundings and try to apply it to their lives if they deem it to be relevant. By doing so, they then also become an individual who can socialize other individuals into behaving a certain way or using particular products.

As women see more formal conversations and depictions of reproductive health products related to menstruation, contraceptives, cramps, and other products related to women's health, they begin to believe that the only way for society to progress is in the direction were talking about reproductive processes is no longer stigmatized; a future where talking about heavy periods evokes the same concern as talking about a migraine. There was one participant who showed optimism about the effects of period product advertisements on stigma such that greater exposure to these advertisements leads to less stigmatization. Julie said "Everyone's kind of has to talk about it, so I think it's definitely been easier to talk about since that moved on and I think even TV commercials and stuff. I think they just made it more open and the world in general. It's not the fact that we grew older, but it's because the world is more accepting of it and I think that's a big thing like you know, you see birth control ads, you see pad ads all the time, tampons so I think all that made such a difference in generation, make it more easier to talk about." Conversations about periods have changed significantly. In the 1950s, period products such as pads were sold in plain, white packaging on the bottom shelf (Freidenfeld, 2009). The reason for this was so that women could be discreet about what they were carrying. Today, there are aisles full of menstrual products, each with informative labels and colorful packaging, indicating that times have changed.

Adapting to get through the day

In our lives, we pick up patterns and use these patterns. Take for instance, the bus schedule. The bus comes at 7:23am every morning and once this pattern is realized, a person who has a 5-minute walk to the bus leaves can leave her home at 7:15am instead of

7am like she previously has been doing. For college women who have been experiencing puberty since they were tweens or teens, the reproductive health patterns come from themselves. Women use these patterns to predict what will happen and prepare for it. For example, Julie experiences heavy periods. She shares, "I also had period jeans. I wore them on my period because I know, it was kind of like the new period pants, but it wasn't called that. It was thick enough where if you leak a little bit, it would absorb it or it was dark enough where you wouldn't see it. I used to wear those specifically because I was like if anything happened these pants have me covered s that was my thing. Whenever we had those long tests like those 2, 3-hour ones, I used to be like, oh, that, I can use my pants today. They were saved for my period occasion, and I still use period panties, but they're like less, but like that was all my methods. I used to figure out new ways. I remember figuring out one day that if you put another underwear under your under one, and then you put another pad on that one, so like instead of putting 2 pads on the same underwear, wear a second underwear with another pad, it helps prevent it more. It was always like what new method can I try now because in middle school, I had missed 3 years so come high school, I tried to like limit that a little bit so it was always like to figure out the newest mechanism to help me so it was just always, such an adventure, like a game, like how can I do this by myself." Julie's reproductive health patterns include having heavy periods for the first couple of days, noticing that her school bathrooms did not stock tampons and pads, and realizing that she was missing a week's worth of morning classes once a month in middle school. To adopt to these patterns, Julie added clothing to her item that would put her mind at ease about leaking periods, doubled up on menstrual products when she was on a heavy day so that she would not have to miss classes. After a couple of years, Julie

began to take birth control and while that did not replace the innovations, she had formed for herself, she stated that it was still very helpful because she knew exactly when to expect her period. Julie's experience demonstrates that our world is set up for predictable bodies and puts an emphasis on planning ahead. If a menstruating body is not able to perform predictably, a personal toll is taken on the individual because they struggle to get their bodies to behave in a way that works in our world. Julie had to sacrifice 2 days of morning classes each to take care of her body because her morning teacher told her, you know this is first period like you could easily go to the bathroom before you start class. Nobody should need to go to the bathroom during class' and this "would be [her] worst time like every time." She had no choice other than to adapt and form behaviors that fit into the mold that is expected of her. Part of the need for Julie and other women to adapt is because menstrual blood is stigmatized (Johnson, 2020). In fact, some argue that menstrual blood first all 3 categories of stigma. First, "abomination of the body." Menstrual blood is viewed to be more aversive than other fluids. Second, "blemishes of individual character." Stains, such as the one Julie is describing to avoid is a blemish on her pants, but possibly on her reputation as well. Third, "tribal identities or social markers associated with marginalized groups." Nearly all women experience menstruation and must adapt to conceal this to not be blemished such as the experience Virginia's friend had in the previous chapter. This groups all women together in a tribal sort of way, creating kin. However, what makes this different than typical kin group formations are that although all the women can bond over their reproductive bodies and their experiences of womanhood, they tend to choose not to bring this topic up until much later in the relationship. Women adapt to respond to their

environment and the brain selects for behaviors that have proved to be effective in helping them pass as non-menstruating individuals.

Other participants like Virginia also found birth control to be useful because it helped make her anxiety less severe and she skipped the placebo pills every week to avoid getting her period and to regain control of her life. While birth control did help some participants, it did not help all. Rebecca's experience with birth control it made it less possible for her to read her body. She stopped taking after 3 years and believed that it was too much for her. She shares, "I didn't want to be on it for too long. I had been talking to my boyfriend for a really long time about how much I hated it, how much I didn't like how it made me feel. It was changing my flow, it was changing my symptoms, all this stuff and also because I work in the ER and I want to be a doctor, I knew the risk factor for blood clots so I was like, 'I want my natural hormones back, I want my natural cycle back' and I used to be very in tune with the moon like I would bleed every full moon and that changed with the birth control so I'm very happy I'm off of it and going back to myself… it also wasn't helping with my severe cramping or anything. It wasn't doing anything for me aside from preventing pregnancy so that wasn't enough for me at a certain point." She later shares that she is better able to read her body now that she has been off birth control.

In all the interviews, women expressed that they must balance many competing responsibilities and between school, home, and extracurricular activities, they cannot always keep track of their body patterns, so they incorporate technology to help them. Morgan brought up period tracker apps. She said, "I found information on apps stuff that

was like, 'here's a period tracker, you might want to keep track of it.' I don't think I looked so much stuff up."

Active learning and help from others

There are some patterns that college-aged women may notice but do not see the meaning behind it. Young women rely on older women and the professionals around them to point out the meaning behind patterns to them. Once they learn more about the pattern, women assimilate new information to the repertoire of knowledge they already have. Jocelyn was diagnosed with an ovarian cyst when she was 16 years old. When I asked her about how she learned information about ovarian cysts, she said, "Back then I didn't realize what an ovarian cyst is or anything about ovaries before I was diagnosed with one. I was actually diagnosed with a germline ovarian cyst which is different … I didn't know how important ovaries and women and reproductive health and stuff like that are. I'm thankful the Lord is with me at this time, and … my OB/GYNs were amazing." She also described how it was her mom and track coach who noticed her inability to lose weight despite the strenuous workout she had to do for track.

Susie was diagnosed with PCOS at age 18 or 19, but her diagnoses did not come as smoothly. I asked how her doctors knew what to look for and she responded, "I had gone to a doctor a couple of ties saying, oh my periods are irregular, and they were like, maybe you're not eating right, maybe you're blah blah blah, but it was actually [my university's] health center. I was like, my period's not regular and they're like hmm, and they ask me other symptoms and they were like oh yeah, yeah, that's you and so they took an ultrasound and some blood samples, and they were like yeah, your cysts and your

androgen levels are a little high and I was like, oh, okay, so yeah." In Susie's case, she had picked up the patterns and asked about it, but it wasn't until later that someone validated that her concerns about her patterns. She expressed that she was relieved when she received the diagnosis because it explained a lot of things. Sometimes it's not the professionals and the adults we turn to, but people our same age. Morgan had gotten a UTI and did not realize it was a UTI until her girlfriend had pointed it out to her. This demonstrates that luck seems to be a factor in reproductive health because until women come across an adult or a professional who can label our concerns, they live with these concerns.

In order to adapt, there is a lot of trial and error. After Susie was diagnosed with PCOS, she tried read into it but found that the information out there was mediocre. She said, "I don't think it's been studied a lot because they seem like they don't really know. They'll still put you on birth control and they will suggest, cause it's very different in a lot of people like I saw some recent studies, I don't know if they're super, I don't know how much they actually got out there. There was this study that looked at how PCOS or some version of it related to insulin resistance and how that also affects the androgen because of the insulin cycle. I thought this was really interesting so for a little bit, I tried to eat like in a way a diabetic would eat, trying to like to manage when my insulin was activation and I actually kickstarted my periods back." So even though Susie was trying to read as much as she can about PCOS so that she could better treat her body, there is a lack of research in women's health in general so she took the little information she could find and adapted her lifestyle to assimilate that information. Similarly, Julie's experience with consulting a physician about a UTI has led her to conclude that "There's so little information on it that and the

medicines are also, he's like, if this medicine doesn't work, just come back and we'll try this again 'cuz apparently the medicine aren't' too accurate and they don't work on everybody." Numerous studies have shown the lack of research done on women ranging from health issues like drug effects (Holdcroft, 2007) to our evolutionary history (Konner, 2011).

Adapting because of unexpected situations

While college women adapt as much as they can and do their best to attempt to prepare for anything that might come their way, sometimes they just can't. Returning to the bus metaphor, When the bus goes off the schedule and arrives late at 7:30am, there is a slight panic in the individual. This slight panic is infrequent, however with college women, this slight panic can come as often as once a month. College women spoke about techniques they have adopted and different situations they have been with a lot of pride in their voices. Growth regarding periods is knowing what works for your own body and what to do in different situations, but there is no way to know completely because sometimes periods are inconsistent and unpredictable. While unpredictableness should be okay and mistakes can be forgiven, in actuality, it is not because of how our society is structure.

The way our body functions is reliant on our environmental conditions. Stress, experienced by all college women influences the body's natural cycles/patterns. Mary shares, "My period is wack. I have a general idea of when it's going to come so I'll wear a pantyliner to be prepared in case it happens out of nowhere and I'm typically good at it, but as I'm getting older, stress really impacts your period. I'm getting more and more stressed. For example, I didn't get my period for the entire month of June. Now I do medications … for my anxiety and that also impacts my menstrual cycle and I think because of those, now

that I've gotten older, I can't stay on top of it because it just happens one day." Mary shows that as our environment is constantly changing and nothing is stationary, our reproductive health patterns also do not stay stationary.

Trial and error are practiced throughout a woman's lifespan as they learn about puberty, start to experience it, and learn to live with it. One thing that might work for one person might not work for another. Take for example, Julie and Morgan who both shared their experience with UTIs. Julie learned from her mother to consume a lot of cranberry juice to prevent UTIs and then taking antibiotics to 'fix' UTIs while Morgan learned from her girlfriend to take over the counter the counter medication to stop the UTI from bothering her. Women's reproductive health falls on a spectrum and college-aged women must learn where they fall along this spectrum to better care for their bodies and pick and choose which advice and products to use. Women spend the entirety of their reproductive health experience learning about the information that is exists, the behaviors that exist, and adjust it to fit their own bodies. Towards the end of high school and into college, women have for the most part figured out what works for their bodies. Whether it is passing as a non-menstruating individual or getting rid of UT's, college-aged women are now also able to give advice based on what they've experienced and form bonds with other over shared struggles and create a new kinship group for themselves as they step even further outside the familiarity of home. As undergraduate college women receive their bachelors and go into the next stage of their lives, they will continue to adapt because as you'll see from the next chapter, women are living in a world created for men.

CHAPTER FOUR: WHAT IS WOMANHOOD?

"I don't think it was an overnight type of thing. I think definitely growing into myself through college and understanding myself and like growing up a lot more, I would say that it probably happened through college. I would definitely consider myself an adult, a woman at this point."
– Lorraine, college graduate

Womanhood has no standard definition across time, society, and place, yet it defines the experiences women have. Womanhood today is different from womanhood a decade ago because as people change, so do the definitions and as definitions change, so do values, and as values change so do actions, policies, and stigma leading to changes of college-aged women today compared to when their mothers were college-aged females. This study focused primarily on college cis females because they are defining what the next meaning of womanhood is. Many people mark the transition from *girl* to *woman* to be the moment they get their period because they become reproductively available, however it is much more complicated. First, the question of if people are born into womanhood or if you become a woman needs to be addressed. Simone de Beauvior famously said, "one is not born, but rather becomes a woman" indicating that womanhood is not predetermined when you are born. It is something that must be achieved through experiences and an internal feeling. Sojourner Truth famously came out with her piece, *Ain't I a Woman* in 1851 where she expressed frustration at the racial divide between White women and Black women by pointing out the physical and generational attributes of intersectional womanhood. She says, "That man over there says that women need to be helped into carriages, and lifted over ditches, and to have the best place everywhere. Nobody ever helps me into carriages, or over mud-puddles, or gives me any best place! And ain't I a

woman? Look at me! Look at my arm! I have ploughed and planted, and gathered into barns, and no man could head me! And ain't I a woman? I could work as much and eat as much as a man – when I could get it – and bear the lash as well! And ain't I a woman? I have borne thirteen children, and seen most all sold off to slavery, and when I cried out with my mother's grief, none but Jesus heard me! And ain't I a woman?" To find the answer, the final question in the interview was, *how would you define being a woman?*

All the participants quickly disagreed that a biological process like getting a period defines womanhood. When I asked Morgan about the definition of women having a biological basis, she said, "I know with trans people, they most of the time don't have children if they are transitioning from male to female, but they are also women at the same time, they are valid in their identity. I would say maybe like post pubescent, and if you identify as such, you are a woman, not to say that you have to have the reproductive organs." Morgan challenges the claim that there is an anatomical basis to being a woman. I would like to note here that my study focuses on cis female identifying college women because the experiences of a cis female becoming a woman is different from a trans female becoming a woman. Neither experience makes either one any more of a "woman" than the other, but to acknowledge the challenges and not diminish any experiences, I chose to focus on cis females. One survey participant is a transwoman, and her survey response is not documented in the tables shown in this paper. After disagreeing with the textbook definition of woman, nearly all the participants took a second to pause and think about what makes a woman a woman. The definitions the participants gave varied, but they all agreed that if a person identifies as a woman, then they are a woman. Some participants expressed that womanhood is society dependent. For example, Beatrice expressed that

womanhood is dependent on culture. She says, "it's like how some cultures, when you have your quince[anera], you're considered a woman after that. I mean that's not biological." Beatrice is referring to a quinceanera which is a celebration of a girl's 15th birthday throughout Latin American cultures. This, similar in meaning to a Jewish Bat Mitzvah are cultural ways that becoming a woman is standardized. Mary, started off by saying that "womanhood and manhood are social construct and we will define it by the way you dress, the way you talk, the way you act, like periods," but later said that "I think I would define crossing that realm of womanhood which equivalates crossing into adulthood by the same standards that govern society so I think if you are old enough to vote, I would say yes, you have reached adulthood through our American societal standards … if you can vote, then I can classify you as an adult, you can now use these terms that are associated with you as an adult which we have termed to be man and woman." Mary's explanation agrees with Beatrice and states that there is a cultural aspect to womanhood. In the U.S., becoming an adult at 18 years old issues new responsibilities to individuals which makes them a woman in the U.S. This shows that womanhood changes depending on the culture you live in which suggests that womanhood is reflective of culture and society. As culture changes, what makes up womanhood changes as well.

The other definition of is that womanhood is based on personal experience rather than societal explanations. Lorraine shared, "That's funny you ask that. Growing up, I used to say, if you're not paying bills then you're not an adult. I feel like up until I turned 20, when I was 19, I felt like a kid, really now, I feel like I'm coming into my womanhood. I feel like, I guess it's a maturity thing and where you are in life because even people who have kids at young ages are still like, a lot of them are still kids themselves and it's based on how

they act. Having kids, yourself doesn't make you an adult or a woman automatically. You're a woman, but you're a kid with a child. I really think it's about how you present yourself, how you act, just how you handle yourself in general is what makes you a woman." In other words, Lorraine shares that to her, being a woman is using a repertoire of built skills and experiences to figure out how to handle yourself in the face of anything that comes your way. Beatrice agrees and said, "I think about who I was in high school and who I am now and that's not even a big difference, it's like a year maybe and I just like grew so much and I thought I was mature in high school, but just one year away in college, I learn so much and the things adults tell me, oh you don't understand and I'll be like, no, you're crazy, but now I'm like, no, you were right. I think that I don't even think I would consider myself fully a woman in high school like developed like that. I think I'm closer to like woman status now than ever. I think when you're in high school, you're still a child." Beatrice compares who she is now to who she was about a year ago and the challenges she has had to accomplish, indicating that it is based on the experiences she has had for the past year that makes her a woman. She also implies that she may not have reached womanhood yet because there are still things she hasn't learned. The experiences that count towards growing into womanhood include things that help you develop the skills to be more confident in your body such as getting over learning curves and knowing where to go when there is a question that needs to be asked. Susie shared that part of becoming a woman includes figuring out what their individual body's unique needs are. She says, "Things can be so complex and so many different things can cause so many issues and so it's kind of like figuring out what works and what doesn't work for you. At least for me, it's been a huge learning curve, taking a lot what, for example, what period products to use, what kind of

sexual position I enjoy, or anything related to sexual health has been a journey especially, just talking about it in general can feel taboo, even like bringing the conversation with my mom can sometimes feel like, how do I approach this conversation to ask a her question of what she does kind of thing. I guess also getting recommendations from people and listening to them talk is then a good point of encouragement but also for me trying to new things and of course the internet, just simply google searching something."

In order to give a definition of *womanhood*, participants were required to reflect on society's definition of womanhood and adjust the definition to fit their personal experiences. The U.S. is historically, and some contest still is, a patriarchal society so many of the definitions set in place have been determined by men. Women have understood, internalized, and overcome the definitions prescribed to them at birth. In a study looking at how 349 college students from Mexico and the United States view women in different menstrual cycle phases, it was found that premenstrual or menstrual women are deemed as *irritable* and *moody* (Marvan et al, 2007). When I asked Mary what some of the symptoms she feels are when either her period is coming or when is on her period, she says, "I don't get the stereotypical hormonal period with your period. I don't get like angsty or really annoyed, pissy stuff like that as most people do. I don't get that. I feel like that's also just my natural state. Sometimes I'm really annoyed at things so I'm like, no, okay, this is, okay, just built like this. I think the only distinctive thing is the cramps, but I also have stomach problems so sometimes I'm like, ahh, is it my stomach problems or am I cramping, and I have to feel around the location of that, oh it's cramping, oh it's stomach problems that whole thing." Mary uses the label "stereotypical" to talk about patterns of irritation or moodiness that is associated with periods for some women because this pattern has been

brought up repeatedly and honed in on that it has become a stereotype. Moodiness have been indexed with periods so much so that when we hear someone say, "Be careful, she's on her period," nearly everyone understands what that means. Although in many parts of society it is society who defines and sets up expectations for women and how their body works, women have been adaptive about how they can use some of the stereotypes in their favor. Daria who was on her track team in high school shared that sometimes some of her teammates will cite a period cramp to get out of a difficult practice when they are not actually on their periods. I asked if she is able to tell the difference between someone who is genuinely in pain and someone who uses it as an excuse and she responded, "Yeah, I feel like when girls are around other women all the time, like when our girl coach would come, you would rarely ever hear, 'I'm cramping,' but whenever you hear 'I'm cramping' around a girl coach, it was like, they're on their death bed, they're cramping, you can sense it, you can feel it, you can see. When they're around guy coaches, they're like, 'Oh, we're running a lot today, let me pull the period card because what is a male figure going to tell me. You know what I'm saying, if that makes sense? You can tell when it's real and when it's serious and when it's like, I can get out of it because I can get out of it." In Daria's experience listening to her teammates converse with male and female track coaches, she describes how her teammates use stigma around periods, especially when it comes to men, to get them out of things that they do not want to do. Similarly, Mary understood the uncomfortable-ness men tend to feel when topics regarding reproductive health is brought up and shared, "I remember one time, I purposely said something, I love to make my male teachers uncomfortable, there's something very sadistic about me and I used to say, I need to go to the bathroom and if they told me no, I would be like, 'Oh, but I need to change my pad, my

tampon,' and I would say that explicitly that… One time I told him that … and he like *shuddered in disgust* and I looked at him and I said, you need to calm down, it's a natural thing of life." This occurred during Mary's sophomore year of high school. Luckily for Mary, she had built up the confidence in herself and was reassured that natural things like periods are not something to hide behind that this comment did not change her behaviors regarding talking about reproductive health. When I asked the interviewees with fathers and brothers if they talk to them about the reproductive processes happening in their bodies, some said only if their mom isn't around and other said no. The survey showed that 18/73 participants with fathers and 5/42 participants with brothers talked to them about their reproductive bodies.

In a few of the interviews, the idea of educating men about what happens to the female body would help alleviate some of the negative stigma associated with reproductive processes. Often, rumors and stigma sprout and spread because of a lack of knowledge. Morgan had brought up the need for educating men and when she was asked to elaborate, she said, "honestly, I think when it comes to educating men, … I think we should do it at the same time we're educating women about it. It sounds so rude to be like, 'oh, a man knowing what a period is,' but that's honestly what needs to happen. Women and men need to both know about how the body works and I think that goes with women knowing how the men's body works because you now, it takes two to make a baby, like they both need to be educated on human bodies and how it works and functions so that we're both making the smartest decision for ourselves." Daria's commented on something in our microsystem where men need to be educated about women's bodies and vice versa is necessary out of respect for each other as well as each other's future plans. She admits that her suggestion

for men to be taught about what happens to the female body at the same time as women may be deemed controversial because she sees that her culture separates men's health from women's health and these two do not concern the other. She provides an argument against this type of mentality by pointing out that to reproduce, these two supposedly distinct realms have to overlap. Mary's comment for the need for men to be educated about reproductive processes is on a macro level. She had mentioned how men are uneducated about this topic and when I asked if this is why stigma exists, she said, "100%. There's 100% because men are the people who are the policymakers, the lawmakers. Men are the people who make the curriculum, who guide the curriculum of what's going to be taught with sex ed and stuff and how these people are taught and yeah, if you don't understand how it works, that is exactly, that's how it's going to be taught. It's also how it's going to be portrayed. I was telling my roommate about this last year and I said, every problem could be solved if everybody could be educated the exact same way. If everybody got an accessible, comprehensive education the exact same way as one was not better than the other, the other was not lesser than and leaves things out … if everyone got the exact same thing, I told her, I promise you … Trump never have been elected. If education had worked properly, the exact same way for everybody, we would've been fine… really, if you have a problem and you want to address it, you have to start with education." Returning to Foucault's idea of biopower, Mary demonstrates that when the government controls women bodies through policies and curriculums, they are also influencing the way society controls women because the ideas society accepts are based on the knowledge they receive about reproductive health. In this case that knowledge is little to known. This because especially worrisome when the people who have biopower are people who do not

experience women's reproductive health processes and don't have the experiences and struggles associated with reproductive health at the forefront of their minds.

Media also plays a huge role in defining womanhood. Lorraine said, "The media really puts emphasis on like [how once a girl starts puberty, she is a woman]. I mean like, I think, this is funny. I don't know if I've ever really been asked it before. If you're sticking to like the sexual part of being a woman, I understand where the media is coming from with saying like you're going into puberty and you're transforming into, I understand where they're coming from. I think it has a lot more to do with like, your personal feelings and also, you can't be excluding trans women and like they're not going experience getting their periods. I'm sure that's a terrible thing to always hear. Honestly, I would say kind of feeling like you're growing up and you're more of an adult and connecting that to your maybe femininity, that's not exactly the word I'm looking for, kind of like that. It's easy to be like a girl, there's no expectations, you're kind of just being a girl, but I feel like being a woman is like, I wasn't a woman at 13 you know. It's a very adult kind of thing I think." Lorraine is not alone when she lightly protested at the thought of becoming a woman overnight when her period first started. Fortunately for many of the participants, there seemed to be some autonomy for deciding when they became a woman. Many of them said that they do not feel like they could call themselves a woman until at least college. However, one of the interviewees did not have the same fate and unfortunately had to grow into womanhood not under her own terms. Rebecca shared, "It's really complicated for me because of the path I've been on and because I matured early, and I developed early. Men were responding to me in ways that they shouldn't have been at the age I was and I wanted attention at that time, but I also didn't want anything more than attention so it's like I don't want to want to

be touched inappropriately or I don't want to have sex with you or anything, but also at the same time, I wanted to feel confident as a young, developing woman and then with the other side of it, STIs, it's just like so many people lie. They just, I don't know why it's such a, it's like there's just a culture of people lying to get what they want from you instead of being honest and, I'm sure you can relate to this, you work so hard to be an honest open person with everyone around you and they do the complete opposite so you're like, what did I do to deserve this? Do you not care about human life or about me as a person? Even if we're not in a serious relationship or something, do you have no morals? So, that was tough." Because of how big of a role media plays in our everyday life, it values put on different things. In Rebecca's case, someone defined her body as a woman's body before she got a chance to do that for herself. This becomes especially harmful when we begin to index female bodies. In American society, young women with matured bodies experience a disconnect between physical maturation and mental maturation because of the indexes we have placed on parts of the female body that has been replicated in many cartoons, comics, and other animations.

The last factor found in the interviews that places a considerable role in how the definition and stigma surrounding womanhood started is how our society is structured. People are a product of their environment; thus, the decisions women make are in response to the social, political, and economical events that are happening around them. When I asked how Cameron made the decision to get an IUD, she said, "I was 18. I just graduated high school and it was a lot of different things. After I graduated high school, I took a gap year and during that gap year, I lived in South Korea and I guess, so this is 2017 summer when I got it. I was about to go on my trip and also politically, the country was

very different because Trump got elected and there were a lot of rumors about reproductive health for women not being as available or insurance not being able to cover it after he started his term, so I was a little worried. I was like, okay insurance might not cover birth control anymore because of these policies that may happen so while I am able to, I should maybe just get an IUD that last a couple of years. Mine lasts 5 years I believe and next year I'm going to get a new one. So, I was like, okay, I'll do that just to be safe in case insurance policies change and whatever. In regarding to my trip, I had never lived abroad before and this is very dark and kind of pessimistic, but as a woman, I'm sure you understand too, you never know. You could be a bad place at a bad time, and something could happen to you, and I wanted to make sure if I get, let's say raped, sexually assaulted, if something like that happened, I would be too a degree protected reproductively. That was a lot, so I guess a combination of all that led me to making that decision." Although I asked participants what being a woman is defined to them and each one of them had a different, women do not have the final word on how womanhood is defined, and it is because of this that women have to take control of what they are given and find a way to live and thrive within those means. Cameron got an IUD in response to a conservative politician taking office since many conservative policies regarding reproductive health tend to limit the access to reproductive health resources women get such as an accurate and inclusive sex education, birth control, abortions, and many other things. She also got an IUD in preparation for the unknown which is living in South Korea. Cameron cannot foresee what could happen in a foreign country so she got an IUD that will protect her so that she, not insurance companies, governments, or policies, can continue to decide for her what happens to her body. In order to protect herself and the definition of womanhood she

wants to keep for herself, she first needed to think about how the government and society defines her and then figure out ways to stay one step ahead of the actions that may result from societal and political definitions placed on her. Society also plays a huge role in how women perceive themselves and give themselves value. Rebecca was the first interviewee in the study, and she challenged what being a social science researcher meant for me. In my courses at Emory and my outside of school research experience, I have always been taught that when I am conducting interviews or facilitating focus groups, it is important that I keep my emotions and thoughts to myself, but interview Rebecca showed me that for this study, it was important that I share my thoughts and be as vulnerable because it is what I would have done if methods of participant observations were utilized. Although I could not conduct participation observation in a traditional matter, I realized here that by being vulnerable, supportive, and act in a way a close friend would act in response to what these wonderful women were sharing with me, it was a type of virtual form of participation observation. In response to Rebecca's story, I told her that I am proud of her for overcoming her challenges and how much she is needed in this world as an advocate and how lucky her future patients are going to be to have someone like her as a physician. A portion of her story was shared earlier, here is her full story. "I purposely didn't wear makeup because I figured I would cry at some point during this interview. I would say well two things. STDs and molestation slash rape, assault. I think those two are the absolute worse and the hardest of my journey cause that stuff follows you. It's baggage that you can't get rid of. You can learn how to deal with it, and you can learn how to heal from it, but it's always going to be something that you think about, it's always going to be something that partially frames you as a person. It's really sad cause on one side, with the assault side, the

sad part to me, or the worst part to me is that it's something that has been passed down through generations with not just my family, but also women in general and it's so disgusting and I just wish there was something I could do as a woman to just change it but there's nothing really to do and it's sad especially considering that it happens when people are young… It's really complicated for me because of the path I've been on and because I matured early, and I developed early. Men were responding to me in ways that they shouldn't have been at the age I was and I wanted attention at that time, but I also didn't want anything more than attention so it's like I don't want to want to be touched inappropriately or I don't want to have sex with you or anything, but also at the same time, I wanted to feel confident as a young, developing woman and then with the other side of it, STIs, it's just like so many people lie. They just, I don't know why it's such a, it's like there's just a culture of people lying to get what they want from you instead of being honest and, I'm sure you can relate to this, you work so hard to be an honest open person with everyone around you and they do the complete opposite so you're like, what did I do to deserve this? Do you not care about human life or about me as a person? Even if we're not in a serious relationship or something, do you have no morals? So, that was tough… Consent is a huge thing, and I know more on the anthropological and psychological aspect of sex, but especially in the medical field, you have to look at everything. You have to look at social stuff, cultural stuff, actual scientific stuff, you have to look at it all. It's not fine if you're having safe sex, but you're raping someone. That's gross. That's absolutely unacceptable and you have to be put into jail, so we need to inform everyone about all the different branches of reproductive health. Kids need to be taught this so that when they become adults, they don't do stupid stuff that could hurt other people." Because her

traumatic experience, Rebecca developed an STI which is how her mother came to realize that she is no longer a virgin. Coming from a religious household, there was a lot of stigmas around sex and STIs. I asked if she had ever stigmatized herself for having an STI and she said that she did. Rebecca said, “Definitely. When I first got diagnosed. I hated myself. I got into a severe depression, I felt disgusting. I wasn’t in my own body. I hated it. It just made me feel so gross because I’ve always been told that people with STDs are the worst people ever and that they’re hoes and they slept with everyone even from my mom, she even told me that stuff and now it’s like ‘Oh crap, now I’m in this category.’ If people knew, then they would think those things about me, so it was really hard. I would cry every day because I had to heal from it because I had a very severe case I guess so it was a lot and my mom would tell me she had dreams about me where I was this monster and, I had herpes, and the herpes would spread to my brain and I was covered in sores and all this stuff and she would tell me this when I was in college and it would just make me feel so bad about myself and it was like people were seeing me as this devil or something like when I just had an unfortunate accident and I had been lied to or taken advantage of and that’s what happened. So yeah, it was really difficult. It took a long time and a lot of prayer for me to figure out who I was after the diagnoses and how to navigate it and how to be comfortable with myself and how to maintain my health and stuff. Now, I’m fine. I haven’t had an outbreak in years and my boyfriend is fine. He’s never gotten it from me and hopefully that stays the same. It was a lot." According to a study looking at the factors that influence college students’ decision to seek testing for STI’s, one of the factors include being perceived as “loose,” “dirty,” “stupid,” “irresponsible,” and “not caring about yourself” (Barth et al., 2010). Since Rebecca started to stigmatize herself, this shows that girls to

adopt the definitions society has set up for them, but in Rebecca's case, part of her journey to womanhood is, with the help of boyfriend, realizing that she is so much more than an STI and that it is not her fault she was taken advantage of.

With a reproductive health basis, the definition of a woman I propose is, "an individual who grows into their bodies amidst the socioecological forces that challenge their understanding of themselves." It is difficult to come up with a definition that encompasses all the individual paths and unique experiences every woman must go through to find a sense of confidence in themselves is just part of the definition. The rest of the definition of a woman is unique to an individual, similar to how reproductive health varies from one person to the next. One thing I noticed is that in our medicine dominated black and white world, things either work or not, but the reality is, are many more nuances. When I asked Julie what the most difficult part of being a woman is, she shared, "I think it's just figuring out what works for me. You know what I mean? Like how often do I have to change out of a tampon, how often do I have to change my pad and it's like going through world while going through so while being able to live some sort of a normal life. You can't just be identified as a girl because you have a period, and you live your life differently. You have to suck it up at some point to live the same as everyone else and being able to do that while figuring yourself out is so hard sometimes because you have to balance it out, you have to think about it at all times, like this is happening right now and this is. I think also for me, it's like, what I eat too. So, like during my period, I generally eat less so I figure out, and I generally won't like some things and it's not like, it's just figuring out everything surrounding it and be like a regularly functioning human being. Like that is so hard, just to live a normal life, like something that should just be given to you every day is just not. It's

just that you have to work around all the nooks and crannies and figure out what works for you and how to live a life and do all this at the same time." Julie puts into words what many other people in the interviews shared. Part of being a woman is to be able to identify and acknowledge the challenges that they have, but to not let those disadvantages stop them from doing what they want. Similar to how health exists on a spectrum, the meaning of womanhood may also be fluid depending on individual's personal experiences and personal values, but the most important thing is that the individual herself sees herself as a woman. Many of the interviews shared that the hardest thing about reproductive health is the constant trial and error they must go through to adjust to new environments or changes in the body since there's no way to google answers to this since every body works different. Lorraine said, "I would definitely say, how complicated things can be especially with female anatomy and the human body itself. Things can be so complex and so many different things can cause so many issues and so it's kind of like figuring out what works and what doesn't work for you. At least for me, it's been a huge learning curve, taking a lot what, for example, what period products to use, what kind of sexual position I enjoy, or anything related to sexual health has been a journey especially, just talking about it in general can feel taboo, even like bringing the conversation with my mom can sometimes feel like, how do I approach this conversation to ask a her question of what she does kind of thing. I guess also getting recommendations from people and listening to them talk is then a good point of encouragement but also for me trying to new things and of course the internet, just simply google searching something." Part of being a woman expressed here is finding the answers themselves because no one is going to hand it over.

The limitation to the answers given for*, what does it mean to be a woman?* and *what is the hardest thing about learning about your reproductive bodies?* is that since the interview questions were mainly about reproductive health, reproductive health was at the fore front of people's minds. For example, when one person was asked this question, she said "I needed to learn a lot by myself because of my thyroid issue and so like, if you have an abnormality in your period, it could just be because your thyroid problems have changed. If that happens, you have to go to the doctor and get a blood test to make sure it hasn't changed. I have to be so conscious of my own body and think like, Okay so A changed, does that mean B changed too? I think it's always been like I have to be so aware of what's happening to me that like, so I can basically treat what the root cause of the problem. That's always been my thing. I got diagnosed with my thyroid problem before I started my period. That was always a bigger thing for me. I think he was just like, oh your period started late and it's always the fact that it could be due to something else, and you have to fix the other problem before you can fix the reproductive problem. That's why I was always so interested in what is wrong with my body because if you're not aware then you just miss out and I think that really played a big role for me." Julie's response is health related. I would expect the answer to this question to be varied from the same people if the questions leading up to this one asked about a different topic like gender wage gaps or female expression.

One thing I struggled with when I was collecting and analyzing data is whether the interviewees felt that becoming a woman is a good thing. Nearly everyone had expressed that there are many challenges that come with being a woman and that they wished it didn't have to be this hard and that they wish it didn't have to be this way, but during the

entire discussion, there was a hint of pride in all the interviewees as they were reflecting about how much they have learned and how far they are now into their reproductive health journey. I think it would be safe to say that all the interviewees are proud of how far they have come and are angry at a society that made them believe there was something wrong with their body when in reality there is something not quite correct about indexes and definitions society has placed on womanhood. Over time they have taken these frustrations at the way the world exists for them and have both "suck it up" to get through the day as well as challenged it by talking about parts of reproductive health openly.

The biggest lesson I got from all these interviews and from doing the background research is that part of being a woman is to take care of your body, nurture it, and give yourself grace. At the time the interview took place, many of the college-aged women I talked to sounded apologetic to their past selves for being so unforgiving with themselves. I noticed that it seems easy for women to be nurturing to their past selves, those around them, but not necessarily to their current selves. Through the acquisition of tools like social to their current selves. Part of being a woman is being able to reflect in the moment and have the self-confidence to reassure themselves that they are okay and if there is a problem that can be fixed, it will be fixed. Some women learn to give themselves grace on their own, but many others relied on some social capital to reassure them that they are okay. For example, Rebecca was able to stop internalizing the stigma associated with STI's after revealing that she got it to her boyfriend and his response was support, rather than disgust.

This study looked at college-aged women who are currently in college or graduated Spring 2021. When I was recruiting participants for the interview and the survey, I reached out to

a diverse set of major department heads at Georgia state colleges and posted a call for participants on social media. The range of majors of the participants ranged from pre-medicine to international affairs to film. Even though all these majors are different from each other, each interviewee found a way to nurture those around them so that they don't have to have the same negative experiences they did. Rebecca, a recent college graduate is in medical school now and when I asked how she is going to change the next generation of women's experience regarding reproductive health, she said, "Acceptance. Literally acceptance. That's my motto for everything because I was denied that. Acceptance for the struggles that you've gone through, accept you even if you're being very anxious about something. I struggle with anxiety, I struggle with depression, I struggle with a lot of things that these other women, they struggle with and they're getting mistreated in hospitals for and they're getting mistreated in clinics for so it's just like, look if you feel uncomfortable with any of the other doctors, hey, I'll step in. if you feel more comfortable with me, that's fine, if they want to talk about whatever they're going through or if they want to relate with me, they want to have personal stories. Patients do that a lot. They like to talk about themselves and talk about what they're going through and doctors brush that off. I will sit there and talk to you and if you have an STD or something like that, I'm going to give you your treatment and tell you that you're okay, you're going to be okay, there's nothing wrong with you, this doesn't make you less of a person and give them counseling in how to be safe in the future and give them as many resources as possible. I want to show my compassion through my practice because I feel like that something we've been denied a lot. Women and then women of color, we've really been denied that in not only the medical field, but that's where I'm headed." Other women like Julie are optimistic about the future.

Given that she had a difficult time finding accommodations to her menstruating body in middle and high school, I asked if she was worried about if her future working environment is also not going to be accommodating. She responded "I feel like as we've gotten older, people are more understanding towards it so I feel like hopefully, the workforce will be the best of that. I feel for me middle school was the worst of it and high school and college have gotten better. I'm hoping that that's the peak of it where it'll just be so normalized, but for the longest part of my life, I was like, how am I going to do anything in my life because I would take 2 or 3 days out of the month to sit at my house and just like die in my bed. How is that ever going to work? For me, birth control was kind of the answer to that. It was like you know what, there is a possibility of life after this." Other women are also hopeful about what the next decade may look like in research. Susie shared that they hope more funding goes into research about diseases and problems that women struggle with. The conversations about future actions does not imply that women are not nurturing towards other people now. Nearly all the interviewees have expressed how they improve the reproductive health experience of their smaller communities. Morgan, Rebecca, Daria, and Beatrice have younger female siblings who they share advice with. Morgan told her sister, "Just like make sure to wash yourself in the shower, make sure there's no blood leftover at the end of the period or anything. Make sure to take out the trash at the end of your period like um, to make sure nothing gross grows in there. I don't know, I feel like I was just like, this is how you use pads, this is how you use tampons, this is what is available. I use a diva cup, that may not be comfortable for you yet. You might just want to use something else. These are the pads I use; these are the ones I like for this reason" and even though the conversation was a little awkward, she still did it and "it was like 'Hey Payton, you're a

growing woman and I love you and this will be a little bit awkward, but we will have this conversation." Rebecca acts a non-judgmental person if her sister needs someone to confide in. Rebecca's sister, "had to ask me a lot especially with the past couple of years, you know finding yourself, sexual orientation, where you fall in the you know, libido and stuff. She's had a lot of questions about libido and sex drive and things like that so I'm really glad that I could be there for her and explain as much as possible or just listen to her and not have her feel judged because it's different when it comes to the family and parents and things." Daria has two younger sisters and "I talk to my sister who's 16 all the time about, I feel like sex education and stuff like that and being her co to co and things like that just cause I don't think we get it from anywhere else and our parents act like it doesn't exist and school just tries to throw some sugar on it and move on." Beatrice passes on her regrets to her siblings so that they don't face the same fate. She says, "I told my sister all of this and she's about to head to college like she was with me through this whole time I would go home and call her and update so I'm hoping she learned something from me and maybe I had to be the sacrifice so it's like, maybe I don't want to do this." Overall, women are nurturing because it is the strongest shield against societal expectations, definitions, and pressures of them.

CONCLUSION

Perceptions and conversations about reproductive health changes across a single lifetime and between lifetimes. It is a reflection of current societal values placed on women. People act based on what they know. As more information is acquired, behavior begins to change. It is important that we look at how girls learn about their reproductive health because if not given enough information, this may lead to internal stigma, lack of confidence, and physically harming the body by accident. By interviewing college-aged women from Georgia about the tools they used to grow into womanhood not too long ago, the result of this study adds to the understanding of how and where girls from Georgia go to learn about their bodies. These results can be used to plan and implement outreach activities to convey information to girls that include breadth and depth. The constant reminder for women, especially young girls that they are not alone in their experiences may mitigate some of the feelings of alienation girls begin to feel as their bodies are changing in ways that feel unfamiliar. This study also demonstrates the pressing need to combat alienation of girls from their own bodies as well as alienation from their peers going through the same experience which can be done through greater open discussions about topics concerning female reproductive health. For instance, knowing that many women turn to the internet for clarification, it would be a good idea to direct students to trustworthy websites such as *bedside.org.* Additionally, having a general idea of the topics that lead to women's doubts in their bodies calls for school educators to touch on these topics so that the idea that there is something wrong with their body never crosses a women's mind. It was found that at the beginning of their reproductive health journey,

many women received little to no formal conversations with an adult about what to expect. As they navigate the first few years of the biological processes of womanhood, they turn to multiple sources for answers such as a female guardian, search engines, and social media. Although typically it is a female guardian, often the mother, that provides an introduction to these changes, many college-aged women do not continue to use this resource out of fear of stigmatization. Women opt for resources that do not require them to be vulnerable and share what is happening to their bodies with other people. It may be possible that when women are offered a safe space where they are asked to be vulnerable and know that they can be vulnerable without judgement, such as the interview conducted, women are more likely to receive advice they are seeking or get information for later use.

Stigma is sourced from the societal expectations of how the female body should act and is in effect because of the objectification by male gaze. When Julie shared embarrassment from having a leak at school with her white dress, it was because the male gaze and society had reinforced the idea that being on a period has to stay a secret and the failure to keep that secret has consequences. Objectification theory suggests that girls and women are accultured to internalize an observer's perspective to base their perspectives on themselves (Fredrickson & Roberts, 1997). One study found that a greater tendency to objectify the body, or in other words fall under the male gaze, increases shame and anxiety felt by women and diminishes awareness of internal bodily states which can later lead to mental health risks such as eating disorders, sexual dysfunction, and unipolar depression (Fredricks & Roberts, 1997). Mary shared that she and her female friends commonly share things with each other like accidentally leaking onto their bedsheets in the middle of the night to which everyone's immediate response is to offer advice on how to remove the

stain. It would be interesting to see the prevalence of stigma and the male gaze in girls that attended all girl's school for the first few years of getting a period.

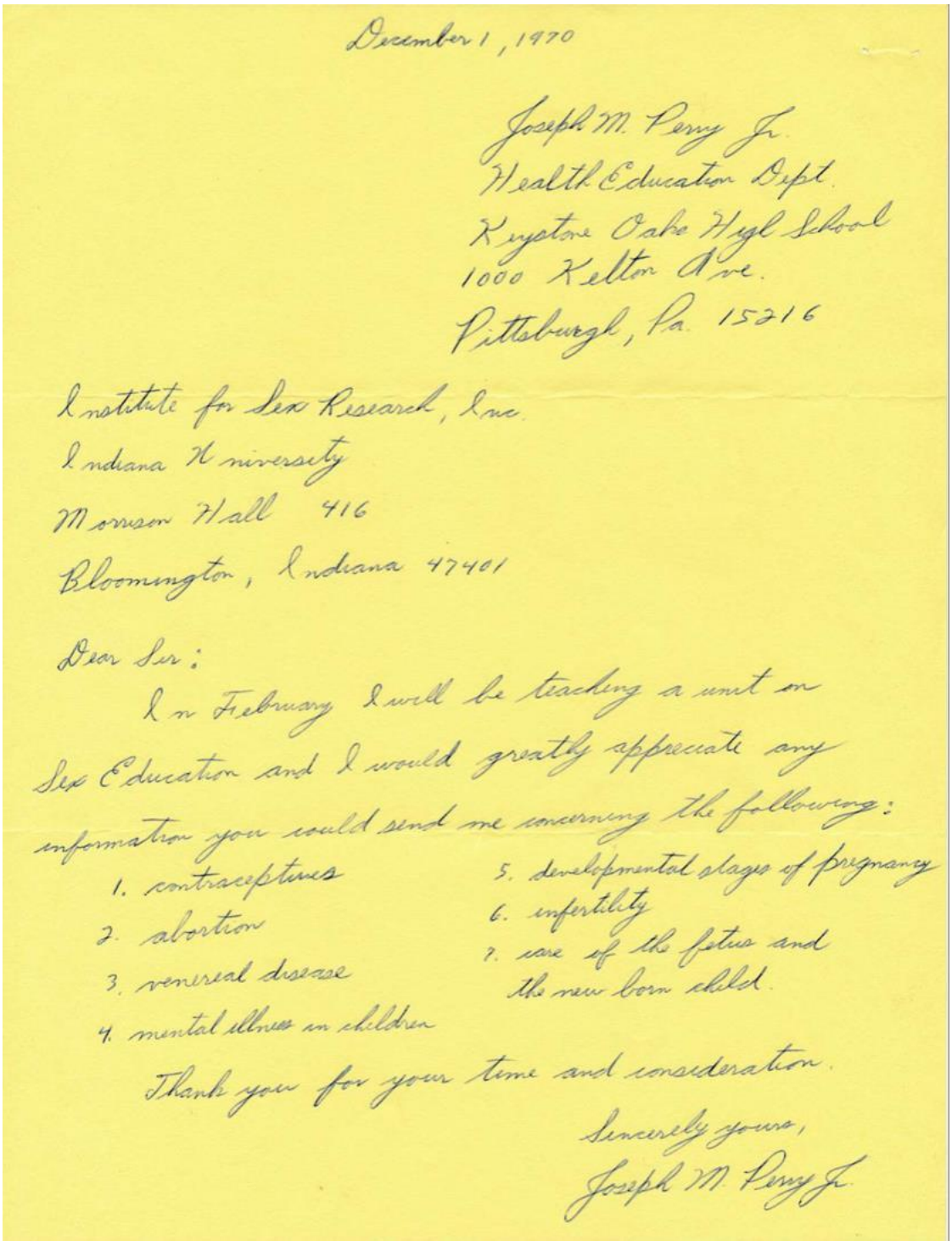
As girls get older and their repertoire of knowledge grows, so do the resources they have. After a period of time menstruating, being on contraceptives, or living with a diagnosis, girls begin to turn to their social groups for advice and for a place to relieve some worries. During the entirety of their reproductive health journey, regardless of who they know, what they know, or which resources they have available, the interviews revealed that all girls are adaptive and make the best of any situation they are in. At times, the situation is out of the hands of the woman so one shared trait shared by many, is the need to overcome the obstacle of internalizing stigma and blaming herself and her body. There is a need for women to shift their mindset from feeling like the body has failed her to nurturing the body, forgiving it, and redirecting the frustrations from herself to societal expectations about how a woman's body *should* work. Beatrice was able to do this when she had been diagnosed with an STI. She knew there was something wrong with her body and went to her school's health clinic. The receptionists told her there was nothing wrong, but she was confident enough, knew her body well enough, and did enough searches on the internet to know that there is something wrong. Beatrice went back to the clinic a few days later and spoke to receptionists, who she pointed out, unlike the first receptionists she saw, were women of color just like herself. The care she felt that she received from them was much less dismissive and they gave her an STI test to which she tested positive for. Surprisingly, according to the quantitative data, the internet did not play as large of a role as expected and according to the interviews, women were more likely to get satisfactory answers after confiding with a friend rather than looking at search engines.

The study on how women acquire knowledge is just beginning. This study demonstrates how the environment is shapes reproductive health behavior. For girls who go to college, college provides an environment different than high schools do, creating a greater support for girls to rely more on others for reproductive health knowledge acquisition. This period of time is also supported by the fact that women are older in college and older women have less body shame than younger women do (Grower et al., 2019). As mentioned earlier, to best address the needs of a community, the more specific the research objectives are, the more catered an intervention will be and the more successful the results will be. Future research should look at the needs of women coming from different socioeconomical and racial backgrounds to see where the health knowledge gaps are and create a community program to teaches girls about their bodies. An intersectional approach to these studies will be the upmost importance with a huge focus on the history of the community at large. The Harriet Tubman Women's Clinic in Clarkston, GA does specifically that and addresses the gaps of knowledge among daughters of refugees who have or are entering puberty. Programs such as these need to be more widespread to lessen the burden of learning about the body of girls. Future research is also needed to look at how transwomen learn about and come to define womanhood itself. The results this can be compared to the results of these thesis to better find a definition of womanhood that is inclusive of all women. Lastly, women's reproductive health research is in response to society beliefs, thus it is also important to investigate what men are taught about women's reproductive processes and how it affects the way they view, treat, and understand women needs.

With the rise of social media and the increasing conversations about a woman's place in society, conversations and attitudes about women's reproductive health will continue to change. Drawing from Foucault's biopower, Scheper-Hughes and Lock's political body, and the effects of stigma the participants have shared on their thoughts and emotions, future studies should look at the effect of increasing conversations about topics pertaining to women's reproductive health on women's image of themselves, men's understanding and attitudes towards women, and changes in institutional structures such as schools and workplaces. Overall, due to the limited information college-age women receive from people around them, they are resilient and find ways to solve the problem with the resources they have on hand. The process of acquiring knowledge is challenging, but with each barrier that is overcome, the individual gains a better understanding of her reproductive health needs and a greater confidence to stand up for it and herself.

Appendix

Image 1: Letter from Joseph M. Perry to Paul H. Gebbhard



December 1, 1970

Joseph M. Perry Jr.
Health Education Dept.
Keystone Oaks High School
1000 Kelton Ave.
Pittsburgh, Pa. 15216

Institute for Sex Research, Inc.
Indiana University
Morrison Hall 416
Bloomington, Indiana 47401

Dear Sir:

In February I will be teaching a unit on Sex Education and I would greatly appreciate any information you could send me concerning the following:

1. contraceptives
2. abortion
3. venereal disease
4. mental illness in children
5. developmental stages of pregnancy
6. infertility
7. care of the fetus and the new born child.

Thank you for your time and consideration.

Sincerely yours,
Joseph M. Perry Jr.

Appendix A: Surveys were collected on Qualtrics

Survey Questions for High School Students after a sex education class:

1. What is your gender? (*Female, Male, Transgender, etc.)*
    a. _____
2. Which of the following do you think you have a better understanding about? *Select all that applies*:
    a. How sexually transmitted diseases are transmitted
    b. How to prevent sexually transmitted diseases
    c. Safe sex between two females
    d. Safe sex between a female and a male
    e. Safe sex between two males
    f. Birth control pills – (used, access, how they work)
    g. Birth control implants – IUDs, Nexplanon (used, access, how they work)
    h. Birth control condoms (used, access, how they work)
    i. Abstinence
    j. Abortion
    k. State laws related to reproductive health
    l. Federal laws related to reproductive health
    m. Planned parenthood
    n. Female reproductive anatomy
    o. Male reproductive anatomy
    p. Menstrual Cycle – hygiene, products, what to look out for, etc.
    q. Breast Cancer – detecting, resources, etc.
3. Which of the following do you wish you had learned more about? *Select all that applies*:
    a. How sexually transmitted diseases are transmitted
    b. How to prevent sexually transmitted diseases
    c. Safe sex between two females
    d. Safe sex between a female and a male
    e. Safe sex between two males
    f. Birth control pills – (used, access, how they work)
    g. Birth control implants – IUDs, Nexplanon (used, access, how they work)
    h. Birth control condoms (used, access, how they work)
    i. Abstinence
    j. Abortion
    k. State laws related to reproductive health
    l. Federal laws related to reproductive health
    m. Planned parenthood
    n. Female reproductive anatomy
    o. Male reproductive anatomy
    p. Menstrual Cycle – hygiene, products, what to look out for, etc.
    q. Breast Cancer – detecting, resources, etc.
4. On a scale of 1-10 with 1 being "not confident" and 10 being "confident," how confident do you feel about your understanding of your body?
5. On a scale of 1-10 with 1 being "not confident" and 10 being "confident," how confident do you feel about looking for resources related to reproductive health?

Survey Questions for Undergraduate Females from GA:

1. Do you identify as a female?
    a. Yes
    b. No
2. Did you attend a GA public school from kindergarten to 12th grade?
    a. Yes

b. No

Questions related to education

3. Name of the high school you graduated from and the year:
    a. _____; 20XX
4. When did you begin learning about reproductive health in public school?
    a. *Reproductive Health definition:*
    b. Elementary School
    c. Middle School
    d. High School
    e. Never
5. When were your sex education class(es) held in High School?
    a. One day out of the school year
    b. One week out of the school year
    c. One month out of the school year
    d. One year
    e. Other: _____
6. How often did you attend sex education class(es)?
    a. 4 years
    b. 3 years
    c. 2 years
    d. 1 year
7. What material did you learn about in public sex education classes? *Check all that apply*
    a. How sexually transmitted diseases are transmitted
    b. How to prevent sexually transmitted diseases
    c. Safe sex between two females
    d. Safe sex between a female and a male
    e. Safe sex between two males
    f. Birth control pills – (used, access, how they work)
    g. Birth control implants – IUDs, Nexplanon (used, access, how they work)
    h. Birth control condoms (used, access, how they work)
    i. Abstinence
    j. Abortion
    k. State laws related to reproductive health
    l. Federal laws related to reproductive health
    m. Planned parenthood
    n. Female reproductive anatomy
    o. Male reproductive anatomy
    p. Menstrual Cycle – hygiene, products, what to look out for, etc
    q. Breast Cancer – detecting, resources, etc.
8. On a scale of 1-10 with 1 being "I don't remember anything" and 10 being "I remember everything," how much information do you remember from high school sex education?

Questions about religion:

9. What religion do you affiliate with the most?
    a. _____
10. Do you share the same religion as members of the home you grew up in?
    a. Yes
    b. No
11. Which of the following have you learned from your faith? *Check all that apply*:
    a. How sexually transmitted diseases are transmitted

b. How to prevent sexually transmitted diseases
c. Safe sex between two females
d. Safe sex between a female and a male
e. Safe sex between two males
f. Birth control pills – (used, access, how they work)
g. Birth control implants – IUDs, Nexplanon (used, access, how they work)
h. Birth control condoms (used, access, how they work)
i. Abstinence
j. Abortion
k. State laws related to reproductive health
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m. Planned parenthood
n. Female reproductive anatomy
o. Male reproductive anatomy
p. Menstrual Cycle – hygiene, products, what to look out for, etc
q. Breast Cancer – detecting, resources, etc.

12. On a scale of 1 -10 with 1 being "no influence" and 10 being "complete influence," how much do you consider your religion when thinking about reproductive health?

Family household

13. Who makes up your household? (i.e., Mom(s), Dad(s), Grandparent(s), Sibling(s), Pet(s))
    a. _____
14. Which of the following has been discussed in your household? *Check all that apply*
    a. How sexually transmitted diseases are transmitted
    b. How to prevent sexually transmitted diseases
    c. Safe sex between two females
    d. Safe sex between a female and a male
    e. Safe sex between two males
    f. Birth control pills – (used, access, how they work)
    g. Birth control implants – IUDs, Nexplanon (used, access, how they work)
    h. Birth control condoms (used, access, how they work)
    i. Abstinence
    j. Abortion
    k. State laws related to reproductive health
    l. Federal laws related to reproductive health
    m. Planned parenthood
    n. Female reproductive anatomy
    o. Male reproductive anatomy
    p. Menstrual Cycle – hygiene, products, what to look out for, etc.
    q. Breast Cancer – detecting, resources, etc.
15. Who have you discussed the topics selected above with? *Check all that apply*
    a. Mother
    b. Father
    c. Grandmother (paternal or maternal)
    d. Grandfather (paternal or maternal)
    e. Older Brother(s) (Full, Half, Step)
    f. Older Sisters(s) (Full, Half, Step)
    g. Younger Brother(s) (Full, Half, Step)
    h. Younger Sisters(s) (Full, Half, Step)
16. On a scale of 1-10 with 1 being "clarified little to no confusion" and 10 being "provided full clarification," how much information did conversations with your family members?

Independent Online Searches

17. How do you search for answers about reproductive health? *Check all that apply*
    a. Guest Mode
    b. Incognito Mode
    c. Signed in and did not clear history after
    d. Signed in and cleared history at least a day after
18. Which of the following have you searched the internet about? *Check all that apply*
    a. How sexually transmitted diseases are transmitted
    b. How to prevent sexually transmitted diseases
    c. Safe sex between two females
    d. Safe sex between a female and a male
    e. Safe sex between two males
    f. Birth control pills – (used, access, how they work)
    g. Birth control implants – IUDs, Nexplanon (used, access, how they work)
    h. Birth control condoms (used, access, how they work)
    i. Abstinence
    j. Abortion
    k. State laws related to reproductive health
    l. Federal laws related to reproductive health
    m. Planned parenthood
    n. Female reproductive anatomy
    o. Male reproductive anatomy
    p. Menstrual Cycle – hygiene, products, what to look out for, etc.
    q. Breast Cancer – detecting, resources, etc.
19. On a scale of 1-10 with 1 being "unsatisfied" and 10 being "fully satisfied," how satisfied were you from the answers online?

Other sources

20. Which of the following do you discuss with your friends about? *Check all that apply*
    a. How sexually transmitted diseases are transmitted
    b. How to prevent sexually transmitted diseases
    c. Safe sex between two females
    d. Safe sex between a female and a male
    e. Safe sex between two males
    f. Birth control pills – (used, access, how they work)
    g. Birth control implants – IUDs, Nexplanon (used, access, how they work)
    h. Birth control condoms (used, access, how they work)
    i. Abstinence
    j. Abortion
    k. State laws related to reproductive health
    l. Federal laws related to reproductive health
    m. Planned parenthood
    n. Female reproductive anatomy
    o. Male reproductive anatomy
    p. Menstrual Cycle – hygiene, products, what to look out for, etc.
    q. Breast Cancer – detecting, resources, etc.
21. On a scale of 1-10 with 1 being "none" and 10 being "completely," how much do you feel you and your friends share confusions about reproductive health?
22. Which of the following do you discuss with your primary physician about? *Check all that apply*
    a. How sexually transmitted diseases are transmitted

b. How to prevent sexually transmitted diseases
c. Safe sex between two females
d. Safe sex between a female and a male
e. Safe sex between two males
f. Birth control pills – (used, access, how they work)
g. Birth control implants – IUDs, Nexplanon (used, access, how they work)
h. Birth control condoms (used, access, how they work)
i. Abstinence
j. Abortion
k. State laws related to reproductive health
l. Federal laws related to reproductive health
m. Planned parenthood
n. Female reproductive anatomy
o. Male reproductive anatomy
p. Menstrual Cycle – hygiene, products, what to look out for, etc.
q. Breast Cancer – detecting, resources, etc.

23. On a scale of 1-10 with 1 being "not at all" and 10 being "fully," how clear are the answers your primary physician provides?
24. Who/Where do you go most for reproductive health information? (People, websites, programs, etc.)
25. Is there anything that was not asked about that you would like to add?
26. Would you consider participating in an interview to share more about your experience learning about reproductive health?
    a. Yes – email:
    b. No

Appendix B: Interview Questions

1. When did puberty start for you?
    a. Had you learned about puberty before that?
        i. From whom?
    b. Do you remember what the first time was like?
        i. What about the first time you bought pads or tampons for yourself?
    c. Has there been a situation where your body wasn't 'acting' like how you were told it was going to?
    d. Now that we've had our periods for a couple of years, have you gotten better at reading your body and knowing what it needs?
        i. Did anyone tell you to look out for these body cues?
    e. Do you feel like you are limited either physically or mentally when you're on you're period?
2. Where did you learn about hygiene – period hygiene, shaving?
    a. Did you have to google any of this stuff?
3. When did you start to learn about birth control and sex? Masturbation?
    a. What kind of information did you learn from each of those sources?
    b. What about masturbating and your anatomy? How did you learn stuff related to that?
4. Do you remember the first time you resorted to google over asking a parent or friend?
    a. What else have you googled if you don't mind me asking? I can share mine too
    b. What do you think you would have done if you couldn't have googled these questions?
5. What has been the hardest thing so far about understanding your individual reproductive health well?
    a. What does reproductive health mean to you?
    b. What was the biggest area of confusion you had related to reproductive health?

c. Has talking about reproductive health gotten any easier?
d. How would you change the curriculum?

6. What does it mean to be a woman?

Appendix C: Digital posters made on Canva

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