The Inception & The Projection of the Female Body in Biomedicine: An Exploration of Transitory Fertility in Cobbs Creek, West Philadelphia

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Introduction

In most cultures, procreation is encouraged. Productive adults contribute to society by raising the next generation of responsible citizens. Having children is framed as a necessary life stage for most. While the decision to not have children has become more popular in recent years, many would still consider the decision to start a family a pivotal one. In the United States, it serves as a prerequisite for the successful realization of the "American Dream": complete with a nuclear family, a fenced-in backyard, and a scripted role for women. To pass on one's legacy is a way to fully achieve the dream before death. Children, made of one's own blood and bones, represent an important accomplishment. While adoption is an option, many couples attempt to become pregnant before exploring other ways of starting a family. The abilities of the female body become central during these attempts. What happens to the dream if the woman cannot naturally conceive?

Television programs spin plots to focus on the grand problems that accompany a woman's infertility, often framing medical miracles as the ultimate solution to troubles presumably caused by fertility struggles. Such interpersonal troubles are depicted as resulting in marital issues leading to separation, social isolation or mental illnesses. After years of trying to become pregnant with no success, the main couple will finally conceive after intense efforts poised to shock and entertain the audience. The last scene in these programs usually focuses on a heterosexual couple, finally holding their biological child. Tears stream down the woman's face in a victorious conclusion as she gazes at her *own* flesh, and the credits begin to roll. Documenting the perceived beginning of the fertility journey to the birth of a child, programs like these convey a specific message to viewers: female fertility is linear, fixable, and corporeal. Female success in these programs is measured by the presence of a biological child.

On the other side of the screen, a fourteen-year-old Jane*[1] turns off the program and walks away. She lives in a city and attends an understaffed public school with a high rate of teenage pregnancy. The sexual education program at school explains birth control measures to students, but does not explain how to access such resources, nor does it detail female anatomy, pleasure, or consent. Jane has been sexually active for two years and has never had protected sex. She also has never become pregnant, leading her to believe that she is infertile. Jane has heard of women not being able to conceive and she assumes she is one of them. With this belief, she continues to have unprotected sex and is surprised when she eventually becomes pregnant.

Following the birth of her first child at fourteen-years-old, Jane is convinced that she is *too* fertile. For this reason, she abstains from sex for 8 years and turns to the church for guidance. After her period of celibacy, Jane decides to become sexually active again. Two months into a new relationship, Jane is in the emergency room and almost dies from an ectopic pregnancy. Afterward, she is terrified of sex and of her body. Jane decides she was not made to have sex. I am on a call with Jane 6 years after her ectopic pregnancy. She is now 30-years-old and her daughter is 15-years-old. Jane explains that, after years of therapy and a college degree, she does not believe her body is defective. It is dynamic and strong. She no longer limits her sex life from a fear of becoming pregnant and views her fertility differently than the 14-year-old girl, who relied heavily on the White mainstream pop culture portrayal of female bodies in her understanding.

In much of contemporary U.S. society, women are viewed as having the ability to conceive or not. They are either fertile or they are infertile. It is a zero-sum framework that emphasizes a woman's lack of control in matters of conception. Her body precedes her

[1] All names have been changed.

interactions with the world, leaving women with the task of contending with social stigma or judgement created by her fertility. As such, fertility in the United States is framed as a problem which needs fixing, an uncontrollable failure or success of the female body. Since this framework emphasizes the biological ability of the female body, this "fixing" usually happens in a clinical setting. A physician may recommend fertility treatments to a woman who is failing to conceive or may suggest birth control to a woman who wants to avoid conception. Female fertility can be created, or it can be curtailed. Either way, the female body is manipulated by diagnostic measures to serve the woman and those who are impacted by her fertility.

Just as biomedical response to fertility is condensed to two extremes, we may claim that female fertility itself is conceptualized as a binary in the United States. A woman can either naturally conceive, or she cannot. With such a simple vision of female fertility and a lack of detailed sexual education that elucidates the ebbs and flows of fertility across the life course, it is no surprise that the subtle complexities of conception and the fertility experience are not fully understood by most.

By most biomedical accounts, the female body takes center stage during pregnancy. Childbearing creates an imminent maternal responsibility, long before the birth of a child. Habits and prenatal care prepare women to nurture a child outside of their bodies. Without this physical conception, motherhood is, in some ways, relegated to fatherhood (Sandelowski, 1995). Fatherhood, as opposed to motherhood, is not of the 'body': men do not physically give birth to children, thus there is a natural difference between the two. Since men do not carry the child for nine months like women do, men's relationships with their children may take a different form. If a woman decides to adopt due to an inability to conceive, she may be criticized for her lack of corporeal connection to the child. Her womanhood may be questioned. Despite the complex

process of bringing life into the world, let alone the additional challenge of successfully raising and supporting a child, it seems society is less concerned with celebrating and supporting the female body and is instead obsessed with correcting its failures. Questions surrounding the fertility of the female body are critical: *can* she conceive? Did she conceive at the right time in her life? Why would she *not* want to conceive?

It is unclear how a woman's perception of her own fertility dictates how she presents herself to others, how others perceive her, or how she may feel about herself. In this work, I explore ideas surrounding the female body and fertility from the perspective of women in the predominantly Black, low-wealth neighborhood of Cobbs Creek, West Philadelphia. The narratives show the transitory nature of perceptions of female fertility, and the limits of biomedicine to contend with the shame and uncertainty surrounding conception or lack thereof. During my conversations with the women of Cobbs Creek, female fertility was consistently central in definitions of family planning. The definitions alluded to how the women managed their bodies in both private and public spaces, allowing us a glimpse into their fertility experience. In this work, I stage a comparison between how "fertile" women manage their bodies in public spaces and their self-reported, largely dynamic view of their own fertility. In doing so, I illuminate the subtle complexities of female fertility on the level of the individual.

I begin by connecting current depictions of the female body in medicine to theoretical frameworks of family planning and, as a result, applied initiatives aimed at managing fertility. I then turn to reviewing documented realities of women experiencing infertility and the limited canon of ethnographic imaginings of female fertility, especially for Black women. After outlining my methodology and presenting my findings, I critically discuss the implications of transitory fertility and how the fertility experience is largely ignored in clinical settings. I

conclude by calling for more ethnographic and qualitative investigation of female fertility to support the concept of transitory fertility and to operationalize the term as a resource for health professionals in diagnostic clinical settings.

Background

An understanding of the experience of fertility as it is conceptualized by the women of Cobbs Creek, West Philadelphia requires background. As such, I establish a foundation by beginning with a broad review of how the female body is written about in biomedicine and assess how this impacts self-perception of the female body. To build upon this, I then review how the female body is discussed in and applied to rhetoric regarding family planning. As will be shown, self-perception of the female body is also impacted by conversations and interventions that are usually considered part of family planning. Lastly, I review some of the existing work aimed at understanding female fertility. I contend that a large amount of scholarship focuses on the biological basis of fertility or the psychosocial experiences of 'infertile' women who are seeking fertility treatments. From this, I call for more ethnographic work analyzing perceptions of female fertility in order to draw connections between the psychosocial experiences and biological basis of fertility. I conclude this review with an explanation of my intended contribution to the field, namely through the concept of transitory fertility, in advancing our understanding of the psychosocial experience of female fertility.

Portrayals of the Female Body

Before discussing female fertility, it is important to understand how the female body has been conceptualized in biomedicine. Scholars, such as Emily Martin, have argued that scientific

language further perpetuates gender roles in modern society (Martin, 1991). For example, Martin analyzes the science of conception as described in medical texts and finds that descriptions of female anatomy align with traditional ideas about female gender roles, specifically passivity in courtship. The egg is framed as a stationary, lazy "damsel in distress" while the sperm are seen as heroic fighters, racing to attain it. Further, the medical description of menstruation largely centers on the limitations of a feminized cell to conceive. Extensive literature exists on the effects of aging and fertility, attributing a failure of the female to replenish germ cells and a decrease in the female's oocytes (European Society of Human Reproduction and Embryology [ESHRE], Capri, 2005). Martin's interpretation of the female body in medicine can be applied here, as women are seen as the limiting factor in later-in-life conception. While women "lose" the ability to conceive at older ages, men sustain or experience only a slight decrease in their virility. Medical literature is concerned with biomedicine aiding in the "preservation" of female fertility, another phrase which implies the fragility of the female body. Since the ways in which we write about the female body seem to be impacted by socially normalized gender roles, we may question if medical treatments for female-specific conditions have been similarly impacted. In the United States in a time of increasing medicalization (Conrad, 2005), women approach biomedical intervention with a sort of "pragmatic ambivalence" (Lock & Kaufert, 1998). In other words, women seek biomedical intervention if they perceive it as serving their best interests, contributing to feelings of empowerment or independence.

While Emily Martin has unpacked the power of scientific language and its reinforcement of gender roles, Dána-Ain Davis focuses on the applied clinical experience of Black women seeking reproductive treatment (Davis, 2020). Her work centers on how racism bleeds into obstetric services for Black women and multiples the stress, or burden, of the Black female body

and the fertility experience (ibid). In her conversation with one woman, Davis witnessed "overlapping crises consisting of both infertility and obstetric racism" (ibid, p. 56). With this, Davis elucidated the hesitance of Black women to seek biomedical treatment: it is easier to avoid these situations than to deal with the emotional consequences of them (ibid). If medical encounters are inspiring such isolation and hurt for Black women, it is certainly not serving their best interests. Coupled with the perpetuated gender roles in biomedicine (Martin, 1991), Black women face yet another barrier in accessing reproductive health care.

Sometimes, reproductive healthcare can fall under the broad category of family planning. As a term that is used in everyday conversation, the concept of family planning deserves its own analysis. The phrase enlists different meanings across groups and amongst individuals, colloquially depending on context and the discipline which is defining it. With such variation, discussions and understandings of family planning have the potential to further define a woman's view of her body and her position in society. While it has been demonstrated that how we write about and handle the female body can impact self-perception (Martin, 199; Davis, 2020), we may posit that conversations and initiatives, such as those considered "family planning", can have a similar impact.

Management of the Female Body in Family Planning

Biomedical initiatives which center on women, such as so-called family planning programs, have historically been constructed to leverage the female body for large-scale societal benefit. Family planning is hailed as a great public health achievement (Tsui, et al., 2010). Historically, the term family planning has been synonymous with state or federally sanctioned programs that encourage contraceptive use. That is, family planning is viewed on the macro-

level as a vehicle to influence other areas of society by controlling fertility. In fact, family planning has been described as a way to decrease female fertility and lighten the burden of childbearing (Cleland, et al., 2006). Larger societal issues relating to environmental capacity, demographics, poverty reduction, and even the sociopolitical landscape of nations have come to be dependent upon the notion of family planning and, as an extension, the management of female fertility. Different disciplines, such as demography, describe family planning as a "rationalist paradigm" that can be used as evidence for the mobilization of new global initiatives (Krause & De Zordo, 2012). This view of family planning has been applied by governments and global health organizations.

Disease propagation, namely HIV, has been largely documented as a consideration prior to conception (Wilcher, et al., 2009; Halperin, et al., 2009; Kapiga, et al., 1998). In Vietnam, decisions to expand a family are largely concerned with the ability to care for children (Gammeltoft, 2012). This includes financial situations, the health of the woman, ideas of nationalism, and even the ability of the land to support the future population (ibid). This "rationalist paradigm" of family planning is reported to be pushed in large part by the Vietnamese government (ibid). Various campaigns encouraging contraception use among women materialize as public meetings in popular markets, or even government-sanctioned visits to the homes of women who are not currently using birth control. Here, the government applies family planning tactics first to prevent unintended pregnancies and second to grow the next generation of productive citizens. Family planning is mobilized to control population numbers and is framed as being the linchpin of the future of the country. Vietnamese women shoulder the weight of these family planning interventions, their ability to give birth to able-bodied children definitive of their womanhood (ibid). Through these initiatives, the fertility of the woman has the

power to impact multiple aspects of Vietnamese society - the pressure of this role is unavoidable, which was shown to impact self-perceptions of the female body (ibid). When one's fertility can either elevate or diminish social status, anxiety can only be expected.

Methodologically, ethnographic work within the social sciences has, to a limited extent, illuminated individual rationalities associated with family planning. The decision to conceive can be considered a "conscious choice" for individuals (Coale, 1989), though it may not always be. Even after conception, the decision to expand or start a family can be largely contingent on the individual's sense of normalcy or belonging. Considerations to conceive are intimately linked to fertility as an agent of socialization for women and the subsequent management of their bodies. The ways in which one becomes a parent, whether through pregnancy, adoption or by other means, exposes the individual to new relationships and in-group associations. For this, a woman's fertility and the decisions which may accompany it create the social world in which she lives. As such, in-depth ethnographic accounts are important in the attempt to understand self-perceptions of female fertility. In the following sections, I analyze various participant definitions of family planning and, in turn, deduce the major considerations of individuals when deciding to grow their family. As previously stated, I suspect that these family planning conversations and actions impact how a woman manages her body, and thus self-perceptions of fertility.

Female fertility in scholarship

Despite the many scholars concerned with family planning initiatives and the control of female fertility, female infertility remains an under-resourced and unrecognized condition in low-wealth communities in the United States and abroad (Bornstein, et al., 2020). Unlike a broken arm but similar to chronic back pain, infertility is an internally and externally invisible

condition (Rhodes, et al., 1991). Existing literature examines female infertility with a biomedical focus; that is, scholars have studied women who are receiving fertility treatments and engaging with reproductive technologies (Cwikel, et al., 2004; Rapp, 1999). It is known that, in the United States, formal diagnosis and treatment legitimize patient experience by affirming their symptoms as "objective signs" of a known disease (Kleinman, et al., 1978). Thus, women who receive fertility treatments may formally consider themselves as unable to conceive a child, and others may know them as such due to their treatments. Public knowledge of treatment and being labelled as "infertile" may result in "insult to self-esteem, body image, and…femininity" (Cwikel, et al., 2004, p.127), or self-stigma and perceived stigma (Fu, et al., 2015). In other words, biomedical diagnosis and treatment have been shown to stigmatize women labelled as 'infertile' in the United States and abroad.

In women treated for infertility in a clinic, scholars point to gender role identity, career role salience, and societal pressure as influences of a woman's distress level surrounding her infertility (Miles, et al., 2009). Despite the promise of biomedical treatment, women still experienced these emotions. In fact, it has been posited that the increase in medical intervention with regards to female infertility has contributed to these feelings of distress through a "fragmentation" of the body (Martin, 1990; Stanworth, 1987). Cognitively, if events are perceived as harmful, and stress overwhelms available coping strategies, depression or anxiety may result (Lazarus & Folkman, 1984). This stress coping model (ibid) has been applied to women experiencing infertility to conceptualize their emotional suffering.

Failure to conceive has been described as a "biological loss" for women (Sandelowski, 1995). Intervention procedures, such as those commonly found in fertility treatments, focus on the biological basis of infertility. This sole focus often neglects to confront feelings which may

result from the diagnosis, failing to engage with the role that stigma and stress may play in suppressing fertility. Although fertility clinics provide spaces for recognition and the formation of support groups amongst women, clinics have also been reported as reinforcing the "liminality" of fertility (Allan, 2007). This description of fertility supports the idea that infertility in clinics can be viewed as an "in-between" period for women hoping to conceive (Warner & Gabe, 2004). The limited success rates in fertility clinics in increasing conceptions serves to create more ambiguity and uncertainty in patients, contributing to feelings of resentment and uncontrollable failure after treatments. Again, existing literature alludes to a binary associated with female fertility, seemingly perpetuated in clinical spaces. Women can either have children, or they cannot. The individual's experience of their own fertility is understudied, contributing to our limited understanding of the connection between the psychosocial and the biological basis of fertility.

In recent years, the ethnographic approach has proven vital in understanding labelled medical conditions or treatments in terms of an individual's experience (Lock, 2008). If we wish to understand fertility in the United States, a comprehensive approach leveraging biological, social, and cultural variables must be utilized. The dynamic experience of fertility must thus be examined with both a qualitative and quantitative lens to be fully understood, necessitating the use of ethnography. An integration of methodology and the eventual operationalization of female fertility has the potential to amplify fertility experience across life stages to inform biomedical initiatives.

Currently, there are fewer ethnographic investigations aimed at understanding the psychosocial experiences of fertility than there are quantitative studies examining the biological basis of fertility. To date, the limited amount of fertility ethnography has revealed subtle

complexities of fertility which may only come to be known through qualitative investigation. For example, after pregnancies some Gambian women reported using contraceptives in order to let their bodies "rest" and "heal" to increase fertility before their next attempt at pregnancy (Bledsoe, et al., 1998). With numerous miscarriages or still births, Gambian women view their fertility as being reduced, and thus try to manage their bodies with medicine. Management of their bodies may in turn avoid "mishaps", which Bledsoe and colleagues describe as perceived failures in delivery or pregnancies. Again, we observe fertility as a changeable, socially legitimate "in-between" (Bloch & Parry, 1982; Warner & Gabe, 2004) that is not a binary. The subjectivity, or "gray space", of fertility has even extended to biological considerations through consistent inference of the definition of infertility. Namely, in a classic ethnographic study of infertility, women were identified as infertile after engaging in one year of unprotected intercourse without conception, or as "secondarily infertile" after failing to become pregnant after previous pregnancies (Inhorn & Buss, 1994). More technically, the biomedical standard for starting fertility treatments is after one year of unsuccessful attempts for women under 35-years-old and six months for women over 35-years-old.

While there are already few ethnographic investigations of fertility in women, there are even less on fertility experiences in Black women. It seems counterintuitive, especially after the Center for Disease Control (CDC) found in 2014 that Black women were two to three times more likely as White women to have pelvic inflammatory disease, a condition which can lead to pregnancy complications and infertility. Furthermore, Black women have nearly a four times greater risk than White women of dying from a pregnancy-related cause, independent of age or education (Tucker, et al., 2011). Despite these figures, present-day health outcomes for Black women are understudied, a possible product of negative historical influences, including racism

and discriminatory health practices (Prather, et al., 2018). These documented health inequities are thought to be shaped by contemporary social conditions and patterns that are best understood through healthcare experiences of the Black population (Williams & Jackson, 2005; Williams, 2006; Zierler & Krieger, 1997).

The current social conditions experienced by Black women that impact reproductive health inequalities may be in part a result of traumatic historical events. In their review of the literature, Prather, et al., (2018) contend that current reproductive and health status of Black women may be illuminated by the impact of context-dependent, race-based historical events. They go on to posit that these events may still be contributing to levels of chronic stress and negative self-image in Black women, especially regarding their reproductive and sexual health. Historically, the Black female body has been an externally policed entity, stripping the individual woman of bodily agency and control. Physically, eugenics programs sought to control the size of the Black population, coercing women to undergo irreversible sterilization (Schoen, et al., 2005). Additionally, there is a long history of exploitative medical research, especially in regard to reproductive health, that has led to strong distrust of the medical establishment by Black communities (Roberts, 1999). As such, it is unsurprising that the Black population is reported as reluctant to engage in clinical trials or even to refuse treatment (Clack, 2009). As a result, adverse maternal outcomes for Black women, including premature birth and high rates of maternal mortality, are rampant (Davis, 2020). While the Black population is reluctant to trust biomedicine, this observation is being extended to Black women and their use of assisted reproductive technologies (ibid). With their attempts to access these resources, Black female bodies are subject to obstetric racism which may further complicate the fertility experience

(ibid). In conclusion, the Black woman's experience with healthcare systems and biomedicine has been one of manipulation and mistrust (Randall, 2006; Clark, 2009).

Stereotypes of Black women as "hypersexual" and as an extension, hyper-fertile (Peterson, et al., 2007; Stephens & Phillips, 2003; Wallace, et al., 2011) is widely reported in the literature. Black women being labelled as "sexually-unrestrained" is not new – some scholars argue that these tropes have influenced U.S. public health policy since the 17th century (Maurer, 2000). These stereotypes are hypothesized to have historically emerged as a means to justify enslavement, sexual violence, and rape (Donovan & Williams, 2002). Stereotypes pervade classical scholarship as well, infamously in E. Franklin Frazier's 1949 conclusion that Black women are strong and independent, place little value on marriage, engage freely in sexual activity, and have no notion of "male supremacy" (cited in Dill, 1979). Frazier used misconstrued "historical evidence" to cast these judgements on the entire demographic of Black women. The following work contends that these stereotypes continue to permeate the everyday lives of Black women in Cobbs Creek, West Philadelphia and adds that they may be affecting how women attempt to present their bodies and their fertility in society. Furthermore, the Black women who bravely shared their experiences consistently expressed their knowledge of these stereotypes and detailed their attempts to combat them through their actions.

The present work is one of only a few which conducts an analysis of fertility in women who are *not* currently receiving treatments for infertility. While we have limited knowledge of the experiences of 'infertile' women, we have even less knowledge on women who go on to successfully conceive. Considering the fact that, in 2019, the CDC reported over 10,000 babies born each day in the United States, it is difficult to fathom this glaring gap in research. In any instant, tens of thousands of women in the United States are pregnant and even more may be

trying to become pregnant. Others may be attempting to limit their fertility through contraception or abstinence. Either way, most women are grappling with their fertility on a daily basis: it is a way of life. It is a way of existing in the world for women, and it is still not fully understood. To develop a foundational understanding of the psychosocial experience of female fertility is a grand, yet achievable, aim.

Here, I attempt to lay the groundwork for future scholarship seeking to accomplish this goal. I work with Black women to illuminate their experiences in pregnancy, family planning, and the conceptualization of their fertility. I suggest that women who can naturally conceive also experience emotions similar to 'infertile' women when trying to become pregnant. Moments of perceived infertility or fertility, which I describe as *transitory fertility*, is a phenomenon devoid of biomedical labelling. These periods of fertility change across a person's life and are based on life experience and belief rather than medical diagnosis or classification. Without the promise of biomedical diagnosis in previous studies, women still experience feelings of shame and isolation during periods of transitory fertility.

Methods

Study Setting

This remote study was conducted in the Cobbs Creek neighborhood, located in West Philadelphia. This low-wealth community is designated as a medically underserved area by local Sayre Health Center (SHC). According to SHC in 2017, 35.0% of their service population was below 100% of the federal poverty line compared to 13.5% of Pennsylvania as a whole (Sayre, 2017). The same assessment found that Cobbs Creek is 73% African American.

Recruitment and Study Sample

In order to update this data and prioritize community opinions about healthcare and access, in 2020 and 2021, SHC funded a Community Health Needs Assessment (CHNA). Residents were eligible if aged 18 to 89 and lived in the catchment area of 54th to 63rd street between Market Street and Baltimore Avenue. Additionally, due to the COVID-19 pandemic and exposure risk, prospective participants were required to have access to a telephone in order to participate. Recruitment was predominantly through social media advertisements, flyers in SHC, and community liaisons employed by SHC.

As an extension of this study, I utilized a snowball sampling method to identify participants who were interested in discussing family planning and pregnancy. Female participants of the CHNA were asked at the end of participation if they would be interested in commenting on fertility, pregnancy, and family planning in Cobbs Creek and if they could be contacted. Participants were contacted if they replied 'yes' to both questions. Besides identifying as female, CHNA participants did not have to meet any additional criteria for the present study. Selection criteria was kept minimal in order to hear a large array of fertility experiences, not just women who are diagnosed as 'infertile'. With such a sensitive topic, it was important to first introduce participants to SHC and establish trust, transparency, and reliability before inviting women to answer questions about fertility and reproductive health.

Data collection ended in December 2020. Eight women participated in the study, with their ages ranging from 20-50. Seven identified as Black and one identified as White. Out of the right participants, five had children and two of these women were in committed relationships. One of the women was in a same-sex relationship and was interested in IVF treatments. The other woman who was in a relationship was engaged to her long-term boyfriend. Most

participants reported living in Cobbs Creek for the entirety of their lives, with many living within a 1-mile radius of their immediate family. Semi-structured telephone interviews averaged roughly 60 minutes. Participants were encouraged to speak freely about any of their experiences relating to pregnancy or to their feelings surrounding conception.

Analysis

Interviews were audio recorded, transcribed, de-identified and imported to NVivo 12.0 software for coding and analysis. A qualitative codebook was developed in order to sort participant comments into systematized themes based on frequency. Codes of particular interest included experiences of transitory fertility, emotions associated with fertility, and management of the body. Most frequently mentioned themes in analysis included connections between medicine and the female body, a participant's perceived control over pregnancy or conception, and participants classifying themselves as "fertile" or "infertile."

The findings of this work revolve around the narratives of the eight women who shared their stories. As such, I present many direct quotations and attempt to draw conclusions through a close reading of their descriptions. I use pseudonyms when referring to each woman, but in each case, their ages are accurate.

Methodological Considerations

Preparation for this study spanned nearly two years. As an affiliate of the University of Pennsylvania (Penn), it was vital to base the present study on a foundation of mutual trust and respect. For the past decade, Penn has expanded its undergraduate campus well into historic West Philadelphia. These expansions have displaced West Philadelphia residents beyond 50th

street, thus severing generation-long ties to communities that existed pre-gentrification. Clinics like SHC are especially aware of this displacement and the resentment it has inspired in some residents of the catchment area. Although affiliated with Penn, SHC is careful to advertise itself as "Sayre Health Center" and not as a branch of the clinic-system based at the Penn Perelman School of Medicine. SHC found that residents responded less to their initiatives if the Penn name was associated.

My involvement as a researcher in the CHNA allowed me to connect with prospective participants before the current study. In addition, after COVID-19 restrictions eased in the spring of 2021, I began to volunteer in-person at SHC. These vital steps developed credibility and familiarity that I believe allowed participants to trust me with their narratives. If I had attempted to conduct this work without affiliation to SHC and as an independent Penn researcher, I am confident that I would not have had success. Even with years of preparation and relationship-building, I was able to interview only eight women. The personal topic of fertility is difficult to speak of in a private setting; with a stranger, the pressure is only amplified. As such, I applaud and admire the women who have made this work possible. With this work, I hope to lay a foundation for future sociocultural studies of female fertility and to elevate the voices of the women in Cobbs Creek, West Philadelphia.

Results

The women of Cobbs Creek brought me on a journey through their lives, complicated by their fertility. Each of them self-identified the simultaneous limitations and abilities of their bodies even though none of them were receiving fertility treatments. I begin by presenting the ways in which women defined family planning. These definitions can then be connected to how

each woman consequentially managed her own body in accordance with these ideas. Management and presentation of the female body is then questioned in terms of the fertility experience. To draw this connection, I identify instances of transitory fertility in an effort to illuminate its scalar nature and to provide a more comprehensive view of the fertility experience. An assessment of the consequences of transitory fertility comes with a presentation of the described emotional experiences, many of which are reminiscent of those reported by 'infertile' women.

Defining Family Planning

The portrayal of the female body in biomedicine has been explored through existing literature. Here, women describe their ideas surrounding the limitations and abilities of their own fertile bodies. At the beginning of our conversations, women were asked to define family planning. In the following explanations, female fertility is negotiated through family planning. Whether through a conversation with a partner, a clinician, or visibly "taking care" of one's body through public displays, family planning is not simply an internal, self-initiated process. The woman is hardly ever the only stakeholder in these conversations; instead, many individuals and important life decisions seem to depend on her ability to conceive. This aligns with portrayals of the body in medical texts: it shoulders responsibility and blame both in the case of conception and in the failure to conceive.

Stacy is 33 years-old, the mother of a 10-year-old girl, and has a bachelors and a master's degree. When asked how she would define family planning, Stacy described a formal gathering of multiple people:

> "...when more than one person comes together to talk about discuss, problem-solve, brainstorm...how they want to have a family or raise a family. Also, [discuss their] different beliefs or how the child will be brought up cultural-wise, or religion...." -Stacy*, age 33

Although subtle, Stacy includes the phrase of "how they want to have a family" in her definition. In this group of individuals, which may include partners or family members, the future-mother's fertility is called into question. If the woman cannot or does not want to naturally conceive, what are the other ways the group can "raise a family"? For Stacy, the status of female fertility is a central aspect of family planning. The ways in which a group of people decide how "they want to have a family" fundamentally necessitates a conversation of female fertility, meaning that the female body is a focal point in these conversations. If the woman cannot naturally conceive or expresses concern about becoming pregnant, conversations may shift to alternate methods of having a child. Either way and across situations, the abilities and the potential limitations of the female body are subtly made public.

Once a group, couple, or family unit decides that they want to try to conceive, the family planning conversation changes in form but maintains its focus on the abilities of the female body. There is a degree of preparation that must be discussed. Amy, a mother of two, summarizes this sentiment:

> "...taking the precautions to become or not become pregnant.... taking care of yourself during preconception to either conceive or not conceive. [Even if you] don't want to have kids, you should still be getting your body prepared now for whenever you do decide to have children. You are getting your body ready for the baby. Healthy eating, no drugs and alcohol. Also being on or not being on a certain type of birth control, that would be taking care of yourself." -Amy*, age 35

Amy describes the "preconception" period as the responsibility of the woman. If the precautions she outlines above are not met during this period, the female body is not ready to conceive. Activities such as "healthy eating, no drugs and alcohol" and talking with a doctor to begin or to end birth control are readily visible to others. As such, the female body is subject to intervention

or judgement during periods of “family planning”. The woman herself is expected to prove to others her readiness for conception. After attempts at conception are made, it is possible that the women who did not visibly “prepare their bodies” would be blamed or stigmatized for their ‘complacence’ or even labelled as infertile. Thus, Amy identifies there is a public component to family planning, similar to Stacy’s definition.

Tying into its public element, family planning may be largely dependent upon the social and professional limitations caused by pregnancy. Darlene is a graduate student, originally from Illinois, living with her long-term fiancée. She explained that some women in her program have been trying to get pregnant, but must consider the “red tape” that exists in the academic world:

> “...figuring out if you can get pregnant...[having] people who help you get baby information... [having people] advocate for you at your workplace, because [students] don't have formal pregnancy leave.” - Darlene*, age 33

While Darlene and her partner are not planning on having children soon, she recognizes that as a woman, she must start looking for “information” like daycare options and prenatal care. Darlene’s use of the word “advocate” implies a need to alleviate the burden placed on her body during pregnancy. To explain her word choice, she described that every woman “feels like they’re the first woman to ever be pregnant”. In this way, women are trailblazers – they need to constantly make their bodily needs publicly known to receive support. This is advocacy. We see this specifically for Darlene and her colleagues in the workplace environment, an experience that she claims has shaped her definition of family planning. Again, family planning extends beyond intimate groups, such as the family: it permeates, and greatly impacts, the working and social lives of women.

The phrase “family planning” connotes an active intention to understand the realities of starting a family, and thus may be viewed as inherently positive when compared to the alternative: not planning for pregnancy. The term “unplanned pregnancy” is often stigmatized as irresponsible, especially when at a young age or outside of marriage. Within the Black community, and specifically in Cobbs Creek, Nicole described the lack of family planning. Nicole, a 20-year-old who just bought her first home and is currently single, has lived in West Philadelphia for her whole life. She observes:

> “I haven't had conversations, even in my own family…it's never a conversation, like, how to plan for pregnancy. Or just plan for a family rarely, even in like, my own family, I don't have a lot of people who are married. So, there are a lot of single mothers in my family…Pregnancy just kind of happens, you know, without them planning for it. So yeah, there aren't many conversations, there's a lot of disconnects when it comes to family, and in the Black community.” -Nicole*, age 20

Nicole went on to say that, as a young single Black woman, she is giving herself time to think about what she wants her family to look like. Her career and financial stability are her main concerns as a young adult. Although she has no timeline for starting a family, Nicole explained that she is “intentionally preparing for marriage” which she believes is the first step in the pregnancy journey. Nicole describes above that preparation for marriage, and thus for children, is something that has been largely absent in her own family. Her preparation will entail “letting go of things that don’t serve [her] as an individual” because she does not want to “carry things that don’t serve [her] or a future relationship.” Nicole’s observation of her own family’s lack of transparency regarding parenthood and pregnancy largely impacted her definition of effective family planning. While the lack of conversation described by Nicole has been interpreted as indifference toward unplanned pregnancies and “single mother households”, it is more likely suppression in its purest form. There is a hope of ending the cycle with each new generation: if the circumstances are never spoken of, perhaps they can be avoided.

As a Black woman in Cobbs Creek, Nicole contends with the stereotypical trope of Black women being without restraint and becoming the matriarchs of broken families (Frazier, 1949). Her understanding of family planning is further complicated by what Nicole envisions she must do to create the 'ideal' family:

> "Because I am a Black woman, understanding the things that come along with birth…there aren't many examples of how it affects the Black person in general, and specifically the Black woman. And I know that Black women have much higher rates of complications in pregnancy and birth. And not to, like kind of allow that to perpetuate fear in your life and in your planning, but just understanding the ramifications that come along with that… before getting into family planning, understanding and doing research so that you're not just kind of left to make these assumptions on your own." -Nicole*, age 20

The described burden shouldered by Nicole is jarring. Before conceiving, and especially after seeking medical advice, she believes that she should enter an examination room already armed with a considerable amount of medical knowledge to advocate for herself. Based on Nicole's story, we can say that Black women experience an additional complication of family planning. Nicole acknowledges her positions as a Black woman in the United States and seems to draw power from the inequalities she describes. She refuses to let "higher complication rates" create fear – she instead will use the information to create action. Nicole's approach to pre-conception or family planning is one of acceptance and desensitization: she clearly feels that it is her responsibility to navigate the incongruities of healthcare for Black women. She is not indifferent to the "ramifications" of being a Black woman in West Philadelphia, but she allows her knowledge of historical inequities to guide her approach to family planning.

As has been shown, when asked to define family planning, women did not exclusively focus on contraceptive considerations. Instead, conversations seem to be largely situational and usually include a type of compromise or negotiation. To the individual, the act of family planning is not an exclusively limiting concept, as implied by the observed interchangeability

between “family planning” and “contraception” in many works to date. Family planning seems to be the act of making a conscious effort to build a family unit, ultimately depending on the fertility of the female body. To further elucidate this concept, we will explore the ways in which women understand the limitations or the abilities of their fertility and their consequential attempt to manage it.

Management of the Female Body

Family planning, as described above, to closely linked to how women choose to present and manage their bodies. Women may “manage their bodies in resistance to prevalent forms of thought that would impose certain regiments of time and behavior” (Strathern, 1992; p. 67). That is, with different life stages, women may modify or limit their bodies in order to reach a certain social or personal goal. With that, we return to the story of Jane. As a 30-year-old, Jane reflects on how she was taught to present her body as a 12-year-old:

> “It was kind of like, you know, keep your legs closed. The males have agency in terms of what can happen to me versus me having agency in terms of caring for my body and being informed...I don't have a role, so to speak, in this and my body was kind of vilified.” -Jane*, age 30

Jane identified this initial socialization as a model of behavior that she followed for the first 25 years of her life: how she chose to manage and present her body was dependent upon the opinions and actions of others. During sex, Jane explained how she thought it was something that needed to be “done to her”. When Jane was a preteen, she felt that the best presentation of her body was one of passivity and indifference: “the males have agency in terms of what can happen to me.”

To elaborate on this idea of body management, we return to the story of Darlene. Darlene spoke about the amount of control she believes she has in becoming pregnant, bifurcating the

concept between the "outward" sense of control over pregnancy and her partner's role in this (a), and her dueling "inward" lack of control (b).

> (a) "[My partner] is very supportive. If I do not want to naturally have a kid, then that is my decision, and he will adapt to that... he has taken a backseat to the fact that, you know, the baby would be coming out of my bones not his." -Darlene*, age 33

> (b) "[My friend] has had a couple of miscarriages. I was sort of spooked, but...it happens more than you think. And I think that realizing that has given me some doubt. I think I would recognize that there's less control than I may think in getting pregnant. Like how much can she sort of control in order to protect this, like, little baby floating around in there?" -Darlene*, age 33

Darlene went on to elaborate on (b) by sharing the story of her sister, who is older and starting to feel like its "too late" for her to have children. Besides miscarriages, Darlene often thinks about her own biological clock as a further complication to pregnancy. She concluded, after a few minutes of conflict, that it's "never the right time" to get pregnant – there is "always a way that it is out of our control." As such, Darlene's interpretation would prompt us to question how women may manage these physical 'limitations' and how that may impact ways in which they choose to manage their bodies.

Amy, a mother of two, shared her experience with contraception as her attempt to manage her body and thus her fertility. Her tone was one of ambivalence, and she nonchalantly described her peace with the fact that her body will not ever comply with her own expectations:

> "I have prayed for some time, but this has been the best thing that works. So, I'm not against [my birth control] or hate it. But it's just like, I know my body... I understand I am limited...I would rather not have bad side effects [to birth control] but I have to pick the best of the worst because doing nothing got me a baby." -Amy*, age 35

Amy has embraced a passive role while interfacing with medical interventions, and her explanation projects a learned indifference after years of failing to find a suitable birth control. She will sacrifice comfort in order to control her fertility and prevent pregnancy – a framework which will continuously resurface as we explore Amy's story.

Both Darlene and Amy have identified their bodies as limiting factors. Darlene's reflections on miscarriages and her biological clock charged her voice with a sense of urgency: as a graduate student with years of school ahead, she cannot control her fertility as she would have hoped. Amy's comments suggest a deferral to biomedical intervention, introducing the idea that her body uniquely restricts her from living a comfortable life. She must choose to either control her fertility with an uncomfortable birth control method and prioritize future goals or live without birth control-caused pain and possibly have a child. In both instances, options are limited.

While Darlene and Amy described their internal understandings of control with regard to their own bodies, Nicole shared her observations of how the Black female body is publicly managed:

> "Black women have carried the world on their shoulders. And we're used to it. So sometimes it's not necessarily taught for us to learn about those things, because we're focusing on survival. We're focusing on just like making it through or reaching goals and striving for new things. And, of course, it's not for everyone, but at least in my experience, my family has been like that. And pregnancy was not planned most of the time, right? I actually am starting to have more conversations with my family just about, like, why no one is married, why we aren't in positions to be in healthy relationships, why others aren't in the picture at all. I think that's where it starts with, like having those conversations preparing your mind. And that's something that I'm doing. And I'm super grateful to be able to do, of just understanding everything that my family carries, and being able to change that in a way for the better. So that my kids don't have a broken family." -Nicole*, age 20

Nicole's quest for answers from her family as to "why no one is married, why we aren't in positions to be in healthy relationships…" reflects her hope to change the trajectory of her own life. Nicole explains that the women in her family have focused on "survival" for so long and are mostly concerned with presenting themselves as strong individuals. During our conversation, Nicole used the verb "to carry" at least a dozen times. Her description of the Black female body was constantly bridged with the term "carry": the women in her life focus on carrying many

different responsibilities, including the maintenance of their identities as "capable" to counteract the stereotypes associated with Black women in the United States.

Instances of Transitory Fertility

The ways in which women manage their bodies may be traced back to how they view their own fertility. As I have posited, the fertility experience is a fluid one. Transitory fertility, or the idea that there are periods of perceived fertility or infertility that change across an individual's life, is a possible way to comprehensively describe this experience. Environment and life experience further contribute to transitory fertility, and thus the fertility experience.

Jane's story introduced the present work, her testimony attributing her felt bodily confusion and ambiguity to a dearth of resources in her community. Beginning as a 14-year-old and continuing through her adulthood, Jane describes below how her understanding of her fertility dictated the choices she made. The change in Jane's understanding of her fertility is documented between (a) and (b):

> (a) "I mean I got pregnant as a teenager and it wasn't my first-time having sex. It wasn't my first partner. There was condom usage sporadically. Honestly, I don't know if I was thinking whether I could get pregnant, you know, because I had sexual experiences prior to my pregnancy. So, it was kind of this, you know, until it happened, I thought I couldn't get pregnant, and then I did." -Jane*, age 30

> (b) "I was afraid [to have sex] after [I gave birth]. Afraid that I will get pregnant again. Which spoke to my ignorance. I may have moved in with my grandmother. Around 19 years old. And there I had cousins who were in a church. And so, from that time, I remember it was like, I didn't have sex for about eight years. It was eight years of celibacy." -Jane*, age 30

Within the 9-month gestation period, Jane went from believing she could not conceive to believing she was hyper-fertile. Her perceived infertility led her to have unprotected sex, while her perceived hyper-fertility led her to take a celibacy vow for fear of becoming pregnant. There seems to be a mutualistic relationship between Jane's understanding of her fertility and the

expectations she felt obliged to uphold in her community: one greatly informs the other. Overtime, as her environment changed, so did her perspective on her body. Jane's management of her fertility dynamically changed as her priorities changed. The constant fluctuation of Jane's view of her own fertility, beginning with her conviction of infertility and ending with a fear of her perceived hyper-fertility, serve as evidence for the idea of transitory fertility. As Jane would say, her understanding of her body and fertility is still evolving.

As briefly mentioned, Stacy is the single mother of a 10-year-old girl living in Cobbs Creek. Raised in a conservative household, Stacy explained that she was the stereotypical smart and ambitious daughter: when she was sent to college, her parents expected multiple degrees and marriage. Marriage should come before children. An unplanned pregnancy complicated Stacy's plan:

> "When I got pregnant...I was very, very shocked. Because I didn't think I could. Because at one time I did try, and it didn't happen...I always thought that I could [naturally conceive]. You know, I always wanted to be married with two daughters and live in Delaware and have a fancy house and car. But that changed when I thought I couldn't have children. My dreams were like kind of shattered. It wasn't, you know, how I planned it to be...I just felt, not bad, but ashamed. Ashamed that I didn't follow my dreams." -Stacy*, age 33

At the time, Stacy was a 23-year-old woman who, as she says, "didn't think" she could get pregnant. With one pregnancy test, Stacy's understanding of her fertility changed. At one point, Stacy believed she would have trouble naturally conceiving and within minutes, her dreams "shattered" with the realization of her fertility. Stacy's undulating conception of her fertility and her emotional experience are an instance of transitory fertility. The events that would ricochet from the realization of her pregnancy, such as an inability to "be married with two daughters and live in Delaware", create her fertility experience. Coming to terms with her fertility was a struggle for Stacy, especially with regard to her parents:

> "I was kind of afraid to tell my family [about my pregnancy] because they viewed me, as..."she's not having sex...[she's] making a life for herself". And I was kind of afraid of the changes, how they would think about me. So, I hid my pregnancy from them for five months." -Stacy*, age 33

While Stacy's understanding of her fertility rapidly changed, she needed to find ways to express it to others. By hiding her pregnancy, Stacy attempted to slow the changes which she knew would inevitably result. Stacy anticipated her parents' view of her would shift and she was devastated by this.

With the stories of Jane and Stacy, we can begin to tease apart the intricacies of the psychosocial female fertility experience. For both women, self-perception of their fertility changed and impacted how they interacted with the world. These undulations in understanding also affected the mental states of these women, as we will see in the next section.

Emotional Experience

The connection between fertility, life achievement, and goals identified by the women thus far presents an additional question: how does the ascribed value and pressure of female fertility impact a woman's mental state of being?

Mary is a single, 30-year-old woman with a busy career. One of the first things Mary shared was that she plans on adopting in the next few years. When probed as to why she would like to adopt over other options, Mary explained that she believes she is infertile. She has "never really had any reason to feel like that" but insists that she can most likely not have children. I asked her if she had any experiences that may have led her to think about her body in this way, and Mary started by describing her relationship with a man in college. At the time, Mary and her partner used condoms, but she would take pregnancy tests every week to make sure she was not pregnant. She went on to explain this period in her life as tumultuous:

> "We thought about conceiving. And I was excited. That's another thing too. I don't like that excitement that you get when you think you're pregnant and you find out you're not and now you're so disappointed because it was never there. I don't like that feeling. And I've had that feeling in college. And every time it was so disappointing like I'm, like heartbroken, literally heartbroken because I love kids. So, I went on birth control because of those constant disappointments, like the disappointments more like, like it was just like it was really upsetting anxiety. And as I've been told, I didn't want to keep up with that... I just want to finish school. The rational side of me was like, but this is a good thing [to not be pregnant]. You're still in school, you're not ready. And that was the part that I couldn't present that was like, this is a good thing, because I'm not ready. But I'm still disappointed." -Mary*, age 30

Mary described her emotions as a "roller coaster." With each negative pregnancy test, she felt relief for her career but disappointment that she would not become a mother. Conflicting roles in society, as a mother and as a professional, drove Mary to take matters into her own hands to avoid what she describes as "crippling disappointment." Pragmatically, she turned to biomedical intervention to control her fertility and as a result, to decrease her anxiety. Here, we see an alternate use of biomedical services: contraceptives were not created to alleviate mental health issues and anxiety, such as that described by Mary. I later learned that Mary is still on birth control. The initial assumption of her own infertility is a way to avoid falling back into the emotional roller coaster of uncertainty that came with the question of fertility. Mary does not want to maintain hope of a pregnancy that may never happen; instead, she focuses on maintaining her workplace success and feelings of positive self-worth.

Next, we return to Amy's story. We have seen her attempts at managing her fertility through contraception, and her learned indifference at never finding a birth control option that is both comfortable and effective. Amy's experience with birth control can be further contextualized through her pregnancies. At 35 years-old, Amy has two children, both of whom were unplanned pregnancies. As Amy explained, the two fathers were not the kind of men she had envisioned starting a family with. For the first unplanned pregnancy, "everyone was excited": there was a baby shower, the father was involved, and Amy's mother and grandmother

helped. After the birth of her first child, she said to herself, "[For the next baby] I'm gonna make sure that I'm married and it's gonna be great." She would "get it right the second time."

However, Amy's second pregnancy was not what she had hoped for: it was unplanned, and with a man who she described as toxic. Amy explains how she felt during that pregnancy, and the residual feelings she still experiences years later:

> "And I feel like I actually do have some resentment towards my body today, just because...when I found that I was pregnant, [the child's dad] was kind of was like, well, maybe we should rethink this...I don't know, maybe I do need to let it go. But like, I harbor some negative feelings because of my negative memories about [pregnancy]." -Amy*, age 35

After having two unplanned pregnancies, Amy explained that she attempts to set boundaries for her body. The only way she would consider having another child is if her partner brought it up in conversation:

> "[In the future, I want a partner] to take initiative and like, really say "I want you to have my baby"...because I felt bad just randomly becoming pregnant twice." -Amy*, age 35

Amy expressed shame and frustration at her body for becoming pregnant. The timing of her pregnancies did not align with her life goals. She had hoped for a long-term relationship with a "good" man followed by marriage and then children. The order had been "messed up." Amy's inability to control her fertility, and her body's spontaneous pregnancies, have largely dictated how she views relationships and her future. Amy ended our conversation by describing one of these relationships:

> "When talking to my manager at work, who has been trying to get pregnant for like 2 years and is married...financially steady, I almost feel guilty for getting pregnant so quickly and without planning it." -Amy*, age 35

Amy's understandings of deservingness are outlined here. She, as a single woman without the financial means to have a child, is able to become pregnant while her highly 'deserving' manager

cannot. Amy explained that she has a hard time conceptualizing why "good people can't get pregnant" and can't understand why she would get pregnant so easily.

These feelings of shame and guilt that Amy describes may be understood by women through concepts like fate. Stacy's explanation below exemplifies this. She has learned to accept how becoming pregnant is beyond one's control, and that everything happens at specific moments for a reason:

> "[If pregnancy is] not meant to be, but maybe other things are in store for you right now. You know, it could come at a time...when you're in a deep, dark place. And you'll be at your wit's end, but maybe if you are pregnant it can bring you some joy and relief." -Stacy*, age 33

Stacy went on to tell the story of her daughter's paternal grandmother, who was in a "deep, dark place" because she was alone. Her son had moved out, and everyone else around her had died. When Stacy became pregnant, her daughter's grandmother had a new will to live. Stacy chuckled, saying that she had a "glow" and "always wanted to be with my daughter". She believes that her daughter came at the perfect time. Stacy's pregnancy happened for a reason: to save her daughter's grandmother's life.

As we have seen, the female body can take on many meanings. Whether that be through its fertile abilities or its limitations, it can connote frustration, shame, guilt, or hope. We end with another thought from Nicole, who spoke about the displays of emotions that she witnessed growing up:

> "My mother, my grandmother, my aunt, my cousins, as Black women, they're more so focused on providing and being independent, and, you know, kind of just being the superhero woman. And it's not, it's not healthy, and essentially does what women aren't created to do everything." -Nicole*, age 20

Nicole hypothesizes that the expectations of Black women and their need to refute stereotypes in their everyday lives is detrimental to their mental health. These extra social responsibilities

associated with the female body can also create some of the emotions which we have identified here. Whether from a need to appear "independent", to prepare the body for conception, or to alleviate the complications of an unplanned pregnancy, the social weight of the female body is a heavy one to carry.

Discussion

The women of Cobbs Creek have voiced definitions of family planning, allowing us to analyze how they manage their bodies in public spaces and, as a result, experience their own fertility. As mentioned, none of these women are currently receiving fertility treatments, but periods of infertility or hyperfertility inspired the same shame, resentment, and guilt as women who are biomedically labelled as 'infertile.' While we first considered family planning and body management to understand instances of transitory fertility and thus the fertility experience, it is important to note that, in each direct quotation presented, these emotions continuously reappeared. Emotional experiences such as those described are not limited to women who actively seek biomedical treatment in a clinical setting. These emotions also appeared in the cases of unplanned pregnancies. Often, pregnancies were considered inferior if they were unplanned. For the Black women who participated in this work, unplanned pregnancy seemed to 'doom them' to confirming stereotypical assumptions associated with Black femininity. While stereotypes surrounding Black women and their reproductive health are overwhelmingly present in the literature, the ways in which these tropes bidirectionally inform a Black woman's perception of her fertility and decisions are not.

Overall, it seems that a lack of control over one's fertility at any given point in their life causes unease and the other potentially negative emotions. Based on these limited accounts,

unease surrounding fertility may be a more universal phenomenon than previously thought. If the reported unease is more broadly linked to the female body and its perceived limitations in society, this may affect a large number of reproductive-aged women. Even if women successfully conceive, they still may be experiencing their bodies with the same unease as 'infertile' women. With these findings, there is evidence for the transitory nature of fertility: the way in which a woman understands her own fertility is not merely as 'fertile' or 'infertile', but instead undulates at either extreme or at an in-between space throughout her life.

The fact that no participants sought fertility treatments or biomedical intervention, even during periods of perceived infertility, further supports the notion of medical mistrust in the United States among some communities. Seeking health care to aid in conception was described as a "last resort", and one that most women in Cobbs Creek would rather avoid. Thus, even if evidence-based reproductive medicine is available in a community, women may not readily utilize it. For example, Amy's narrative surrounding contraception described nonchalant indifference, suggesting exasperated acceptance at her body's inability to accept the medicine as opposed to disappointment or frustration at her doctor for not finding a personalized option. As one woman said, "I will take the best of the worst." Women seem to have decided that many reproductive health interventions, even those as common in American discourse as contraception, are beyond improvement and may not be worth their time.

When given the opportunity to explain their reproductive health and fertility journeys in their own words, participants explained their own experiences in terms of societal conditions. With unwavering clarity, Darlene explained that "…social ideas have affected the way we carry out scientific studies. We talk about science as if it's objective, and it simply is not." She goes on

to say how she believes women are meant to see their bodies as "fragile" and as something that must be "guarded":

> "The fragility is real, but it's not specific to women...The limits of what it can do hasn't been tested, just assumed. And I just think that, you know, with the image of our bodies as fragile, we feel we should hesitate before we act. Yeah, I think we feel our bodies with a lot of anxiety." -Darlene*, age 33

Biomedicine has standardized treatment for women who have trouble naturally conceiving, whose bodies are not 'cooperating.' If a body is not cooperating, it may mean isolation for the individual and the assumption that there is 'fixing to do.' The question then, must be posed: does biomedicine perpetuate "female fragility" by ignoring all other aspects of fertility *besides* infertility? In essence, we must assess the role of biomedicine, whether through its current or nonexistent treatment programs, in sustaining the feelings reported here. Either way, the biomedical focus on failures of the female body has notably impacted how women view their own bodies and their fertility.

My work suggests a need for interventions, both within and beyond biomedicine. Within biomedical encounters, what can healthcare workers do to quickly assess a woman's perception of her fertility to proceed with or stop treatment? Transitory fertility explains the fluctuations of how a woman may perceive her own fertility, but how can we know where along the scale of 'infertile' or 'hyper-fertile' a woman may be at a specific moment? These questions are beyond the scope of the present work, but directions for future investigations include operationalization of the term "transitory fertility". If an instrument, such as a scale, could be created to quickly assess the patient's perception of her fertility in an isolated clinical encounter based on current life events, we may be a step closer to currently acknowledging and supporting the female body. Whether assessment leads to a diagnosis and eventual medication or simply allows a physician to

have a supportive conversation with a patient, it would contribute to the cultivation of medical spaces with uplift female narrative experiences.

Outside of biomedicine, it may be useful to build community-based sources of support for women to share their fertility journeys. It also seems support is needed for Black women who may be considering fertility treatments but are hesitant due to the public nature of it, medical mistrust, or the obstetric racism that is known to accompany such services (Davis, 2020). Focus groups provide a safe space for women to vocalize their biomedical experiences, share knowledge of services, and visions for the future. These supportive resources may originate at community stronghold centers, such as churches or recreation centers. Or, if a local health center is influentially prominent in a community as a socially trusted force, these resources may reside there. Women suggested that the local Sayre Health Center in Cobbs Creek needs to be more vocal and present on media outlets, as many do not know the extent of their services. Even if focus groups are generated or marketed by a health center, it would be vital to create a boundary between these community resources and biomedical treatment. The created space should be clearly separate from treatment or clinical care in order to encourage the low-pressure exchange of ideas, especially in Black communities where biomedicine has historically wronged them.

When considered in tandem with women's' descriptions of the silence surrounding unplanned pregnancies and "broken families" in Cobbs Creek, it would be productive to carve a communal space for conversations that are too often muted in an attempt to avoid confronting stereotypes. Community outreach was also identified as a possible source of support for women who are struggling with feelings surrounding their own fertility. Demystifying the concept of fertility through interaction with other women may be the first step to changing the conversations

and preconceptions surrounding women's bodies. We return to Darlene's previously considered sentiment to summarize this point:

> Women are getting [pregnancy] information from their mothers who haven't been pregnant for 35 years...women get pregnant and give birth every day. So why does it feel like *I'm* the first person?

The fertility conversation has to begin somewhere. A community-specific space for women to share their experiences with pregnancy, reproductive health, family planning, conception, and contraception will provide support systems that may not be found elsewhere. A woman's family and the institution of biomedicine both cannot offer the contemporary, rich, and varied narratives that women are eager to share with each other. To view themselves as women with bodies that are dynamically changing offers a unique empowerment that may help gain some distance from the medical metaphors that slip into our everyday language (Szasz, 2007).

Conclusion

To date, biomedical research has focused on solutions to "fix" the inability to conceive, or the infertile, female body. For women who are not receiving fertility treatments, there is no biomedical acknowledgements nor investigations of emotions surrounding transitory fertility. In this work, I have presented the narratives of the Black women of Cobbs Creek, West Philadelphia in an effort to understand how they perceive their fertility. These self-perceptions affect the ways in which these women present, or manage, their bodies in the social world, and how they may define family planning. I go on to explore the self-reported emotions of these women, drawing comparisons between their emotional experiences and those reported of women who are labelled 'infertile'. As I have established, transitory fertility describes self-perceived undulating periods of fertility or infertility in a woman's life. Although eventually able to

naturally conceive, women who experience transitory fertility reported similar emotions as women who are ‘infertile’ and receiving treatment in a clinical setting. Furthermore, I go on to posit that most women do experience transitory fertility.

I hypothesized that a woman’s understanding of family planning, and the subsequent ways in which she presents or manages her body, are influenced by her fertility experience. The fertility experience can be described using the concept of transitory fertility, which is dependent on the life experiences, events, and beliefs of the individual. After reviewing existing literature, I presented individual definitions of family planning and analyzed the centrality of female fertility in these accounts. This led into an investigation of how women manage their bodies, which cleared a path to understanding the fertility experience in these individuals. An overarching theme through this continuous analysis were the emotions of shame and guilt that women reported.

To frame these findings, the influence of biomedicine on women’s views of their bodies was considered. Emily Martin has shown that medical texts have been influenced by social dynamics, such as gender norms. To understand the interactions of the Black female body with reproductive medicine, Dána-Ain Davis frames the clinical experience as ‘ceremonies of degradation’ which inspire humiliation and shame in Black patients (Davis, 2020). I extend these claims by highlighting the biomedical treatment of fertility as similarly influenced, with its sole focus on the reproductive “failures” of the female body, or infertility. As reflected through the idea of transitory fertility, women are similarly viewing their bodies with doubt, resentment, blame, and anxiety. With these reported emotions, there is a focus on possible failures of the female body, even before attempts at conception. This overlap poses the question of how Western biomedical treatment options may be shaping a woman’s perception of her own body.

While I hypothesize that the concept of transitory fertility is universal, the events which shape a woman's temporal concept of her fertility is not. As such, it was necessary to explore the historical inequities experienced by the Black community that also point to well-documented and ongoing medical mistrust. The stereotypes associated with being a Black woman in biomedical apparatuses in the United States was also reviewed. When the narratives of Black women were analyzed alongside contemporary considerations of medical mistrust and stereotypes, each woman's fertility experience became clearer.

As the brain-body, or the mental and the physical, connection is a mutually influential one (Clark, 1998), it is yet to be determined if the psychological basis of transitory fertility may have biological connections. While the call for the use of epidemiological methodology and quantitative analysis in *infertility* studies is still salient (Inhorn & Buss, 1994), to recognize the dynamic nature of female *fertility* over the life course, more qualitative and ethnographic work is needed. Broadly, this work seeks to bring awareness to the vastly rich and largely untapped potential of female fertility as the subject for ethnographic and qualitative studies. Many of the women represented here engaged with contraception and visited physicians for reproductive health concerns. But, through their narratives, we have seen that some did not necessarily reveal their true sentiments to their physicians. Outside of the clinical encounter, it was suggested that focus groups within communities would provide a safe space for women to share their pregnancy and fertility narratives with other women. Clinically, in order to quickly understand the fertility experience as it is to their parents, an instrument to quantify transitory fertility would be useful to aid in diagnostic treatments. As fertility has proven to be subtly complex in ways that go beyond the scope of this work, it is only sensible that the biomedical assessment of fertility make space for the female voice outside of *in*fertility.

The women of Cobbs Creek, West Philadelphia have courageously shared their stories with me. With this work, I have attempted to put their experiences at the center of a reconsideration of the social and political reproductions of inequities in medical settings. Biomedical studies to date have focused on the biological basis of infertility as opposed to fertility, and for this, have failed to uncover the subtle complexities of the fertility experience. We must question how, in a highly medicalized society such as the United States, this subtle and not so subtle biologized priority permeates into everyday fertility discourse. In my future scholarship, I will continue to add to the field of critical medical anthropology through fertility ethnography in order to assess the social implications created by biomedicine's focus on female reproductive shortcomings. Through this work, I envision a framework of female fertility which leverages both psychosocial and biological elements to fully construct the fertility experience. With such an understanding, we invite the possibility of providing patient-centric healthcare to women, especially those who have been continuously ignored and wronged by biomedicine on the basis of race.

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