We are the Bridge and We are the Gap:

Black Women's Sisterhood as a Practice to Increase Health Status

by

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ABSTRACT

Over the last four centuries, Black women have been overwhelmingly understood, imagined, and defined through a Eurocentric and oppressive lens. The Eurocentric or white lens places pseudo-characteristics on Black women that inaccurately describe them. The qualities ascribed to Black women are rooted in racial ideologies that benefit and progress the interest of White supremacy. This history has placed Black women in tension with institutionalized medicine, discouraging them from seeking or using healthcare resources. Without trust in a system positioned to heal, treat, and prevent health ailments, Black women cannot dialogue with those that are a part of that system. Paulo Freire argues that "dialogue is the encounter between men, mediated by the world, in order to name the world (Freire, 2000, p. 90)." By centering Black women and their voices, I envision (re)naming the world. Understanding how Black women from Lincoln County, Mississippi describe their health and bodies sheds light on their daily experiences that facilitate self-care, womanhood, and identity.

This dissertation covers three related studies that are addressing: 1) how Black women from Mississippi see their bodies outside of deficit health, 2) how Black women's sisterhood has been a collective effort to build womanhood and health, and how societal stereotypes can interfere or damage the progress of sisterhood, and 3) the importance of allowing for Black women's ways of knowing to create liberatory data collection methods that represent who they are and their truth. I examine these dynamics using a mixed-methods approach including community-based participatory research and rapid ethnographic assessment sampling techniques (e.g., working with a community advisor),

semi-structured interviews, Sister-girl Talks (focus groups), participant observation, and autoethnography. The results of the three-study mixed methods dissertation has both theoretical and practical implications for understanding the vital role that Black women need to play bring healing to their health in both healthcare settings (e.g., clinics) and healthcare planning (health evaluation programs and interventions.

DEDICATION

This dissertation is dedicated to my husband, Andre, and children, AJ, Halle, and Heze, who have fallen asleep on the couch so that I would not be alone while writing late at night and waited patiently for me to complete this chapter in my life. Now we can fall to sleep on the couch while spending time with each other. To my mother, Elaine, who has been my life-long cheerleader and whose knees are probably sore from "prayin' me through life." My mother is my anchor, my community advisor— my strength. Sister, you know I had put you in here, Lare'L thank you for always making me feel like I am a genius. And to my friends who have supported me by lifting me up and rooting for my research, the long nights and pre-COVID lunches in the lab would have been lonely without you all, long live the SHESC Black Avengers. I love you all and am truly grateful to be blessed to spend my time on earth with you. Lastly, but most importantly, I dedicate this dissertation to my family members who left this earth way too soon due to health inequities that I hope to chisel away at in my lifetime; Big Momma, Pawpaw, Aunt Jeanette, Aunt Dot, Uncle Charlie Dee, Aunt Jo, and Uncle Jimmy Dale — without you with me life is incomplete. Because of you, I am passionate about the health of Black individuals.

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Life was full of disease as I traveled my doctoral journey, diseased in the ways that racism became unashamed to violently destroy someone's life in our country and diseased physically where the COVID-19 pandemic prematurely stole lives and livelihood. And through all of this, the beautiful Black women I worked with in Mississippi allowed me to continue learning from them. This dissertation is made possible because of them. I must thank my nurturing committee members that keep me grounded. To Dr. Ore, you helped me see the literary scholarship of Black women in a different light; it was you who helped me pick up my tools to get to work on building onto Black feminist strategies that push Black women's knowledge to the forefront. Dr. Davis, you helped me reflect on how I can continue to be an intentional and positive addition to the bridge of Black women's sisterhood and most importantly, you taught the importance of self-reflexivity and how it needs to be in the center of all research approaches. Dr. Brewis, I appreciate you for being an advisor who saw the research vision that I had and actively supported me by being a structure that I could lean on. Dr. SturtzSreetharan, you were my mentor since day one on my Ph.D. journey and never stopped walking with me. And to Dr. Wutich, I remember the impromptu meeting that we had when I was deciding on Ph.D. programs to apply to, and you guided me in the right direction then and continue to be the wind that blows in to shift things in the right direction.

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CHAPTER 1

INTRODUCTION

I was eight years old when I first experienced personal loss. Just a few months earlier, my aunt had helped us move from Mississippi to Florida. Shortly after her return home to Mississippi, she passed away. I remember the warm Florida sun hitting my face through the window in my mother's room when we received the call that my aunt had passed away from this earth. With tears welling in her eyes, my mother looked at me and told me Aunt Jeannette was gone. This was the aunt that I rode with in the front seat of her old beige and plum-purple striped Chevy pick-up truck to get seafood from Louisiana. This was the aunt who could fix anything from a vehicle engine to the weighing scales at my uncle's seafood market. This was the aunt who was tough as nails, I'd never seen cry, and whose voice would carry over the roaring whistle of a train. Yet, she was silent about the pain she was experiencing from her failing health or, rather, the system failing her health. My aunt had been diagnosed with rheumatoid arthritis, but in actuality, it was lupus. Aunt Jeanette was 36 years old with two young children— she wanted to live, so in the words of her daughter, "she became a medical experiment." This makes me wonder if her silence regarding her health occurred because she exhibited the mythical traits of a Strong Black Woman (SBW) (Beauboeuf-Lafontant, 2009; Jones & Gooden-Shorter, 2003; Wallace, 1990)? Or was it the product of the lack of attention given to her narrative by medical practitioners—a part of Black women's lives that intentionally and artificially connects them to a sisterhood built at the expense of their health?

Within this dissertation, I am compelled to visualize southern Black women's health outside of statistics that have mis-measured and devalued their bodies. Instead, by drawing on Black women's knowledge and descriptions of health, I want to make visible the ways that Black women "see differently;" it is through this 'seeing differently' that health treatments can be developed which will help close the gap in health equity for Black women. My examinations into Black women's health relied on qualitative ethnographic methods which centered Black women's voices, health experiences, and self-knowledge. Over two summers of fieldwork with health as the backdrop, I partnered with southern Black women to understand their definitions of health outside of biomedical frameworks. Additionally, by engaging the consciousness of Black women's sisterhood as a health practice, I construct a critical methodology to engage with Black women to acknowledge their ways of knowing as expertise and reduce exploitative and extractive research practices that add to the silencing of Black women voices.

Casual inquiries into many Black women's health experiences reveal that they are at risk for various non-communicable diseases such as hypertension and obesity. Indeed, obesity affects 56.1% of Black women aged 20 and over (National Center for Health Statistics, 2017). The southern region of the U.S. carries the most weight and has negative associations with obesity (Akil, 2011; Warren, 2018). Southern Black women, specifically, are viewed and imagined as bodies at risk of ill health, predominantly obesity and heart disease. My research aims to provide a counternarrative to this imagery by asking the following questions: What are the lived experiences and situations of Southern Black women? How do southern Black women experience their "risky" health

and wellbeing daily? How do Black women negotiate and live outside of what is "expected" of their health vis-à-vis their social networks and the medical community?

An ethic of care has been and remains absent from the medical health model in the United States for those living in Black bodies. The medical realities of Black people are sobering when viewed through recent health statistics; for example, in 2017, heart disease was among the top three leading causes of death. Black people have the highest risk of hypertension (blood pressure > 139 for systolic and > 89 for diastolic) across all other racial/ethnic groups in the United States, with prevalence rates of 41.8% and 42.9% for women and men, respectively (Fryar, 2017; Mozaffarian et al., 2016; National Center for Health Statistics, 2018a; Yoon, Carroll, & Fryar, 2015). Indeed, 46.1% of Black women have been diagnosed with hypertension, the most prevalent in the world (Mozaffarian et al., 2016). Obesity rates among Black women and men are also relatively high. Black women have rates around 56.1%, and Black men are lower at 37.5% (National Center for Health Statistics, 2018b). In our current COVID-19 pandemic context, Black people are disproportionately affected by the disease; for example, drawing on available data and demographics of 131 US counties, Thebault et. al found that counties with majority-Black had over a three times higher rate of infection and almost six times rate of deaths per 100,000 cases (Thebault, 2020). This disproportionate toll is further reflected in the COVID-19 death rate: Black people represent 13.4 % of the U.S. population but almost 15% of the COVID-19 deaths (Centers for Disease Control and Prevention (CDC), 2021; United States Census Bureau, 2019). Consequently, the southern states of Louisiana, Georgia, Alabama, and Mississippi were death knells as they told their stories of medical inequity around COVID-19 early on. In April 2020,

70% of the state of Louisiana COVID-19 deaths were Black individuals, yet they only represent 33% of the state's population. Public health agencies were slow to acknowledge this reality: Georgia, Alabama, and Mississippi departments of health could only release inadequate and incomplete statements such as, "At this time, the African American community *seems* to be hit the hardest" (Zanolli, 2020, italics not in original source). Given the realities of Black health being attached to so many diseases, much of data gathered from Black people became a blame game, where the victims themselves became responsible for contracting COVID-19 due to their pre-existing conditions such as hypertension, diabetes, and obesity (Poulson, 2020; Tarof, 2020; Yancy, 2020). The pre-existing political, systemic, and institutional racism was not mentioned. Unfortunately, despite consistent health disparity documentation demonstrating intense need, access to quality health care with positive outcomes remains elusive for many in Black communities, especially in the southern U.S.

(Un)health is one of the most prevalent characteristics attached to Black women's bodies (McClure, 2017; Perry-Harris, 2011; Fett, 2002; Roberts, 1997). Historically Black women's bodies have carried a more significant load— viewed as a machine and unhuman (Browne, 2015; Washington, 2006). Consequently, Black women and their bodies are understood to be raced, gendered, and sexed in ways that are both hypervisible and in direct opposition to White bodies (Browne, 2015; hooks, 2015; Washington, 2006; Giddings, 2001). Many views of Black people that are infused with racial domination to control their identity can be applied in general, but views of Black women specifically resulted in the objectification of their bodies as something which can be taken apart and examined empirically, often without their consent (DeGruy, 2017; Washington, 2006,

Roberts, 1997; hooks, 1992). This history has placed Black women in tension with institutionalized medicine, discouraging them from seeking or using healthcare resources—silencing their health experiences—silencing their health knowledge.

Mississippi is (in)famous for being first and last in many salient events and rankings. For example since 1990, Mississippi has been *first* in the US as the state with the highest adult obesity rate (The State of Childhood Obesity, 2020). Mississippi was *last,* however, in its formal recognition of the 13th amendment to abolish slavery, officially doing so in 1995 (McKynzie, 2013). And one of the most brutal ways that Mississippi is defined is that "M" is for Mississippi and Murder (Zinn Education Project, 2021). Lincoln County, MS, the location of the fieldsite for the data presented in this dissertation, is memorable due to the assassination of Lamar "Ditney" Smith as he was trying to exercise his right to vote at the courthouse on August 13, 1955 (Zinn Education Project, 2021). This intentional "overlooking" of humanizing Black Mississippian is one of the compelling factors in choosing Lincoln County, Mississippi, as my dissertation field site.

Lamar Smith is not the only Lincoln County, MS, citizen to be remembered; Eva Harris is another highlight illustrating why this field site is so critical to creating discourses around the centering of Black women's voices. Eva Harris was one of the first Black women schoolteachers and superintendents for Black schools in Lincoln County, Mississippi. While other Mississippians were migrating north due to the violence centered around Jim Crow laws rooted in White supremacy, Eva Harris stayed behind to help educate local Black individuals (Harris, 1987). Mrs. Harris graduated from Alcorn University, one of the historically Black colleges and universities (HBCUs) in

Mississippi, in 1942, fifteen years after graduating from high school (para. 57). However, because of segregation laws, she was not allowed to attend college in Mississippi to receive her master's degree and instead had to attend Northwestern University in Evanston, Illinois (para. 73). Harris stayed behind in Mississippi as her siblings migrated north to provide access to education for Black individuals in Lincoln County because the state of Mississippi did not provide funding for Black schools (para. 84). The school buildings and education system were all built on the culture and strength—the Black community's identity (para. 96). Through education, Eva Harris played an intricate part in transforming and repositioning Black individuals in this county. However, to appreciate the advocacy of Black women from the "Souf" (south) such as Mississippi you must also appreciate their religiosity. Mississippi is the most religious state in the U.S. (Newport, 2017); and, for many southern Black women, religion has been a part of how they have "gotten ova'" and through circumstances and struggles in life. In a 1987 oral history interview, Mrs. Eva Harris sums up her life as follows: "For my life, God was first in my life, my family, my fellow man, and I came last. Now, that's really been my life" (Harris, 1987). For many Black women of the past such as Eva Harris and in the present such as the women that participated my dissertation projects, this quote rings truth.

Taken together, these examples only scratch the surface of sacrifices that Black people living in Lincoln County, MS, have made to facilitate change to push this Black community out of the margins of oppression and into an environment that captures their human dignity and truths. In this dissertation, I illustrate the importance of focusing on smaller communities to learn from them and push their self-knowledge to the forefront. Specifically, I focus on health self-knowledge of some of the Lincoln County, MS, Black

women in order to understand how their expertise can contribute to alleviating health inequities.

Two projects were conducted over two summers of fieldwork in Lincoln County, Mississippi. The dissertation will answer the following questions central to understanding how Black women's voices and knowledge are vital to improving their health status: **(1) How do Black Mississippian women confirm or reject characteristics associated with the deficit model when describing their health experiences? (2) How is Black women's sisterhood an embodied space for health practices, and what are the complexities around Black women's sisterhood, and (3) How does the social location of Black women's bodies impact the way that data collection is facilitated?** Employing ethnographic research and implementing community-based participatory research (CBPR) approach principles, I focus on the phenomenon of how Black women actively resist dominant views of their health and how they collectively bring subjectivity to their bodies.

To address these questions, I draw on anthropological methods combined with community-based research practices; in addition, Critical Race Theory (CRT) and Black Feminist theoretical frameworks undergirded the two summers of fieldwork for the research projects. Engaging with Black Feminist Thought is one means wherein U.S. Black women reframe their experiences by activating their epistemologies that criticize historical knowledge (Collins, 2009). As Collins argues, these new understandings of self that empower Black women to resist, reject and recast what counts as knowledge (p. 292). bell hooks talks about this as the "oppositional gaze" (hooks, 1992). Back women can use this "gaze" to counter negative views of their bodies (p. 122). The

hyperawareness or self-consciousness that Black women exhibit is derived from their simultaneous rejection of oppression from whites (men and women) and sometimes Black men, where Black women demand that their lived experiences are included in their self-definition (hooks, 2015). In addition to drawing from intersectional perspectives, CRT also offers a robust framework through which to examine Black women's bodies, health, and wellbeing. To use a critical lens is to do work that challenges assumptions and confronts power structures, and critically know what "truths" define what is essential (Davis, 2018). CRT first began as a movement in legal studies where scholars such as Derrick Bell described it as a way to unapologetically insert self (as in, Black self) to critique disadvantaged situations (Bell, 1995). In this sense, it questions the very ideologies that formulate Black women's identities to transform the relationship between gender, race, racism, and power (Delgado, 2017). Because CRT takes a questioning approach, it lends an activist dimension to its topic of inquiry and strives to understand the social situation and lay of racial lines with the aim of changing them (p. 17). CRT critiques whiteness as normative and exposes biases within systems including health (p. 54).

Drawing on data collected in Lincoln County, Mississippi, I examined the constructions of health narratives through the health experiences, health practices, and intergenerational knowledges of fourteen Black women. I aim to "see" how Black women's resistance to the medicalization of their bodies has assisted in redefining not only their health (Chapter 2) but also the collective experiences of Black women's journeys that form intentional networks and shape a praxis that embraces as a sisterhood

(Chapter 3 and 4). I focus on the audacity that Black women exhibit to engage in health practices that employ their agency which is antithetical to dominant reasoning.

The first project that I present (Chapter 2) illustrates how Black women reject the definitions of health that fail to include their experiences and efforts to reform their health. This project makes a case for the importance of understanding how Black women from Mississippi describe their health and bodies. By using the word *describe*, I am referring to how Black women from Mississippi rely on their own lived experiences and self-conceptions to manage and negotiate their health and body image. Biological measurements (e.g., blood pressure and body mass index (BMI)) have been instrumental in creating data that represents the relationship between risk for disease and certain bodies (Browne, 2015; Casper & Moore, 2009). Through the analysis of semi-structured interviews and field-notes, I study (1) the word choice that Black women use to describe their bodies, (2) navigation of health at both the community and medical institution levels, and (3) approaches to managing their health .

Chapter 3 is where I present my second project centered around the sisterhood among Black women from Mississippi. This project provides access to the formation of Mississippian Black women's sisterhood and reflects on how the collective cultural, racial, gender, and class experiences that bridge Black women together are the same intersections that cause relationship disconnections and interrupt health practices. Through auto-ethnography, I meld personal encounters of Black sisterhood to understand broader social meanings and the politics behind "being a sister." I transition from being an insider to an outsider in order to (1) envision how Black women's need for each translates to self-care, and (2) understand how Black women's absence from one another

can disrupt intra health praxis. I explore how Black women build their connections to one another and how those connections can become obscure, unstable, and damaged, causing a break in sisterhood. This reflection includes my lived experiences running parallel to those of the Black women who participated in the project.

Chapter 4 presents a novel methodology for employing a more culturally sensitive, community-based group interviewing technique infused with an ethic of care. I use a method that "looks" beyond traditional ethnographic methods for facilitating group interviews and instead breaks the reigns of the dominant process by replacing them with Black Feminist approaches that open the space to agency, subjectivity, and knowledge production where the researcher is learning from participants versus "teaching" them or exploiting their knowledge.

The dissertation then concludes in Chapter 5 with a reflection and discussion followed by recommendations for applying community knowledge to improve health equity, and, finally, future research directions. Findings from these community-academic partnerships not only contribute to social science, anthropological, and health equity works of literature, but they also advance understandings of the importance in challenging who gets to be considered for knowledge creation surrounding the health of Black bodies and how diverse knowledges enhance strategies for creating health education and communication tools, prevention methods, and interventions to improve the health of underserved community needs.

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CHAPTER 2

CHALLENGING THE DEFAULT: BLACK MISSISSIPPIAN WOMEN'S HEALTH AND THE DISRUPTION OF THE DEFICIT MODEL

Abstract

The implication of scholarship that constructs Black women as "different kinds" of humans is visible through the social sorting that has categorized their bodies as "risk" or "at risk." Deficit models play an essential role in problematizing Black women with behavioral traits that devalue their knowledge of health. Juxtaposed with the politics behind Black women being at fault for dysfunctions within Black communities similarly, deficit models locate the cause of inequities not in the institution (e.g., healthcare) but instead in the individual. The genesis of this belief became firmly rooted in 1965 upon the release of "The Daniel Patrick Moynihan Report," which revealed that the persons at fault for the abnormal Black community were Black women with their primary deformity being a "strong Black woman." Moynihan's argument aided in placing the responsibilities of institutional and systemic racism, sexism, and classism on the shoulders of Black women while relieving White supremacy of any fault. By placing the onus of the "problem" with the Black community on Black women it undermined Black women as being qualified to take care of anything including their health. In contrast to pathologizing accounts of Black women as too diseased and obese or ill-equipped to take care of their own health and bodies, this study uses a combination of Critical Race Theory, community-based participatory research (CBPR), and rapid ethnographic assessments (REA) to argue that Black women know precisely how to develop and maintain a healthy body; physically, mentally, and emotionally. Drawing on interviews

collected in Lincoln County, Mississippi the narratives of fourteen Black women are examined with specific attention to how they describe their health and how embodied knowledge of their health helps them combat the normalization of negative presumptions of Black women's health. In rejecting deficit models of their health and bodies, the Black women in this study demystify their own bodies by understanding health as a journey that includes struggle and threat of maltreatment. In addition, the women enumerate the myriad ways that they routinely care for their own and their family's health, relying on their knowledge of traditional healing practices passed down from their mothers and grandmothers to assist them in the absence of industry professionals. While these narratives describe the important roles that faith and a strong support network plays in keeping them encouraged and confident, a key aspect of maintaining their mental and physical health these Black women also reveal a counternarrative to deficit models of Black women's health. Overall, this article rejects the traditional deficit health lens through which Black women's bodies are viewed and contributes to the growing demands that health research attend to and center Black women's voices and experiences.
Keywords: *Black women, health descriptions, anti-deficit language, knowledge, self-care*

Introduction

A young Black Mississippian woman invites me [CM] to hear her speak from the heart. The very secret about herself that has pushed her forward to study harder and make a better life for herself is the very thing that compresses her deep into depression. This act of dissemblance (Beauboeuf-Lafontant, 2003, 2009; Higginbotham, 1994; Hine Clark, 1989), the process of intentionally hiding certain parts of her life to excel in others, gave

her agency over what was happening internally. Her Southern religiosity has taught her to pray through her pain, leave her sufferings at the altar, and let God take care of them. However, on this day, she trusts me enough not to deny the feelings that she has silenced with prayer, and instead, she speaks on it. In short, she gently removes the "strong Black woman" mask that has been weighing upon her both physically and mentally. *She says: "coming out of my divorce, I gained so much weight. I did, it was a lot of stress, it was a lot of pain [emotional pain], it was a lot of frustration, that was a lot of unnecessary weight [emotional weight that manifested into physical weight]."*

This young woman's focus on her divorce provides a justification for her silence regarding her pain. She didn't want to be seen "allowing" her personal life to cause her weight gain— she didn't want to be judged for using divorce to be an "excuse" for her increased weight—she wanted to be perceived as in "control."

When Black women go to the doctor, they find that their weight is hypervisible while the impetus for seeking medical attention in the first place (e.g., pain) is rendered invisible. Medical professionals focusing on weight as the source of any and all health issues – from broken bones to cancer – is well documented (Boggs, 2011; Gay, 2017; McMillian Cottom, 2019; Strings, 2015, 2019; U.S. Department of Health and Human Services, 2018). With Black women it is no different; and, with large bodied Black women it is particularly problematic. Pain is not always attached to physiological hurt; for Black women, pain is entangled with the complexities of two categories: being Black and woman. In popular and scholarly literature, Black women are often depicted and reduced down to characteristics that do not represent them (e.g., overweight, and nagging or undesirable; hooks, 2015). Resulting in being forgotten to emphasize Black women's

undesirability or exploited to make reputable the stereotypes that are used to define them (pp. 66-67). Consequently, these actions seep into medical care for Black women so rarely are they asked questions that center their experiences or voices. Rather than asking "What do you feel has caused this weight gain,?" medical professionals assume the weight is due to poor (food) choices and an inability to take care of oneself. Yet, it is precisely this simple question which could transform Black women's health from an intrinsic deficit defined by biostatistics "a problem that needs to be managed" into a "person" who knows their health experiences and can take charge of healing. Ignoring Black women's knowledge of their health serves to maintain the stereotypes that have defined them: unnatural, unfeminine, and unhuman (Giddings, 2001).

This paper examines the ways in which the Black body id described through the lens oa a deficit model. The tenets of such model assert a body that is too big, too ill, and too disordered (Hogarth, 2017; Nelson, 2011; Strings, 2019). The analysis challenges the deficit model by focusing on the ways in which Black women in Mississippi, U.S. talk about their own health and bodies by negotiating negative perceptions and stereotypes. By centering their voices and experiences, health is seen as a journey that includes struggles and a threat of mis- or maltreatment by health professionals. Conversely, with a network of support and encouragement, there is confidence to engage in restorative behavior. These behaviors may come as a result of consulting medical professionals but, our findings underscore that often these restorative behaviors are passed down from parents, grandparents, or close friends. Black southerners were challenged with the practice of self-healing to restore health. As a result of Jim Crow segregation laws that did not include the health of Black bodies, the responsibility of maintaining health was

cast up them (Feagin, 2013; Fett, 2002; Townes, 1998). By employing a generational acumen of herbal remedies and medical techniques, Black southerners reclaimed power over their own bodies and maintained the well-being of family and community (Fett, 2002; Townes, 1998).

Literature Review

Health Care Access and Resources Rooted in Structural Disparities

Hammonds and Reverby note that "differential health outcomes between Blacks and Whites have been part of the American landscape for 400 years" (2019: 1). Moreover, slavery, marked by racially divided health care, led to racist public health systems of woefully inadequate access for Black people. Segregation further exacerbated the inequities in access to health care, and, even after (institutionalized) segregation, the system was simply entrenched in racist and discriminatory practices, intensifying observable inequalities today. These inequities are audible in daily life through stories that circulate around Black people, their bodies, and their health. These stories overwhelming blame Black people for their (poor) health and bodies and rely on themes of failure that pathologize Black health. While both Black men and women are accused of these deficiencies, the burden on Black women is thought to be greater given that they are viewed as the people responsible for rearing children and thus passing on generational flaws (Roberts, 1997).

Health Disparities in Black Women

Obesity rates among Black people – women and men – are considered clinically high at 56.1% and 37.5% respectively (National Center for Health Statistics, 2018). And more than 80% of Black women were diagnosed as overweight or obese between the

years 2013-2016 (U.S. Department of Health and Human Services, 2018). In addition to higher rates among Black women compared to their White counterparts, the prevalence of hypertension is reportedly the highest in the world (Mozaffarian et al., 2016). The COVID-19 pandemic has disproportionately claimed the lives of Black people and many of them feel as though they are being sent home to die. The Black mortality rate from COVID-19 doubles the rate of Latino, Asian, and White communities (Garg, 2020; Centers for Disease Control and Prevention (CDC), 2020). Moreover, the disproportional impact of COVID-19 in Black women is even greater given that they are often jobs classified as "frontline" or "essential services" (Collins Hill, 1998; Giddings, 2001; Simien, 2020). In *Black Fatigue: How Racism Erodes the Mind, Body, and Spirit*, Winters (2020) argues that racism literally makes Black people sick because of intergenerational fatigue. And, because Black women do not fit the dominant view of beauty, their bodies are shamed and classified as abnormal. The deficit model of health sees the Black body as failed and flawed. To survive deficit health, people must be knowledgeable of their bodies and use counter narratives that uplift Black women's health from a position of "being problematic" to being *worthy of equitable treatment* and this can be facilitated by centering their voices and stories that are silenced, misrepresented, or half-told.

Interpretation for Health Disposition in Black Women

Deficit Model

Medical explanations for why Black women have larger bodies often rely on circular reasoning that leads to the 'strong woman' and 'mammy' stereotypes steeped in racialized images (Wallace, 2015; Hughes, 2019; Strings 2019). Furthermore, political

narratives like "The Moynihan Report" used stereotypes such as the "strong Black woman" to center flawed biological claims against Black women to continue imaging them as sub-human creatures that could endure "male-work" to justify the exploitation of Black women's bodies in institutions such as the medical system (hooks, 2015; Nelson, 2011; Roberts, 1997; Wallace, 2015). Following this logic, health professionals reason that Black women have large bodies *because they are Black* and that this *largeness*, which is understood as a feature inherent to their race, marks them as medically aberrant abnormal. Black women's overdiagnosis as being obese outwardly brands or marks their bodies as diseased. Within medical literature, Obesity is diagnosed by body mass index (BMI) which is defined by the World Health Organization (WHO) as a person's weight in kilograms divided by the square of their height in meters (kg/m^2). Overweight as a medical category is having a BMI greater than or equal to 25; and, Obesity is diagnosed as having a BMI greater than or equal to 30 (World Health Organization, 2021). Boggs et al. (2011) examined whether Black women had a lower risk of death than White women with similar BMI measures and concluded "risk" of death among Black women increased with BMI of 25 or higher(Boggs, 2011). The superfluous weight on Black women is presumed to lead to their (premature) deaths; yet, the underlying causes of excess weight are rarely interrogated (e.g., Strings, 2019). Instead, medical and public health professionals simply assume that Black women do not engage in healthy behaviors such as exercise/physical activity. Knowledge of their bodies is silenced. In other words, Black women suffer from health deficits that have come to be viewed as inherent to their bodies. In addition, because Black women's bodies do not fit the hegemonic (white) model of an ideal body, their bodies are understood to be uncivilized, diseased, and

defective (Strings, 2015, 2019). This is talked about as the deficit model of health (Ko, 2016) which understands individuals and groups "in terms of their perceived deficiencies, dysfunctions, problems, needs, and limitations" (Dinishak, 2016). It is a common model used to explain disparities in educational success wherein problems in learning are attributed to cultural underachievement *because* of one's environment (Persell Hodges, 1981). The shift from (re)locating the problem in the environment to Black bodies (people) themselves was swift. As political figures used this type of language to define people affected by poverty (particularly Black people), society adopted the deficit model to further pathologize and erase Black people's experiences (Brazziel, 1962; Persell Hodges, 1981). For Black women specifically, these assumptions result in erasure of their womanhood and draw on stereotypes such as "lazy", a description of Black women that the dominant society can exploit (hooks, 2015) . These stigmatizing discourses of Black women have direct historical links to chattel slavery where duties of nurturing white families led to the construction of the mammy (Collins, 2004; Giddings, 2001; Fett, 2002; Ford, 2008; Stephen & Phillips, 2003) who was physically and emotionally strong (Kwate & Threadcraft, 2015). This racialized and gendered construction of the 'strong Black woman' remains a robust stereotype which includes a large body, the (presumed) ability to endure hardships, the tendency to put others before self, regardless of the cost to self (Beauboeuf-Lafontant, 2003, 2005, 2009). This is evident in the culture of medical experimentation on Black women's bodies in pre-emancipatory U.S. (Davis, 2017). One way that this stereotype manifests in medical care settings is in the expression of pain. Black women's bodies were understood under the antebellum theory to be "less sensitive to pain than white women" (Fett, 2002). This theory was (and is) based on a misreading

of the expression of pain. That is, if pain is not audibly expressed this does not equal less sensitivity (e.g., Symonds 1996; Corbett, Callister, Gettys, & Hickman 2017). Indeed, one of the very defining qualities that underpin Black womanhood is strength (Beauboeuf-Lafontant, 2003; Giddings, 2001). Engaging in explicit conversations about pain with medical practitioners are dispreferred as Black women are cast into a system that has categorized them as weak, needy, and addicted to drugs (Beauboeuf-Lafontant, 2009; Fett, 2002; McMillian Cottom, 2019; Roberts, 1997). Black women do not want to be viewed as deficient in health, a common trope in medical contexts. For example, in her book *Hunger: A Memoir of (My) Body* Gay wrestles with how society and medical systems view her larger body; she states how she had to learn not to hate her body because it was viewed as unhealthy and instead embrace and accept who she was (Gay, 2017).

The deficit model of health is used frequently in public health contexts to explain health disparities between Black and White people (e.g., U.S. Department of Health and Human Services (HHS) 2018). Biometric data including weight, AC1 levels, and blood pressure readings tell a medicalized story that makes it clear that Black women live in larger bodies but excludes, social, political, racial, gender, and environmental determinants of health structures that impede their access to living "healthy" lives (Strings, 2015).

Genetic Difference

In addition to the deficit model of health, some scholarship on health disparities relies on genetic explanations for disparate health outcomes of Black people compared to their White counterparts. However, throughout U.S. history determination of race has

shifted in efforts to prove White superior (DeGruy, 2017; Roberts, 2011) causing people to be added or subtracted added and subtracted from racial groups making it an unstable technique of categorizing humans (Roberts, 2011, p. 4). Consequently, it is a political system that controls people by ranking them in social groupings based on biological distinctions according to invented rules (DeGruy, 2017; Feagin, 2013; Roberts, 2011). Particularly, race is a human construct designed to hegemonize genetics and craft Black people as subhuman (DeGruy, 2017; Wilkerson, 2020). The deficit model of health divides people into discrete races to show variations between healthy and unhealthy. Dorothy Roberts (2011) writes "genes are frequently described as 'the cause' of disease, while the environmental and biological actually interact" (p. 121). Thus, such a reliance on 'race' to explain health disparities fails to explain anything at all instead it relies on circular reasoning that Black people are prone to ill health because they are Black. Genetic explanations simply locate the deficits and pathologies specifically to the genes. Black bodies are often blamed for being diseased which functions to legitimate differences or deficits in Black individual's health, widening the gap between who is seen as diseased (Nelson, 2011; Roberts, 1997).

Racism as a Macrocosm of Health Inequities and Disparities

The hyper-surveillance of Black bodies that falsely highlights their deficiencies and constructs them as a problem is nothing new. Black women have been specifically targeted in this construction through the argument that it is women who reproduce children and thus are transmitting this defective Black culture to the next generation (Collins, 1998, p. 169 talks about this). From the rank of professor at a well-established university (Ore, 2015) to a local Black Mississippian woman, Black women's bodies are

seen as unruly, and, as Paula Giddings (1984) explains, a “different kind of humanity.” Because Black women’s bodies are seen by default as deficit in health, their treatment as individuals with the knowledge to self-heal or “restore health” has suffered immensely. Below, we discuss ways of ‘seeing’ that allow us to move the discussion beyond one of deficiency in health to a method and analysis that centers Black women’s experiences and knowledge.

Black Feminist Thought and the Oppositional Gaze

Historically, Black women’s bodies were an essential technology to advance medicine (Fett, 2002; Hogarth, 2017; Washington, 2006). For example, coercive hysterectomies performed at “teaching colleges” victimized Black women to demonstrate to medical students how to perform the surgery (Nelson, 2011).The technologization of Black women’s bodies was foundational for developing a way to operationalize the auditing and objectifying them. These audits of Black women’s bodies, produced as a consequence of controlling white frames of Black women’s health are associated with why Black women have to self-define to negotiate and reconcile controlling stereotypes that were created to dismantle their womanhood (Hill Collins, 2009 p.110). Audits of Black women’s bodies are complicit in framing their health prior to any physical examinations; one perpetual framing is obesity, which resulted in overdiagnoses and miscategorization of Black women as abnormally large (Gay, 2017; Washington, 2006). However, Black women successfully resist this dominating discourse of the always already “ill” body through the adoption of an *oppositional gaze* (hooks, 2015). By developing an oppositional gaze, Black women learn to see themselves outside of conventional representations (e.g., ignorant, and immoral) (Giddings, 2001; hooks, 1992;

hooks, 2015). They learn to refuse to identify themselves in the narrative of health risk and instead “see differently” (hooks, p. 128). When Black women see themselves differently and outside of the social definitions that are prescribed for them, they employ agency disrupt negative descriptors and disentangle their bodies from the deficit category.

In this paper we ask*: What kinds of narratives about health emerge when Black women are encouraged to ‘see differently’? How do Black women disrupt deficit models of their health? And how do Black women frame their bodies and their health as instances of success and assets rather than failures and deficits?* By centering Black women’s experiences of their bodies and health, we can begin to understand how health is reclaimed.

Methods

Research Setting, Community Collaboration, and Recruitment

Black women are at elevated risk to die at early ages from all causes, and Black women living in the South represent a large portion of those at risk (Hall et al.; Kochanek, 2019; Smith et al., 1999; Zahnd, 2019). These facts are evidence of the importance in working with Black women in Mississippi to bring to the forefront their experiences and knowledges of their bodies as a potential strategy to reinvigorate the quest to improve health outcomes for Black women. Connecting both the historical and contemporary experiences of Black women helps explain why Mississippian Black women’s bodies are seen and experienced as unhealthy. The stamp of unhealthfulness can come in the form of obesity, high blood pressure, diabetes, or high maternal mortality, among other negative health outcomes (King’s Daughters Medical Center in Brookhaven, 2015; Mozaffarian et al., 2016; Vance, 2018). Yet, little research ties the statistics of Black women’s bodies to

their "narratives." For Southern Black women, their health and bodies are inseparable from political, social and economic conditions (King's Daughters Medical Center in Brookhaven, 2015).

As noted above, building trust within Black communities of women can be challenging given the legacy of medical malpractice, mistreatment, and misdiagnosis. Although author 1 is a member of the local Mississippi community, we nonetheless partnered with a local community advisor in order to help build collaborative and trusting relationships. Partnering with a key community member to introduce both the research and the researcher to the community of Black women allowed for trust to be nurtured, which facilitated the building of the project as respected and valuable. We then engaged community members to reach out to their personal networks to invite others to join the project for interviews and conversations. Our goal was to convey an attitude of respectful collaboration rather than exploitative research practices(Davis, 2011). Ultimately, 14 participants were recruited and consented into the project.

Participants and Data Collection

CM conducted 14 semi-structured, in-depth interviews lasting between 30 – 90 minutes with 14 participants in summer 2018 in Lincoln County, Mississippi (MS). The interview protocol was previously from a cross-cultural examination of body and related health issues in Japan, north Georgia (US), Paraguay, and Samoa (see SturtzSreetharan et al 2021 for full details). The protocol consisted of five domains of inquiry (1) food and eating, (2) body ideals/body capital, (3) disease/health of larger bodies, (4) bodies, self, and society, and (5) general own-body concerns; each domain had open ended questions such as "Has the kind of food you eat now changed from the past" and "Have you ever

been told by a doctor that you need to lose weight?" Probes such as "echo" and "tell me more" (Bernard, 2017; Bernard, 2018) were used as needed to increase the richness and depth of responses. Domains 3, 4, and 5 are the focus of this study as they captured the pervasive health experiences that press Black women to make the decision to accept or reject variables attached to their bodies defining them as deficit. Eligibility for participation in this community-engaged research included the following criteria: (1) self-identify as a Black woman, (2) be eighteen years of age or older, and (3) residence in Mississippi for at least fifteen years. We relied on a community advisor to assist in convenience and snowball sampling to recruit participants. This was key in developing trust and being seen as "they cool" within the community and as a research partner. The participants were highly educated compared to the national average of U.S. women (U.S. Bureau of the Census, 2019), with 6 of the 14 women holding a bachelor's or master's degree, and 5 of them having completed some college. All of the participants had deep familiarity with Lincoln County, having been born or lived there for some time.

Commitment to reflexivity and positionality

Qualitative data collection has often been extractive with the burden falling more heavily on non-White bodies(Evans-Winters, 2019; Noble, 2018). Semi-structured interviews, however, offer a way to engage ethically with people as the more open format signals that the researcher is not trying to exercise excessive control (Bernard 2018). In addition, semi-structured interviews provide a lot of latitude and leeway to the interviewee and interviewer to modify the order and details of topics covered (Bernard, 2018, 2017). This flexibility offers a vulnerable community, such as Black women, more comfort and control in answering questions and dialoging with the interviewer.

In an effort to create a partnership centering Black women's voices and knowledges in a more collaborative environment, we looked to community-based participatory research (CBPR) combined with a Black feminist lens to challenge historical colonizing practices of research (Wallerstein, 2018). As Wallerstein and Duran note, engaging CBPR in tandem with feminist theory demands that personal lives be understood in relation to the structures that exert control over Black women's lives. In doing so, the lens allows a celebration of the strengths and agencies of these women rather than simply focusing on their victimization (2018: 24-25). CBPR has the added benefit of *community* participation which is a more likely space for Black women to reclaim their power and agency (Collins, 2009) compared to other social spaces which may serve to silence them (Beauboeuf-Lafontant, 2009, p. 57).

Awareness of the positionality of the lead researcher was prioritized throughout the research process. As a Black woman, the lead researcher (and author 1) attended to potential power imbalances between herself and the participants, including access to opportunities in her life that those partnered with in the community may not have (e.g., Ph.D. program). Additionally, as a token of recognition and in appreciate of their time, each interviewee was compensated $20 cash (a 38% increase above the average minimum wage in Lincoln County (Payscale.com, 2020)for their participation. Interview procedures were approved by the IRB of Arizona State University (STUDY#00003997).

Figure 1. Critical qualitative data collection methodology model

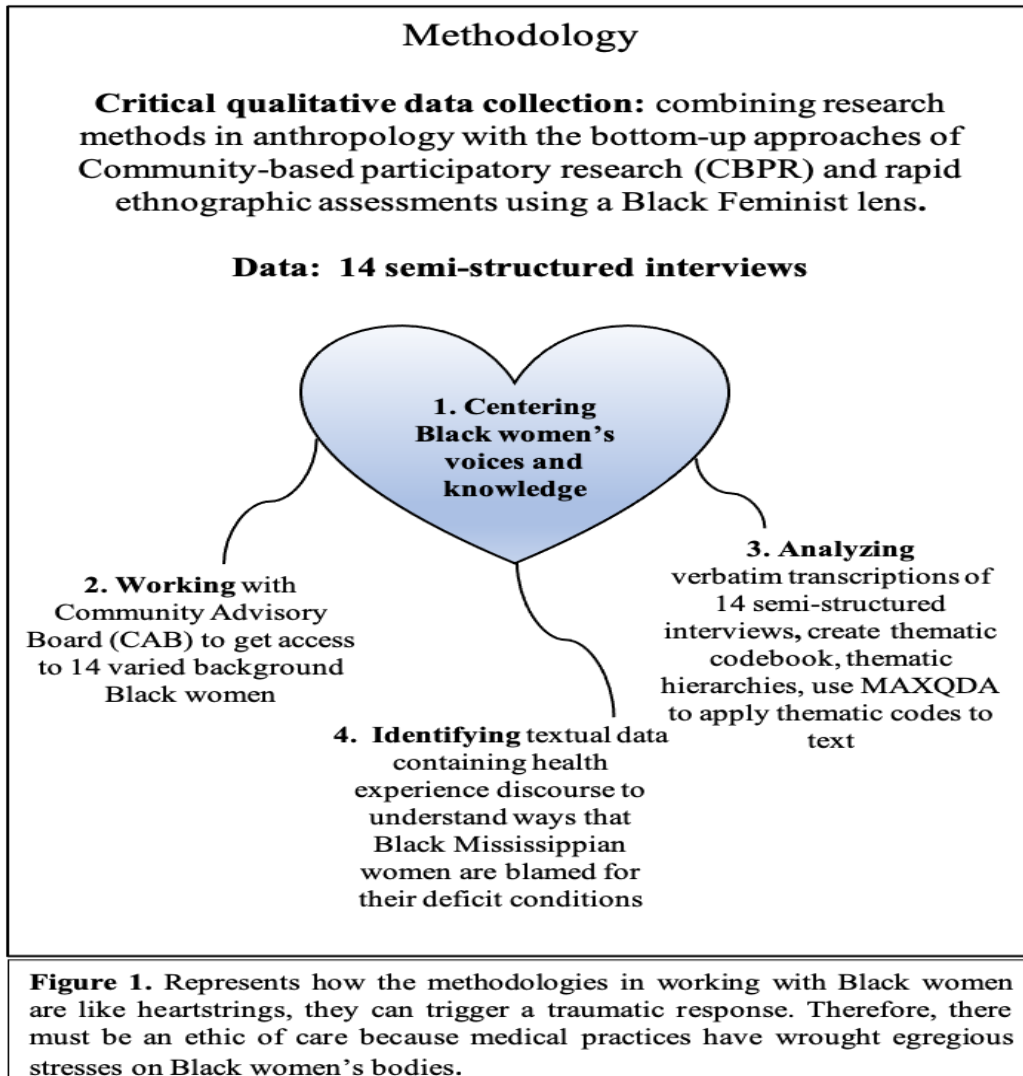


Figure 1. Represents how the methodologies in working with Black women are like heartstrings, they can trigger a traumatic response. Therefore, there must be an ethic of care because medical practices have wrought egregious stresses on Black women's bodies.

Analysis

All fourteen interviews were transcribed verbatim and quality checked by the first author, who is fluent in the variety of Black English used in Lincoln County. The transcripts were then analyzed using two approaches: (1) key words in context and (2) rapid ethnographic assessments (REA). Using MaxQDA (2020), we performed a key-word-in-context analysis to reduce text into thematic categories with similar meaning (Bernard, Wutich, and Ryan, 2017) based on word clustering. Next, drawing on Seidel

(1998) and Sangaramoorthy and Kroeger (2020), the iterative and cyclical approach to REA was used to identify themes associated with the rejection or acceptance of deficit statements regarding Black women's health. The value in using an REA approach is that it requires that the researcher(s) (re)examine themselves time and again in order to ensure that the participants' voices remain centered (Sangaramoorthy and Kroeger, 2020; p. 88). Through this two-pronged approach, the interviews were analyzed for themes which highlight Black Mississippian women's health experiences including the ways in which they describe being blamed for their poor health conditions (deficit model).

Results

Upon completion of the key-words-in-context (KWIC) and REA thematic analysis, six themes emerged from the 14 interviews as shown in Table 1. The first theme, "Black women's ways of knowing and healing their bodies", revealed their knowledge of their bodies and how to heal their bodies based on remedies passed down to them. Some of the words that frequently appeared with this theme include *heal, garden, big momma, grandma nem, food, herbs, teas, trees, and home remedies*. The second theme, "health is a process" reflects the experience of many Black women in this community who understood that health was not gained through quick fixes or through cookie-cutter remedies. Rather, the women expressed the experiences that health is achieved over time while on a *journey*, that includes struggle and the need for preparation or explicit change. This theme featured frequent words such as *struggle*, *process*, *preparation*, a *need to change the process*, and beginning to *cook our foods*. A third theme, "support network," reflected the explicit importance of having other Black women in their lives that they can learn from and lean on to increase their health. The words or

phrases that women frequently used to describe this idea included *let's go walk, encouragement, help, love, support, without them, without her, I need help*. "Self-care of the mind and body" was the fourth theme identified. This idea explicitly recognizes the importance of both the body and the mind to good health. Words that appeared frequently in this theme include *depressed*, *stressed, stress, mental,* and *mental health*. The interviews reflected the women's knowledge that the size of a body was detached from health; this is the fifth theme and is labeled "larger body does not mean an unhealthy body." In other words, having a large body did not equal poor health. Indeed, the frequent words and phrases associated with this theme directly reflected the positive relationship between "large" and "body" and included *love me, loving me regardless, good shape, healthy, fluffy, thick, big-boned, medicines, being the right weight, health issues, sexy, size, criticize,* and *statistics*. Finally, the sixth theme signal some of the women's concern with historical and contemporary mistreatment of Black bodies and using "gut instinct" as a health practice . These Black women do not care that the medical professional has a degree that "allows" them to diagnose and prescribe treatment the Black women "reject" medical knowledge and instead rely on their gut instincts. In such cases, the women used on words and phrases such as, *not taking everything from doctors, faith, they [white practitioners] don't know, distrust*, *them [white practitioners], they, not trusting, trust*, *sick*, and *medicine*.

These six themes demonstrate the ways in which the participants experiences and knowledge were central to their understandings of their health and bodies. And, in talking about their experiences and knowledges of their bodies across these themes, the

women were rejecting a deficit model of their health, providing a counter narrative of how to claim health, well-being, and wholeness.

Table 1. Thematic analysis results.

Thematic code	Key words	*C	Exemplars
Black women's ways of knowing how to health their bodies	heal, garden, big momma, grandma nem, momma nem, momma, back in the day, certain foods, food, herbs, we take better care of ourselves, teas, trees, home remedies, and home remedy	58	"The home remedies. And, uh, true, some of those home remedies work better than what the doctor will say."
Health as a process	journey, is a struggle, process, comes with preparation and a need to change the process, and beginning to cook our foods	50	"And even when I was struggling [with weight], I realize that you struggle in life. And, so, it doesn't have to be permanent."
Support network	let's go walk, encouragement, help love support, without them, without her, I need help	47	"You can try to be a good support, you can try to keep the positive energy, being at the same time when you love someone, you tell them the truth and then you just try to educate them on, um, the, the decisions that they're making about life and you can kind of paint the picture, like, you know, you can be here as long as you like."
Self-care of mind and body	depressed, stressed, stress, mental, mental health	27	"And, I would say, Oh, what's the matter? Try to figure out why she gained weight, if she's sick…Or if she's depressed."
Larger body not meaning an unhealthy body	Love, me loving me regardless, good shape, healthy, fluffy, thick, big, big boned, medicines, being the right weight, health issues, sexy, size, criticize, statistics	25	"You know, people focus so much on how little or how skinny you are but that doesn't necessarily mean that you are actually in shape or that you're healthy."
Trust my gut instincts	not taking everything from doctors, faith, they don't know, distrust, them, they, not trusting, trust, sick, medicine	24	"I think that they are basing on us from white studies."

Themes

How does it feel to be the problem — W.E.B. Dubois Souls of Black Folks

In the following sections, we elaborate on the six themes identified highlighting how Black women recount experiences and tell stories that construct ways to reject the deficit framework attached to their health and health practices. This reveals that rather than accepting the biomedicalization of their Blackness that dominant views have assigned to them, Black women use the positive parts of their health to keep moving forward on their health journeys. Overall, these themes enhance our understanding how Black women living in Mississippi oppose the objectification of their bodies and health that are attached to systems of oppression including but not limited to racism.

Black Mississippian women's ways of knowing how to heal their bodies

Structural conditions have perpetuated the view that Black bodies are a problem. These conditions are pernicious (Lee and Hicken, 2016), requiring Black women to navigate the health of their bodies in two spaces: the community and in the medical system. In their community, Black women are more satisfied with their bodies (Casper, 2009) and are typically provided a safety net to just *be,* as in have the ability to live in their bodies without biomonitoring. Although, there are instances where someone may "call them out" such as saying, "girl what happen to you?" as one Black woman told author 1. However, for the most part, within their communities, Black women feel that they have authority over their bodies to perform healing practices that have sufficiently served their bodies from generation to generation. A 55-year-old Black woman explains how she feels that white doctors look down on the knowledge of Blacks because they (whites) have labeled Blacks as inferior and incapable of taking care of themselves particularly as Southerners. Yet, she quickly lets it be known that "Because… us as Blacks, even though they downgrade us, like we are nothing, we take better care of ourselves. Um… uh… some might go to the doctor, but they [Black people] try to use home remedies." This woman rejects that Black individuals are not equipped to take care of themselves. Another older Black woman signals an alternative orientation to dominant notions of Black women's health by asserting that Black healing practices should not be discounted because they are "home remedies. And, uh, true, some of those home remedies work better than what the doctor will say." By "work better" this Black woman is illustrating not only that she has tried home remedies, but their efficacy result in healing ailments that prescribed medications have not. Herbal remedies are rich in

southern slave narratives. Although not formally addressed, Black women were the doctors and nurses on the plantation and passed that knowledge down through the generations (Fett, 2002; Hogarth, 2017). Whether it was a serious aliment, or something related to a meal that was consumed, these women had a remedy. A 67-year-old woman states, "[Back then] They ate anything that they basically wanted to eat, and they had no problem…" If they did, then they had herbs that they would use to take care of it instead of going to the doctor and getting all these prescriptions that are bad for you." Again, this perspective on Black healing practices emphasis the abundance of knowledge the ways that foods and herbs could be used to heal an ailing body.

Black women have been taught to know their bodies and understand that there are natural things to heal it; self-healing becomes an everyday practice. The older generation of Black women in this research made it clear that they were capable of taking care of themselves in a safe, non-risky way. And, although these women advocated for self-healing, they specifically expressed that they were not anti-doctor or anti-health system. However, they valued their own knowledges and experiences, rejecting the notion that they were failures or that their bodies were failed – rejecting the deficit model.

Health as a process

These Black women author 1 interviewed made it clear that health was understood as *not* something that could be grabbed out of a convenience store, but rather was understood as a journey riddled with conflict and struggle. One participant, a 37-year-old woman who was working on her Ph.D., stated: "You may have to see a dietician or a nutritionist. Until you can gain, uh, the stability that you need to take control. A lot of times it's just harder until you can get your medicine evaluated. Until, you know, until

you can get your support up" and, "until you can, um, find [afford] you some nice shoes [exercise shoes] to go walk in." As this quote makes clear, the process of health was not fast or easy; it required patience and (sometimes) assistance. Importantly, it required several steps in order to be able to ask successfully for a medical professional to (re)evaluate prescription medicine. This participant's utterance acknowledges that a Black woman may first need to consult *other kinds of* specialists (dietician/nutritionist) to prove that their weight is not due to their own poor (eating) habits; then, Black women may also need to evaluate their finances to see if it is in their budget to purchase a pair of good athletics shoes. Likewise, a 65- year-old participant described taking care of health as something that happens in "phases." She said, "[I'm] very proud [of] taking care of myself in some ways. Even if it's just a phase. I don't look 65 yet. They say I don't look it. They say I look like I'm in my early 50s or something like that and I'm not all too big." This participant understood health to happen in phases rather than as one consistent journey. At 23, the youngest research participant who self-described as overweight discussed how the process of losing weight would no longer be a part of her conversations; instead people would just see the end result, "I'm never like, "Oh, I need to lose weight" or "I'm so down because I need to lose weight". I, I might tell somebody, "Oh! I'm trying to lose weight again!". But then I got to the point where I stopped telling people I'm trying to lose weight. They'll see it." Even the youngest participant recognized that health, including weight loss, was a process which took time.

Support network

Throughout each interview, the smiles on these Black women's faces grew as they spoke about the importance of having another Black woman (author 1) "having their

back." Health is a journey; but, as one woman put it, it is "encouraging" when you have someone with a familiar story walking along side you. The world is hard on Black women and many times they feel like they are alone and have to "figure it out" by themselves, but when Black women have someone to who through experience understands them, their life journey is less lonely. To have someone who understands your struggle say "you look good sis" motivates Black women to keep on keeping on. Having a support network is essential to Black women, it is what bridges our sisterhood. One sister shared: "I know it is [their weight] affecting them some kind of way. I try to, uh, talk to them, encourage them to love themselves regardless."

Black women extend their support outside of their immediate circle in the form of personal testimonies to share their positive health experiences. That is, Black women in this community form an unofficial support network for one another's health journeys. This is a critical (albeit informal) resource, especially within the healthcare industry where Black women are placed into situations that repeatedly view their bodies as inherently problematic. A 34-year-old nurse shared: "My circle's kinda like my family, my support team. But, working within the health industry, I do run across a lot of people [Black patients] that are older than myself, um, they come in and out of the clinic that have, uh, concerns about their weight. And sometimes, I freely give my own personal testimony." Black women have been blamed for the condition that their bodies are in, yet through it all they learn to support themselves and have extended this support to other Black women. Having a support network that contributes to learning how to be self-supportive counteracts deficit models that suggests a person is inherently flawed or deficient. And, the nature of a supportive network built on trust—a community can

supply energy and vitality, a space in the world where Black women are accepted for who they are and have the capacity to live and grow.

Trust my gut instincts

Trusting one's gut or relying on gut instincts is used across various contexts to inform decision making. To trust your gut means to rely deeply on your own sense of self and the situation. Due to routine medical exploitation of Black bodies in the South, many Black individuals, especially women, would rather trust their gut instincts and engage in their own knowledge to self-heal than visit the doctor. For Black people, being apprehensive of prescribed medical treatment is deeply rooted in historical malpractices that have permanently damaged and violently harmed Black individuals. A 55-year-old woman describes the confusion around her pre-diabetic diagnosis:

"…I remember the first time they told me, 'You, you are a borderline diabetic'. I was like, 'What's a borderline diabetic?'. And, I'm going, like, they couldn't explain, so I'm really thinking, 'You're really saying that I'm a diabetic and using that 'borderline' is supposed to make me feel better, or what?'. Cause what's, I never, never knew what a borderline diabetic was."

She continues on to say that she understood borderline to mean that "if you don't start doing this and doing that, then you're going to become a diabetic." When she was prescribed medication she told the interviewer that she didn't take it because she "wasn't sick." This example underscores the wariness many of the women we talked interviewed described. Poor explanations by health care professionals of the condition being diagnosed combined with historical experiences of maltreatment and mistreatment, led many of the women to reject medication or treatments. A 56-year-old grandmother put it

succinctly when she said that “I won’t put those pills in me… Because I feel like things are happening with people’s health, also it’s through the medication that they take.” Black women shared that they often felt that the medical conditions they were being treated for did not align with the treatment they were prescribed. Mistrust was so thick with these women that some would rather “hurt” than experience the adverse reactions that the prescribed medication caused them.

Self-care of body and mind

If the body is viewed as an object of technology, ripe for experimentation *or* as an already failed system that is unrepairable, then speaking up about ill health, pain, or disease may be terrifying. Consequently, strong Black women have historically been attached to suffering in silence but some women are working to overcome this trend. These Black women have come to understand that health of the body does not occur without health of the mind; care must be extended to both. Some of the women expressed the difficulty of changing how they think about their health in order to better it. As a 56-year-old woman explained, “My doctor wanted me to lose some weight because my A1C level was so high… So, I did the best I could. Cause I have to have my mind like that because you focus so hard on that and when you begin to fail with it, it pushes you in a whole other zone. It makes you depressed.” This woman was trying to follow her doctor’s advice to lose weight but found that the focus required to lose weight combined with not losing weight caused her to feel depressed. Overcoming the failure requires a healthy mind. And the stress of failing along with depression from not losing weight, creates a situation, as one participant put it: “I would sit and I would eat, eat, eat. Like I

never get full." The women talked about the need to protect the mind while taking care of the body, attempting to hold the deficit model at arm's length where it does less harm.

Women who are successful at this strategy of caring for mind and body talk about the change in their confidence and health. As one 36-year-old woman explained, "I had to fall in love with myself again. So, now, with the love there's a different level of self-respect, there's a different level of, um, level of, of, of my values. You know, things, life is different, and death means something totally different to me now. And, so, I'm saying I have a choice in the matter [of health and wellness]." Successfully retraining the mind to overcome feelings of deficiencies and failures is difficult but, according to many of the women, very worth it.

A large body doesn't mean an unhealthy body

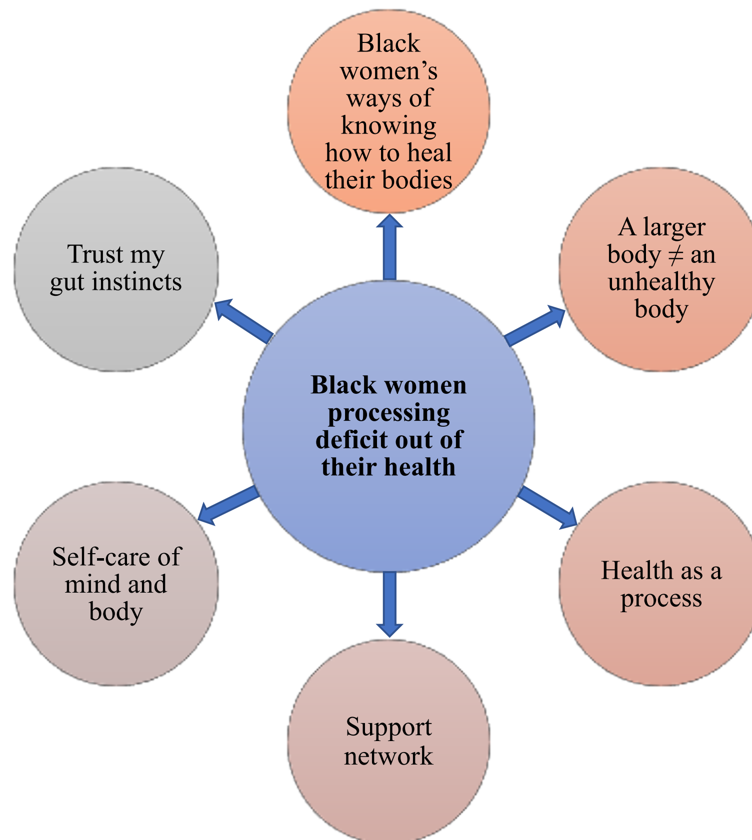
The exemplar of the ideal woman's body is that of a White woman(Welter, 1966). This ideology rose out of the "cult of the True Womanhood," and a "true woman" was defined by her possession of the four cardinal virtues: piety, purity, submissiveness, and domesticity (p. 152). Because White women were upheld as angelic and frail they needed to be protected (by a White man) so that they continued to "own" these virtues (p.159). Contrary to White women, Black women were excluded from womanhood because U.S. enslavement history stripped them of humanity, they were possessions, listed on the "books with the hogs" as one enslaved women recalled (Fett, 2002). Although at one time women with larger and fleshier bodies were prized which tended to be the body of a Black woman, however because of their subservient status Black women were denigrated and excluded from being viewed as a "trophy" — or as a woman(Strings, 2019). Instead, the "Mammy" figure (Black nanny), a handkerchief wearing, larger bodied, asexual

Black woman created by the White southern society was the only "acceptable" larger body for Black women— a body where she had to give up self (hooks, 2015). However, the question that remains is how acceptable is acceptable? The same servile bodies that cooked, cleaned in White households, and even served as wet nurses to White children, today are the same bodies denigrated and disproportionally categorized as diseased.

Having a large body, or as southern Black women might say, "being thick," does not mean that you're diseased (Strings, 2015; Summer 2020 Focus Groups, 2020). Society has dictated what a healthy body looks like and it is not big, Black, and woman (see Hughes 2020) for a discussion of 'thickness' as it relates to body image among Black women). Despite being told that their large bodies are diseased, these women see the positive aspects of their 'thickness.' As one woman expresses, "a female [Black] body can be whatever size she want it to be…[when] she takes initiative to keep herself up." This community of Black women described their bodies in an array of words that were antithetical to the language of the deficit model (e.g., obese) and instead rejected the model through words such as, 'big boned,' 'big,' 'thick,' 'fluffy,' and 'good [body]shape'. These Black women show that they love the skin that they're in. Reaffirming other Black women that their body size is nothing to be ashamed of, one participate shares how her mother has taught her to 'live in her skin.' She explains that her mother has "always been an advocate for being comfortable in her skin, you know, so she [her mother] doesn't have a problem with it [large body]. Actually, she thinks I have the perfect figure. You know, thick southern girl. You know?" Having a larger body is also explained as functional, suggesting it was advantageous during slavery. One woman tells Mitchell that, "if you think about our ancestors, even as they were picking cotton in

the fields, they were, uh, very strong but very thick, um, around the hip area. Um, the arms were very firm, the legs were very firm, because of the work that they did, uh, you know." In this functional explanation of larger bodies, the very characteristics that construct Black women as deviant (firm arms and legs, thick hips), are *reconstructed* as necessary and advantageous for the labor the enslaved bodies performed.

Figure 2. Thematic model



Discussion

For centuries, Black bodies have been viewed as objects of technology (medical, labor, etc.) and/or as deficient and flawed. This has led to mis- and maltreatment of Black people especially in the realm of physical health. Black people are thus viewed as neglecting their physical health, and thus the locus of blame for their poor health. Large

Black bodies are seen as particularly problematic and diseased, leading to mis- and over-diagnoses of medical conditions including metabolic diseases such as obesity, high blood pressure, and diabetes. Understandings of the health of Black people are highly medicalized and focused on biometric indices of health and illness. Rarely are Black people own understandings and experiences are often missing or woefully underrepresented in the scholarly literature. The 14 interviews with Black women in Mississippi shed light on the ways that Black women negotiate their health. We identified six themes which frame the ways in which women negotiate the ways that healthcare professionals and popular discourses describe their bodies and health. By centering their voices and knowledges we make audible the ways in which they reject the deficit model of health and focus their efforts on healing themselves completely – mentally and physically.

All of the Black women overwhelmingly discussed their knowledge of and experience with **self-healing** through foods, herbs, and home-remedy treatments. This kind of knowledge links them to lineages and histories of expertise harkening back to a time when Black people could not get access to medical care or were too frightened by the potential for serious maltreatment from such "care."

Many of the Black Mississippian women described **health as a process and/or a journey**, not something achieved overnight. They talked about health as a struggle that had historical contexts and required continuous attention in order to reach their goals successfully. Moreover, they understood their health as an everyday action item not measured by tool such as scales or ACI readings but rather by their experiences along with their respective journeys.

The women talked about the importance of **support networks and community** in achieving their health goals. Through such networks and the encouragement they provide, the Black women explained that instead of seeing themselves as a "risk," they learn to view themselves differently. In this way, the describe achieving an *oppositional gaze* (hooks 1992) through the help of others. Multiple women described learning to love their bodies, an important achievement given the pernicious but dominant perspectives flawed and failed.

Black women affirming other Black women is how they have continued to persevere despite (or in spite) of health identities that continue to presume their deficiencies . Black women lean on each other, demonstrating that they have a chance at health and a chance to live. They tell their "how they got ova (over)" stories not as a testimonial to other Black women, but also as self-encouragement.

The judgment that larger Black women's bodies receive is instrumental in how they are medically treated. But for these women, **a strong body could be a healthy body**. In medical settings Black women with larger bodies are automatically perceived as diseased. Yet, as a community these Black women resist the notion of disease by seeing themselves differently (i.e. "nicely shaped," and having "strong bodies".) This reveals the disconnect between medical etiologies and embodied knowledge **forcing Black women to trust their gut instincts**. This group of Black women understand that obesity can cause health ailments but they also understand that Black women's bodies do not fit in the mold of the ideal white woman's body but that does not mean that Black women's bodies are sick.

Personal agency over their bodies is something that Black women seek. Their bodies are simultaneously hypervisible and invisible. Society and the medicalization of Black bodies dissects Black women's bodies carving out the bad things like, weight and disease, putting it on display for all to see. Unfortunately, life leaves Black women having to simultaneously nurture and rebuild their mind and bodies.

The Mississippian Black women expressed their understanding of the importance of **self-care for mind and body**. These women revealed a deep sense self that enables them to know when something is going on inside of them. They described knowing that they needed to take care of and love themselves in order to achieve full health. History has painted Black women as feeble minded. Yet, this group of Black women showed us that they know when something is affecting their mental fortitude and how that contributes to physical health-related issues. They show that they are not the problem instead they are working to figure out how to solve the problem. In short, they explicitly reject a deficit model and reclaim their knowledge of self and health.

Conclusion

With the uptick of Black lives extinguished by police brutality and the global pandemic, there has never been a greater need to gain insight into Black people's own understandings of their bodies and their health. Black women have led the focus of this current endeavor to center Black voices and experiences. In the United States, Black women's bodies were audited and sanctioned by guidelines originated during the era of chattel slavery and carried out by the dominate race. Ignoring Black women's own stories and experiences, many of the audits of their bodies frame their health as a failure and deficient. Their larger than white-women's bodies have been consistently over diagnosed

as obese with the prognosis that they are more likely to die of heart disease or complications from type II diabetes, both associated with obesity. Despite many discussions about health disparities and inequities involving the Mississippian Women (Bailey, 2015; Campbell, 2003; El-sadek, 2018; Hayes, 2015;Tussing-Humphreys, 2013; White, 2017), they remain disproportionally affected by treatable and preventable disease. And because of the complexities around slavery and womanhood Black women from Mississippi have historically written off as non-compliant patients with diseased and lame bodies, in of need medical interventions, in need to be "fixed."

However, as this study indicates Black women from Mississippi have deep knowledge of their bodies and of self-healing techniques and remedies. They recognize that drawing support from like-minded networks and communities enables them to reject deficit models of their bodies and health, allowing them to love their bodies and themselves. But they also talk about the time it takes to reach this end goal. The process of health is understood as a journey with struggles and pitfalls. Support and encouragement are critical to the process. The Black women understand that while a large body *can* be unhealthy it is not always and already diseased. Consequently, being 'thick' or 'fluffy' is something to embrace and own. Time and again, these 14 Black women make clear that when their voices are recognized and heard, they can gain the supportive strength to heal themselves both mentally and physically; but, they must be heard and understood on their own terms, not through the dictatorship of biometric profiles.

Key Findings

Our research does not begin to scratch the surface on the positive ways that listening to Black women could impact how their health is viewed and how the medical system approaches Black women's health treatments and interventions. However, there are three salient discoveries: (1) Black women's ways of knowing illuminates the notion of *how to heal* as influential in how they describe and imagine their health; (2) Black women do not fully describe themselves as unhealthy, they find something positive to counter deficit discourses of the disease or sickness they have been diagnosed; and (3) Black women who feel supported tend to trust the knowledge of their bodies, feel that health is a process, reject deficit models, and focus on their faith to restore their health.

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CHAPTER 3

SEEING STRUCTURAL DAMAGE: THE JOURNEY IN CROSSING THE BRIDGE TO BLACK WOMEN'S SISTERHOOD

Abstract

There is a paucity of expression in the voices and lives of Black women concerning the role of sisterhood. In my own experience, I find it a rarity to embrace a sense of belonging in the spaces and places I frequent. Belonging is intrinsically welded to Black women's sisterhood; it represents the intentional attachment to other Black women that share similar experiences (Collins, 1998, 2009; Fuller, 2019; McDonald Bell, 2007). Black women's sisterhood is where we have embodied a space to become human (Giddings, 2001). And while literature primarily establishes Black women's sisterhood as Black women's commitment to other Black women to validate belonging, I take a different approach by employing autoethnography as an analysis of personal encounters of Black sisterhood to examine how Black women describe similar health experiences and health practices as an intentional attachment to each other. Amid COVID-19, Trumpism, and anti-Blackness, I draw on virtual focus groups with 10 Black women from Mississippi, U.S. of diverse backgrounds to make sense of how Black women are both the bridge and gap in their relationships with each other. I demonstrate how Black sisterhood has been a part of locating Black womanhood survival, and how that same connection has been to our demise due to systemic, political, institutional, and internalized racism, sexism, and phobias that cause structural (connectedness) damage leading us to question our relationships with one another. I use my experience of Black women's sisterhood intertwined within the experience of the women that participated in

this research project to reveal how conversations centered on the health of Black women's bodies and the notion of Black sisterhood are mutually informed. I also discuss the defining characteristics of Black women's (un)health and how the notion of our diseased bodies runs parallel to the enduring historical misrepresentations dismantling Black womanhood (hooks, 2015). And importantly, I discuss the complexities around Black sisterhood operating as a health practice and how sisterhood becomes a space operating under cultural principles and standards for consultation regarding physical, mental, and spiritual well-being using certain principles.

Key words: Black women, sisterhood, health, voice, knowledge, lived experience

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I.

The first few years of my life brought me two fictive "sisters" and friends that I vividly remember. First, was Peaches, named so for her skin, which resembled the reddish yellow of a Southern peach. Her "government name" was Cassandra. My other childhood sister-friend was Alicia; she had no nickname, but should have been called "Sunny" because she wore the brightest smile despite having lost her parents in a car accident. Alicia was being raised by her grandmother. We three would roam the streets of our all-Black, "you made it" Mississippi neighborhood, first on our Big Wheels, until we graduated to our 10-speed Huffy bikes. We would ride around together pretending to be

driving cars until the streetlights indicated it was time to get home. When we weren't riding we were at my backyard table talking about life the way 6-year-old girls do. At my backyard table is where we let our imaginations run free, where we expressed ourselves with no shame, and where we nursed each other's aspirations. Like the time I fell off the table trying to hit Whitney Houston's "somebody whooo" high note in "I Wanna Dance with Somebody (Who Loves Me)". The table was my stage. Peaches and Alicia who were spectating from the swing set leapt to my aid when I fell. After rescuing me from my shame, they wiped my tears, walked me to my door, told my mother what happened, and promised to come check on me the next day. At that time in our lives as young Black girls we thought that our bond was unbreakable. My backyard was where the tall Mississippi pine trees acted as a canopy from the heat of the southern sun and the fenceless yards of our neighbors provided a large playground to feel, safe, happy, and unashamed of being Black girls. And, at the backyard table we didn't have to see ourselves as a race or gender, we were able to *just be*. Here is where we were visible in a positive way, used our voices without being seen as angry, found strength without being broken, and were welcomed without the mandate of affirmative action. We didn't quite understand it but that was probably our induction into Black women's sisterhood. I remember the day that I told them that I might be moving away and how we promised to stay in contact; we ultimately broke that promise. I was 8 years old. However, I'm sure in some way we continued to build on our connection because at the early age of six we had learned the foundational recipe to Black women's sisterhood: to be confident to be who you are in an infinite amount of space, unconditional love and nurture, evaporated shame, and topped with active and intentional presence.

II.

Black women have always worked to find secure places to make sense of and cope with their struggles and promote their voices (Berry Ramey & Gross, 2020; Giddings, 2001). They begin transforming kitchen tables and church annexes into spaces of self-care, collective care, and Black feminist organizing (Berry Ramey & Gross, 2020; Davis, 2017; Giddings, 2001; McDonald Bell, 2007). Across four centuries, Black women are seen under the gaze of a Eurocentric lens casting them as an oppressed population (hooks, 1992). The stereotypes anchored to Black womanhood frame the benefit and dependency of racial hierarchy as a service to legitimate and normalize gendered anti-Black suppression. Consequently, Black women and their bodies—our bodies— are understood to be raced, gendered, and sexed in ways that are in direct opposition to White bodies because Black women's bodies are not built on the site of womanhood, a place construct on the four virtues of the "True Womanhood," piety, purity, submissiveness, and domesticity (Welter, 1966); rather, they are constructed with negative images such as being lazy and sexually loose (Giddings, 2001). Distorted self-images precede Black women. Controlling images of Black women such as "bad mother" were designed as societal and structural barriers to normalize punitive policies like coerced and unconsented sterilization (Collins, 2004; Roberts, 1997). Black women work hard to "fix" themselves to become aesthetically and morally acceptable, not only to the dominant society but also intrapersonally. To address "fixing" themselves Black women develop a praxis of creating spaces to be present, affirmed, recognized, and connect to other Black women. Finding a safe space to self-define has been a core theme in Black women's lives; "coming to voice" is how Patricia Hill Collins (2009) explains it. In her

summation of safe spaces wherein Black women find identity, Hill Collins states, "Black women's efforts to construct individual and collective voices have occurred in three safe spaces, (1) in relationships with one another, (2) in music that bellowed Black women's "Blues" and (3) in sheets of paper that took on the voice of Black women writers" (pp. 112-119). Although, this point of finding "safe" spaces to self-form deserves attention we must consider that for Black women, safe spaces are not always free from harm (physical or mental.) However, safe spaces can be viewed as places of familiarity where affirmations can be built and nurtured. For Black women, *familiar* sometimes meets only the bear minimal for survival, their suffering does not come to a halt, and the trauma they have experienced remains an indelible mark.

Engaging Black women to participate in a research study where conversations with other Black women can be an embodied space allows them to unveil their true identity. However, it must be understood that Black women's experiences of oppression are constant and redundant— even while in a nuanced-space with other Black women, establishing trust is required. The principles guiding Black sisterhood such as, respect for individual identity, non-judgement, and validating each other's struggle and practices such as, active listening, intentional engagement, and upliftment were demonstrated throughout each focus group I held. The Black women participants expressed relief that their conversation about their health experiences was with a "sista" they felt they could trust and who didn't judge them. And yet, these conversations revealed that the very foundation of trust attached to similar values and life experiences that stabilize Black women's sisterhood is a direct consequence of the same ideologies and stereotypes that damage and harm Black womanhood. Ideologies that Black women are "trifling" or up to

no good, and cannot be trusted with other Black women's "business" because they do not have *control* of their own lives and therefore need to be controlled (hooks, 1992; Roberts, 1997) casts a distorted lens over Black women rendering them socially unacceptable (Perry-Harris, 2011). Beliefs that Black women need to be controlled are attached to slavery and the process of erasing Black connection— Black family—Black humanity. Watching Black women exercise such suspicion around connecting with each other drove me to consider the structural damage of the very bridge helping Black women to *get ova'*.

My research plan was to learn about the health experiences of Black women from Mississippi. However, the stressed connections among Black women and the influence the disconnection has on combating racial bias in community health is what I discovered. This spilled tea infused with racism, classism, and phobias becomes the mess to be cleaned up to reconnect Black women to one another. I had come to *see* that Black women's unity was built with walls to encapsulate our survival from the dangers rooted in White supremacy. However, even with the self-determination to survive, society's judgement can press so hard against you, causing stress and strain can occur, and ultimately *structural* (bodily weathering) damage follows. I gave each of the sistas' in this research project a pseudonym that described them as someone positive and not restricted to the negative, bitter, and angry way of seeing Black women. Collaborating with a community member, we identified ten pseudonyms: "Hard-working,", "Kind," "Happy," "Peaceful," "Achieved," "Thoughtful," "Beautiful," "Focused," 'Understanding," and "Concerned." The pseudonyms were randomly assigned to each participant using a list randomizer. The women were very perceptive of their "new names," one participant "Understanding" responded that it was good to have names not

associated with being "angry." Names like "Happy" reminded me of the spirit that makes itself present when Black women get together, we become happier and our blood pressures settle down because we can express our stress and "mess" or life issues we're working through in a way that only another Black woman would know and validate. *"Happy" states, "And you got to be careful with people's intentions because you think they [Black women] might have the best intention or the best heart for you. But really, you know, cause my understanding everybody has some kind of underlying intentions of their own, like, what's driving them, you know, everybody trying to get something out of something. So then that goes back to you not truly being able to trust because you like, what underlining intentions do they have with me confiding within them and telling them how I feel…"* and in the same breath *"Happy" says " You know, you would hope to be 'Oh, you saw something in me' that, you know, can be kind of like a knife sharpening, you know, both ends it's like we're supposed to sharpen each other."*

The community member noted in the above quote first illustrates her concerns in trusting other Black women, but then focuses on how Black women are supposed to be like knives sharpening each other. "Happy" is manifesting the positive benefits of Black women being present for one another. The sharpening effect represents how Black women enhance other Black women. And similarly to the astute description of Black women's sisterhood that "Happy," detailed, "Focused" another research participant describes Black women being there for each other is like "Iron sharpening iron." Iron represents strength, many sturdy and long-lasting objects are made from iron, long-lasting like the cast iron skillet that my mom has had for at least 40 years, the one that she says is "seasoned" so well. Iron is also a mineral that lives in our hemoglobin that helps

carry oxygen from our lungs and to our furthest extremities. The comparison of Black women's bonds to iron is very accurate because just like iron being powerful, multifunctional, and multifaceted so are like Black women, and so is our sisterhood.

III.

The truth is that these women's hurt runs deeper than the trifling "sista" trying to pull them back down into the crab barrel. The crab barrel represents a state of comfort while being uncomfortable. And carries historical notions attached to the inferiority of Blackness that has manifested into normalizing intergenerational teardowns. Black women know that we are a part of the solution to building, rectifying, and healing us. There is a necessity for Black women to help each other get through and over the disadvantages in our lives because only other Black women truly understand our experiences. Black women build the very bridge that they cross to support each other. Our bodies have always been used to hold and carry *things*. Black women have performed nontraditional roles that would have never been assigned to *women* (White women), they have carried heavy bales of cotton from the cotton field that has manifested in to carrying the internalized discomfort of not being seen as human (Combahee River Collective, 2015; davenport, 2015). Black women have been and continue to be a technology, the split atom creating nuclear fission producing a large amount of energy that keeps everything running. Black women have had to uplift themselves and others, so we haven't had the chance or time to hash out the problems that were created to divide us. The bridge to Black sisterhood that carries us to and from each other is complex just like bridges that bear loads that are built over obstacles like rivers providing access to the other side.

Bridges have many parts and building one sturdy enough to carry multiple loads requires a studied civil engineer. The civil engineers that build the bridge to Black sisterhood are Black women and their expertise is doing more with less. Black women have had to build over obstacles such as invisibility, hypervisibility, and being blamed for the downfall of the Black family. Black women's hearts and backs bear the load that erases our existence, causing the death of our physical body, and consequently become attached to statistical inequities that define our (un)health through noncommunicable diseases like high blood pressure and obesity. The "un" in Black women's health does not include our experiences but instead is connected to racist stereotypes such as Sapphire that describe Black women as stubborn, evil, and hateful (hooks, 2015). Sapphire is a figure in Christian mythology who represents the source of feminine sin and evil. As religion was used to justify slavery, so too was it used to scapegoat Black women for the depraved appetites and demonic tendencies of Southern white gentlemen (p. 85). And because Black women's character excludes innocence, their bodies by default are always already deficient, diseased, and unhealthy. Although Black women are well capable of *managing* life under dire circumstances, over time we get tired of freedom fighting because of these racially and gendered descriptions lingering over of us, and face the consequence our spirits and minds are impacted, but we are expected to be strong. The "strong Black woman" mask manufactured for us but not by us displaces our experiences, damaging our tools to build our sisterhood bridge. Black women have to either erase and or displace their individual presence (Canaan, 2015) and hide behind being a "strong" Black woman while being required to manage multiple life challenges quietly, with self-*composure*, and choose "strength over self" (Beauboeuf-Lafontant,

2009, pp. 75, 109). When you have damaged tools you try to make do with what you have because trying to fix them or find new ones is at times additional labor Black women, already burnt out both physically and mentally, may be challenged with the expectation of having the additional bandwidth to expend.

IV.

As I self-reflect and begin to define the type of bridge I should be as a Black woman, I think back to Peaches and Alicia with whom I innocently started my journey to Black sisterhood. I think about the innocence that is foundational in building the bridge to Black womanhood and sisterhood. Yet, that same innocence becomes corrupted by the very nature that mitigates coalition building and relishes in opposition, that of being untrustworthy. During a focus group, "Understanding" explained like this:

"It's hard too, it's hard for us to trust other people it's hard for us to trust our own sisterhood, because people being in the flesh, you have envy, you have strife. You have people being vindictive and deceitful and they laughing in your face and talk about you behind your back the minute you leave, and it's very hard to have those relationships with people with other Black women."

Black women have been taught to self-hate. The stability in having a relationship with other Black women for this woman seems to be a road she had once traveled to find someone with a similar story. However, her trust became injured and the pain forever etched in her memory. Trust is foundational in building any relationship and seems to be the missing bolts needed to repair the damage on the bridge to Black sisterhood. "Understanding" is valid in pointing out the reluctancy in trusting other Black women

with personal experiences is in association with vulnerability and the consequence of being backstabbed with disloyal actions. The unfaithfulness of one Black woman to another may be seen as causing more harm when they could have saved themselves from compounded hurt by dealing with the matter internally.

I was young when I first felt the loving and nurturing effects of Black sisterhood. I had not yet, fallen into the obstacles below the bridge that can cause us to dislike ourselves. I had only dipped my toes into the calm and innocent Black sisterhood that Peaches, Alicia, and I had built. And ironically, the first sister I met in freshman year in college was another Alicia spelled the exact same way as the name of my childhood friend. There were many events during our undergraduate experience that we needed each other to get through. However, at some point along the way a "bridge out" sign went up blocking our pathway to sisterhood. My experience with Alicia caused me to be leery of Black women's intentions and how they were sometimes "messy". I was in the forever spin cycle of asking myself "Who(m) do I trust? How do I trust? How do I slice and dice what I say and how I say it?" I have also asked myself "why do I feel so strongly about the bond between Black women?" Enslavement was the catalyst that drove the erasure of Black womanhood—Black women's existence. Black women have labored to find and/or recreate themselves because of racist and sexist ideologies. In some instances, Black women have reinvented themselves to the point where they don't even recognize who they are. I am not referring to physical argumentation, but the twisting and contorting that Black women do to fit a mold that was never made for them and how this contorting causes Black women to lose their shape and become something that they never wanted to be, such as having to always be "on guard," guarding both your physical and emotional

well-being to save yourself from being intentionally or unintentionally hurt. One participant, “Concerned” reasoned that “she wished she could feel comfortable with us [Black women] to get their [other Black women] opinions on different things [personal issues and life advice].” When Black women reshape themselves they hide their culture, they hide their self-love. The politics behind hiding oneself is also in the recipe for being a *good and successful* Black woman. And because of the negative social and cultural conditions that are attached to Black women, they can become detached from themselves resulting in a disconnect from Black sisterhood. Yet, Black sisterhood is the very space where we have formed strategies to resist the systems that oppress and control the perception of us.

Black women have doctored and nursed each other out of conditions that only other Black women would be successful in treating or curing. Black women carve out spaces of *beingness* (humanization) such as the kitchen to counter spaces of *non-being* (degradation) such as society (Davis, 2017). The kitchen for enslaved Black women represented a Black-dominated space where they were empowered and created strategies for survival (p. 218) And still today we have to enter the kitchen to communicate our needs and experiences —negotiate our well-being. The health treatments that Black women provide for one another is not attached to pharmaceuticals or homeopathic remedies, but instead a collective force, an energy which claims that which is superfluous to the negative nature erasure—an ear to hear your pain or a shoulder to lean on to provide a solid structure for you to continue to stand. Black women's value to each other is infinite and can have the efficacy of a medical treatment. Casual inquiries into the health of many Black women reveals that they are at risk for various noncommunicable

disease such as hypertension and obesity. Indeed, obesity affects 56.1% of Black women aged 20 and over (National Center for Health Statistics, 2017) with the southern region of the US carrying the most weight as well having negative associations with obesity (Akil, 2011; Warren, 2018). One of the leading causes of death in Black women is high-blood pressure medically known as hypertension. At 46.1% the prevalence of hypertension in Black women is the highest in the world (Mozaffarian et al., 2016). Hypertension could be a word found in a Black language dictionary defined as being under the constant pressure of *fixing* ourselves to meet societal standards causing a high amount of tension throughout our bodies with the health consequence of our lives being silently taken. However, like the Biblical account of Abraham's experience of the ram in the thicket (bush), a Black savior could be the connection with someone with similar experiences as yours, in this case another Black woman— a sista'.

Black sisterhood is Black women straightening each other's crown. The crown can represent her physical presence so that she appears well put together and not "busted" or disheveled. It represents the protection of her heart so that it does not get broken completely, so that together we can mend it. And, the crown could also represent her health and being there to help each other understand the inequities that impede our health including the consequences of not working towards health. Straightening my sister's crown reaches far beyond achieving dope or trendy hair styles, it is an expression of Black dignity and self-respect. Thus, it requires that we see ourselves in two mirrors, first in the mirror that shows the reflection of self that has been designed for us and, secondly, the view the reflection of self that is in opposition to the narratives created for us (Du Bois, 1996). And then we must draw up our self-consciousness, self-realization, and self-

respect to assess the damage that has been done (p. 13). This enable us to do as bell hooks (1992, 2015) suggests and interrogate the work, come with an awareness of the politics of race and racism, and construct an oppositional gaze that allows one to look with the intent of strengthening our Black sisterhood. We have to become bridges to each other made of cement and steel versus the Southern wooden plank, no guard rail having, dark skinned against light skinned, politics of respectability versus unlady-like bridges that history has provided us the instructions to build. We must redesign the bridge to Black women's sisterhood. Structural damage has been done but at what cost? Is the destruction of a structure required in order to acquire stability or to rebuild something deemed more robust in White society's eyes? The raced and gendered qualities of 'stable' must be recognized and addressed. Our quality of stability should not be braced on "rebuilding or getting back up" but instead reinforced in the strength of Black culture—abilities—worthiness. The analogy of 'rebuilding' suggests that something was wrong in the first place. This is not acceptable. Societies routinely recognize rickety old buildings that have sheltered some of the most anti-Black events as national treasures, they do not suggest knocking them down and rebuilding. Rather, they figure out how to strengthen them—providing support, resources, and access—*recognize* them with a name and a destination: National Cultural Treasure. While healing is understood to come after damage, this is not the only way to understanding something being repaired. Repair can arise from seeing something perceived as broken in a new light. A structure in need of repair can be supported rather than replaced; saguaro cactus in fear of falling over, can be propped up and reinforced, access to resources, repairs, reparations, and re-edification are alternatives to tearing something down and rebuilding. Slavery divided us by fatal invention of race

(Roberts, 2011) and under the Trump administration helped us see through the lenses of violence, invisibility, insanity, and destruction. Having more overt discriminatory practices helped Black people understand that there needs to be a mend to how dominate views of our Blackness causes structural damage to our social connections with each other—weathering us—dividing us. Deterioration of the body associated with the constant exposure to social infrastructures that shape Black bodies and how they move about the world that wear us down physically, spiritually, and mentally; this is the "weathering" I am referring to— a racialized and gendered storm. Geronimus et al. (2006) introduced the "weathering" hypothesis which posits that early health deterioration among Black individuals (particularly Black women) is a consequence of continuous exposure to social, economic, and political inequities due to living in a race-conscious society. Consequently, these internalized racialized and gendered experiences manifest in physiological injury such as increased cortisol levels resulting in elevated blood pressures and cholesterol levels, associated with premature death in Black women (Beauboeuf-Lafontant, 2009; Geronimus, 2006; National Center for Health Statistics, 2017). However, connectedness generated through Black sisterhood becomes a social network to counteract structural violence by providing a space for Black women to meet their basic needs to be seen and heard (Collins, 1998, 2009). Black sisterhood becomes a material resource, with collective knowledge having the most abundant value that becomes the capital that empowers them.

V.

The last day Peaches and Alicia and I played together reminds me of the scene in the novel by Alice Walker, *The Color Purple*, when Nettie has to leave her home (under

totally different circumstances than I); the words Nettie used was how I feel that Black women must see our sisterhood "you and me together forever." Black women read each other, we are visible to each, we have a voice with each, we have security with each other. Black sisterhood is not something guaranteed when Black women's paths cross— there is a process—a spectrum. And within every process there are actions to take, pauses to make and breaks to be had. After a six-year pause in our sisterhood, the undergraduate Alicia and I reconnected . Things aren't the same but we're building and that's what we as Black women must continue to do. There may be one relationship that breaks and another that never even begins but we must not let our bad experiences further weather the structural damage on our bridge to sisterhood. Black women must be careful and protect ourselves, but avoid giving up on the opportunity to build a relationship with the next sister. Black women's sisterhood is what got us through slavery, the Civil Rights movement, the social pandemic of white supremacy, and will continue to play an intricate role in influencing the consciousness of our sisterhood. We must not become the gap in our own survival, we survive collectively, together we are our voice— we are our truth.

> "Black women [together] have survived the rigors of slavery to demand the rights of their race and of their sex. They rose above the most demeaning forms of labor and demanded to be called by their last names. Black women forged humane communities out of rough settlements. They converted the rock of double oppression into steppingstone."
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> -Paul Giddings, *When and Where I Enter: The Impact of Black Women on Race and Sex in America,* (p. 357).

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CHAPTER 4

SISTER-GIRL TALK: A COMMUNITY-BASED METHOD FOR GROUP INTERVIEWING & ANALYSIS

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Abstract

Leveraging ground-breaking work of Black feminist scholars alongside established techniques of focus group and community-based participatory research, we explain sister-girl talk as a novel method for collecting and analyzing group interview data with Black women. We outline the procedures for consultation, facilitation, and preliminary analysis of the sister-girl talk method.

Keywords

Black, feminist, qualitative methods, focus groups, CBPR

Introduction

Anti-Black violence and oppression are among the world's most pressing social problems (Bashi 2004; Khan-Cullors and Bandele 2017; Ore 2019; Bledsoe and Wright 2019). Yet, exclusion of Black scholars from higher education has limited academics' capacity to research and fight anti-Blackness (Deliovsky 2013; Myers 2015; McKoy Smith 2016; Charity Hudley, Mallinson, and Bucholtz 2019). As one remediation, we

detail sister-girl talk as a research method which brings subjectivity to Black women through their self-defined truths as the start of research inquiry (Harding 1993; Collins 1986, 2009) in order to serve and advance their needs. In doing so, we respond to Evans-Winters' (2019) call for centering the concerns of Black women in research. The method is designed to engage long-standing issues with extractive and harmful research conducted with Black people (Roberts 1997; Washington 2006; Showunmi 2017), build trust in the research process (Corbie-Smith; Thomas et al. 2002; Lucero, Wright et al. 2017), and improve the quality of data elicited for social science research (Townes 1998; Christopher, Watts et al. 2008; Davis 2018).

Sister-girl talk is a method for the collection and analysis of group interviews. *Sister* or *sister-girl* is a term of address in Black Languages that signals familiarity and connection among women; the kin term indexes shared experiences as Black women (e.g., McKay 2002; Cole 2011). We understand Black Languages to include "style[s] of speaking English words with "Black Flava"—with Africanized semantic, grammatical, pronunciation, and rhetorical patterns" (Smitherman 2006: 3; see also Baker-Bell 2020). Sister-girl talk is a conversation among two or more Black women for empowerment and knowledge creation, shaped by their experiences producing a collective standpoint validating their truths (Collins 1986, 2009). Joining the ground-breaking work of Evans-Winters (2019), Black feminist scholars (hooks 1991; Collins 2002), and research on Black women's health in Mississippi (Mitchell 2021), sister-girl talk contributes to liberatory research practices. Building on focus group methods (Morgan 1997) and community-based participatory research (Davis and Baca 2015), we detail procedures for sister-girl talk as a method.

The steps outlined below cover community consultation, consent, confidentiality, facilitation techniques, and language use. We discuss preliminary analysis methods, drawing on testifying and call and response, language practices common to group interviews with Black women (Smitherman 1977; Morgan 1996, 2002; Lanehart 2002; Kirkland 2010; Richards-Greaves 2016). Finally, sister-girl talk as a method for liberatory research is discussed.

Step 0. Doing Community-based Research

Building community is a fundamental initial step to choosing sister-girl talk as a method of data collection. First, we recommend partnering with an advisor who has deep community ties in the research site. Advisors, including healthcare providers, religious leaders, or community activists, can help facilitate introductions and build trust. These connections position the researcher as collaborative rather than exploitative (Sangaramoorthy and Kroeger 2020), while simultaneously acknowledging power differentials between academic researchers and many Black communities. Research design that partners with participants and communities, while ethically protecting participants' identities and interests, is key. The enduring context of unethical and harmful research practices can be addressed through these practices.

Step 1. Selecting Participants & Composing Groups

Sister-girl talk was part of our multi-method design; we found it useful to have prior familiarity with the community and participants. Inspired by a theoretical sampling approach (Draucker et al. 2007), we used community-based selective sampling to recruit Black women who could contribute new knowledge to our study. However, any non-probability sampling technique could work. Following recruitment, we formed two

groups of older and younger women (four groups total), following the literature on minimum sample sizes for focus groups (Guest et al. 2017). Within each group, we sought to balance women with different temperaments, perspectives, and relationships. For researchers without personal knowledge of participants, we believe a screening process might yield sufficient information to balance sister-talk groups in terms of temperament and topics.

Step 2. Consenting, Confidentiality & Compensation

To address Black participants' legitimate concerns about extractive and harmful research, sister-girl talk requires thorough consenting procedures. Consent forms should be detailed and jargon-free, clearly communicating the goals and tasks of the project. Another important consideration is confidentiality. Sister-girl talk is specifically designed to build care and mutual support; consequently, participants may want to reveal their identities and exchange contact information with one another. Assigning each participant a pseudonym during the sister-girl talk sessions, and using only these names, is an important way to maintain confidentiality (Showunmi 2017). We recommend choosing pseudonyms that uplift Black women and counter harmful stereotypes, like "Beautiful" and "Kind" (hooks 1992/2015; Perry-Harris 2011). Finally, offering a financial incentive (Darity and Mullen 2020)—especially in low-income communities—to compensate time spent in research activities is mandatory. An hourly rate slightly higher than the average local wage is recommended.

Step 3. Preparing for a Sister-girl Talk

Sister-girl talks should be conducted in local Black Languages to facilitate conversations that are intimate, trusting, and open. Thus, the researcher should be a Black

woman with deep familiarity of *local* Black Languages. While code-switching is central to Black Languages (DeBose 1992), we believe fluency in local Black Languages is likely a requirement for successful sister-girl talk facilitation.

Communicating care and commitment from the outset is key. Consider using texting (with consent) prior to the actual sister-girl talk session to check in and connect with participants. Such outreach demonstrates care and helps to establish the openhearted communication needed for a sister-girl talk to begin. These personal connections are an extension of the "Black nod" (Jones 2017), and provide acknowledgement and supportive visibility.

Step 4. Facilitation & Data Elicitation

Sister-girl talk should create a space where Black women's voices are valued, not heard as being "out of hand." This requires adept facilitation that is more fluid, responsive, and permissive than conventional group interview facilitation. A skilled researcher should be able to piggyback on free-flowing conversations in ways that elicit valuable conversations without impeding flow.

Sister-girl talks can become heated; thus, conflicts should be welcomed. Expressing strong opinions and feelings, with frequent overlapping voices and interruptions, must be encouraged. Ardent conversation is an indicator that the sister-girl talk is yielding valuable data. A good facilitator will help establish a sympathetic and safe space for participants' voices to be heard.

Because of the pervasive suppression of Black women's self-expression in majority-white spaces (Beauboeuf-Lafontant, 2009; Wallace 2015), there are enormous ethical implications to poor facilitation. Breaking the trust established in a sister-girl talk

can do serious physical, mental, and spiritual harm to participants (Townes 1998; Giddings 2001; Jones and Gooden-Shorter 2003; Wallace 1978/2015; Wilkerson 2020). Sister-girl talks should be undertaken only when a skilled researcher is available to facilitate them.

Step 5. Preliminary Analysis

Sister-girl talks often yield preliminary inductive analyses during the data collection. The main mechanisms for this are (1) testifying and (2) call and response (Smitherman 1977). Both mechanisms can facilitate preliminary thematic analysis and identification of typical exemplars.

In testifying, Black women may use verbal affirmations like "Yes, girl, you know like what she said over there," or simply "mm-hmm" to signal uptake of a participant's words followed by a (re)telling of her own similar experiences (Smitherman 1977: 135). This form of repetition is a productive technique for identifying themes and exemplars (Ryan and Bernard 2003). Beyond this, testifying is key to sister-girl talk as it elevates participants voices, instructs the researcher, and highlights core truths often misunderstood.

In call and response, the use of direct repetition, encouragement, affirmation, and completion of one's own or another participant's words is a way of acknowledging and thus unifying speakers and listeners as one (Smitherman 1977:108). Here, too, repetition highlights meaningful themes and exemplars (Ryan and Bernard 2003), a form of preliminary inductive analysis. Additionally, through call and response, sister-girl talk validates Black women's knowledges and contributes to liberatory practices.

Step 6. Closing a Sister-girl Talk with Liberatory Practices

Moving beyond testifying, call and response, and even conflictual talk as forms of affirmation, it is important to embrace silence as a sister-girl talk comes to an end. Center Black women's voices, silences, and experiences rather than the research goals, making space for women to continue to converse in ways that strengthen each other. This may mean that participants want to continue conversations with the researcher or each other; support and encourage this. End on a positive note that recognizes participants' knowledge and resilience. Demonstrate gratitude to the participants for what they have taught you. After the sister-talk ends, make good on promises to stay in touch. Stay connected, too, with the larger community—be active in reaching out to local churches, health centers, and community spaces; be present on local radio and other media.

Conclusion

This paper suggests procedures for sister-girl talk as a form of group interviewing conducted by and for Black women. The method requires the use of special community-building, consenting, confidentiality, and facilitation procedures. Sister-girl talk is also a form of preliminary analysis using testifying and call and response as inductive analytic procedures. When done properly, sister-girl talk can also be a liberatory method that empowers participants while also producing data and analysis to confront anti-Blackness.

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CHAPTER 5

CONCLUSION

Summary of findings

This dissertation aimed to understand the health experiences, behaviors, and knowledges among fourteen Black women from Mississippi. Through this focus on and centering of these women's voices, I uncover how these cultural connections intentionally or inadvertently operate as a sisterhood. Ultimately, I sought to answer the following questions: (1) How do Black Mississippian women confirm or reject characteristics associated with the deficit model when describing their health experiences? (2) How is Black women's sisterhood an embodied space for health practice, and what are the complexities around it? And, (3) How does the social location of Black women's bodies impact the way that data collection is facilitated? Key findings are presented below.

Chapter 2: Highlighted the ways that Black women's bodies have been discursively created as always and already diseased and unhealthy. Historical portrayals of the Black woman and her body have persisted to today, often unchecked, and unquestioned. This means that Black women's bodies are politically, socially, and economically segregated from being viewed as healthy. The knowledge used to determine an individual's health must consider the experiences and knowledges of the person being described. Knowledge is co-produced and multidirectional; recognizing this is critical in order to begin to address health inequities. Black women reject definitions of their bodies as being unhealthy and instead use their knowledge of their bodies to self-define. Living in Mississippi, a state that is considered to have the largest

Black bodies out of all fifty states, these women saw healthfulness even though their bodies were diagnosed as diseased. For these women, health was understood not simply as the lack of disease, but as a chance to continue living despite their "condition." There was a positive perspective that gave them access to hope through their belief that health is a process that is not necessarily found in a medical prescription. The six themes that emerged from this research reinforced that there needs to be an ethic of care when treating and diagnosing Black women's bodies. The ethics of care needs to start with medical institutions listening before speaking and considering other knowledges before diagnosing. Institutionalized medical "practices" have brought violence and misinterpretation to Black bodies in general. Thus, these findings show a necessity to include Black women's voices—their self-knowledge— when diagnosing their bodies.

Chapter 3: Health is a part of the collective experiences that connect Black women. I considered Black women's sisterhood as a dominant factor in how their health practices are formed. Black feminist scholars have defined Black sisterhood as representing an intentional attachment to other Black women who share similar experiences (Collins, 1998; Collins, 2009; Fuller, 2019; McDonald Bell, 2007). Similarly, I found intentional attachments with many of the respondents regarding their health and health practices. However, many women were suspicious of Black sisterhood. The suspicions of these Black women led me to question my standpoint on Black sisterhood. I then transitioned from "their" sisterhood to "our" sisterhood and used autoethnography as a methodology to approach the phenomenon of Black women being disconnected from our sisterhood. As a result, I reflected on the past and understood that Black sisterhood is a process. And, the process included encounters of purposeful Black

sisterhood that lasted for a season or a lifetime. In this case, shared experiences in health were expressed as the main event joining Black women together. Black women described similar health experiences and health practices as an intentional attachment to each other. I emphasized how Black women's collective knowledge has been the force behind surviving physically, mentally, and spiritually. I introduced how the same relationship that bridges Black women to one another is also attached to and shaped by negative dominant views that have disrupted and disconnected Black sisterhood. I considered how harm could be facilitated in places and spaces that Black women have carved out to protect themselves. Although I did not perform a systematic analysis to produce more considerable scale evidence, I found that Black women's sisterhood is complicated. And that Black women's (un)health are defined as characteristic flaws manifested through our bodies —the very misrepresentations of Black women's bodies enduring historical legacies dismantling Black womanhood (hooks, 2015). Importantly, the complexities around Black sisterhood operated as a health practice; a space for consultation regarding physical, mental, and spiritual well-being that can only be maintained through the use of certain principles and standards.

Chapter 4: I revealed a novel methodology to collect and analyze group interview data. Using a method that centered Black women, their experiences, knowledges, language uses, and ways of negotiating with each other created the capacity for more informal and personal conversations that may have otherwise only occurred in the privacy of homes, or in other familiar and comfortable spaces such as, churches or the beauty shop. I found that when Black women feel as though they can *just be*, they employed intonations that facilitated how they truly felt compared to discourse

frameworks that mobilize circumlocutory speaking styles that diverge from the topic of conversation. However, I learned that to facilitate Sister-girl talk, the researcher must have a prior relationship with the community or have been introduced to the community as someone who can be trusted. Trust is foundational in community-based research. It is salient to understand and make space for intracultural communication when working alongside an underserved community, such as Black women. *Sister-girl talk*, a qualitative, community-informed data collection method, served as a liberatory practice where the community (Black women) validated and made the data reliable. The transition towards a self-defined/community-defined space operated as a dismantling tool from traditional anthropological and social science methodologies that frequently function as extractive, assumptive, and harmful to Black communities. And I envision this research methodology being used in future applied research to disrupt power dynamics that intentionally value cultural knowledge to close the gap in health inequities.

Discussion

This dissertation sought to center the voices of Black women from Mississippi. The findings contribute to various scholarly venues including Black feminist thought, Critical Race Theory, and public health literatures as evidence that self-determination is inextricably attached to all facets of life for Black women. Because there is a history that contradicts how Black women's bodies are viewed and assumed to move about the US versus how they choose to move about and be seen, there must be a critical lens used to hone in on their experiences. As a remedy, Black women must be provided opportunities that empower their knowledge; where they are envisioned as experts and consulted before health strategies (interventions) are planned and executed. *To be seen* differently is the

work that Black women do to be detached from dominant views of themselves in order to exercise their own power, agency, and thus create their identities. They carve out spaces that allow them to engage with each other collectively and intentionally. bell hooks states that systematic devaluation of Black womanhood led to the reduction of anything Black women pursued—their humanity. In particular, this research prioritized Black women's wholeness, time, energy, identities, spirituality, and standpoint. Narratives of Black women's health rarely center them; instead, these narratives typically medicalize, overdiagnose, misrepresent, and blame them. Using an approach that focused on Black women's voices, this research listened and attended to the participants stories of health and self-healing. My aim was to learn from Black women and to honor their experiences and knowledges rather than bring a health intervention mechanism which only serves to reduce Black women to bio-measurements, unhealth, and a litany of deficits that can be best described as simply not being white. In opposition to most literature that merely describes Black women's health, this research highlights the ways that Black women *invest* in their health, and in the health of their sisterhood. This dissertation, through collective— sisterhood— experiences, identified that spaces that allow Black women to express how their bodies are racialized, gendered, and classed motivated how they built positive frameworks around their health and generated processes to increase their health status through their collective knowledges. Through sharing how Black women *see* their health as a process and their bodies as a testament to surviving the intersecting systems of oppression that shape their health, this research hopes to lift their voices, knowledges, and experiences.

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APPENDIX A

APPROVAL

Approval

The three-papers in chapters 2, 3, and 4 were written as articles for journal publication. Chapter 4, “Sister-girl Talk: A Community-Based Method for Group Interviewing and Analysis” was accepted for publication in *Field Methods* with the article tentatively for volume 34(2), 2022. At the time of writing this dissertation, Chapter 3, “Seeing Structural Damage: The Journey in Crossing the Bridge to Black Women’s Sisterhood” was submitted to publication to the *Journal of Applied Communication Research*. The co-authors in Chapter 4 have granted their permission for the inclusion of this research in my dissertation, and I am the sole author of Chapter 3.

APPENDIX B

PROJECT 1 RECRUITMENT SUMMER 2019

Project 1 Consent form:

Recruitment/Description:

Project Title: Food and Fat in Four Cultures

Lead Investigators: Drs. Alexandra Brewis Slade, Amber Wutich, and Cindi SturtzSreetharan from Arizona State University

Why is this research being done? Our current food environments have gone through transformational change in recent years, and this has had major impacts on our health – both positively and negatively. We are interested in learning more about how people think about food, community and social ties, family, work patterns, and health and what changes they have seen around these issues in their own lives. We are also interested in hearing about weight and body-related topics as these pertain to food, health, and social and work patterns.

How long will the research last? We expect that individuals will spend at least one hour being interviewed once.

How many people will be studied? We expect about 150 people will participate in this research study.

What happens if I say yes, I want to be in this research? If you would like to participate, we will arrange a two-hour block to meet and talk somewhere you are comfortable (e.g., home). We will record the interview and later type it out. The written version of the interview will not be connected to your name or other personal identifiers. As a thank you we will also give you $20 cash.

Contact Person: Dr. Sarah Trainer, Arizona State University, 206-707-6028 or strainer@asu.edu

APPENDIX C

PROJECT 1 SEMI-STRUCTURED INTERVIEW PROTOCOL

Project 1 Semi-structured Interview Protocol :

Project Name:

Food and Fat in Four Cultures

Participants:

Age	Women	Men
Young (44 and below)	6	2 (these are coupled w/ 2 of the 6 women)
Old (45 and older)	6	2 (these are coupled w/ 2 of the 6 women)

Total N per site = 16 (12 women, 4 men; 4 couples)

Total N = 64 (48 women, 16 men; 16 couples)

Inclusion for participation across each site: long term residence in site; long exposure to site norms; socialized to the area and the norms.

Protocol Begin:

Tell me about yourself.

- How old are you?
- Where were you born? Where do you live now?
- What level of education have you completed?
- Tell me about your family? (Are you married? Do you have children? Who do you live with?)
- What kind of work do you do?

I'd like to ask you some questions about food.

1. FOOD AND EATING

Q1: Do you think the kinds of foods people eat around here have changed over time? Could you tell me about some 'traditional foods' that used to be consumed frequently but now are not?

Q2: In the past in (SITE), what did a typical breakfast look like? Lunch? Supper/Dinner?

Q3: What about now? Could you take me through what a typical day of 'eating' looks like for you? a typical meal (breakfast, lunch, dinner)?

Q4: Do you think the way you eat is typical of people your age who live around here? Why/Why not?

Q5: Does this type of eating match what you think you should be eating? Does how you currently eat match what you would like to eat? Follow up: Why is there a difference between what you think you should eat and what you *do* eat?

Q6: Who does most of the grocery shopping in your family? Who does most of the cooking? Who makes decisions about what you eat? Do you feel these are good choices?

Prompts:

Paraguay: Change since the 1980s [end of the Strossner dictatorship]?

Rural GA: Would you say you eat mainly a traditional Southern diet? (how, when, what, when not). How important is it to you that you get to be able to eat traditional Southern foods? Why?

JPN: Western v. Japanese diet? What about *wagashi* (Jpn sweets) vs. *yogashi* (Wstrn sweets)

Transition Question: Do the foods people eat affect their bodies? How? Which foods? Are some foods healthier than others? Is the effect different today than it was in the past? [Getting at rule based ideas]

2. BODY IDEALS/BODY CAPITAL

Q1: What kinds of bodies do you think Samoans/Japanese/ Americans and Southerners/Paraguayans in general most want to have? Why?

Q2: What does the ideal male/female (masculine/feminine) body look like? Have ideas about beauty and ideal bodies changed over time in America? Georgia? How? What about particular body parts?

Q3: Are their particular jobs or situations where it is better to be smaller or bigger? Work/making an income; women; men; older/younger women/men? Or, give an example from researcher's context to try to make analogy for participant.

Prompts:

Paraguay: Could it hurt people's incomes if they don't look this way? [Prompt: urban v. rural]

JPN: Traditional body ideals vs. contemporary ideals; rural v. urban

Now I'd like to ask you a bit about your health.

3. DISEASE/HEALTH OF LARGE BODIES

Q1: Do you consider yourself healthy? Why/why not?

Q2: Has a doctor (OR NURSE ETC) ever suggested that you should reduce your body size (lose weight)? Can you tell me about that?

Q3: Have you ever been diagnosed with any disease that you think is related to your weight? Can you tell me about that?

Q4: What diseases do you think are related to weight? Are men/women more likely to get them? Are Samoans/Japanese/Americans and Southerners/Paraguayans more likely to get these diseases than other groups of people? Why?

Q5: Do you think you yourself or people in your family are at risk of any of these diseases? Why?

Q6: Are there times when being fat can be healthy? For example, is being fat healthy when you are young? Do you think being fat is healthier for men/women?

Prompt:

Paraguay: Has the diabetes situation changed much since the 1980s?

Rural GA: How would you feel if a doctor told you that you needed to lose weight?

JPN: Do you think women are usually more healthy than men? Why (alcohol consumption)? Gout?

Samoa: Why do people get NCDs (non-communicable diseases)?

Now I am going to ask some questions about bodies in general in PLACE society.

4. BODIES, SELF and SOCIETY

Q1: Are there some sizes of body that are disadvantaged in PLACE society? (Prompt: Are there particular kinds of bodies that get made fun of? Are some types of bodies treated differently by people, such as in the schoolyard or workplace?)

Q2: What do you think of your friends who have thin/large bodies? Your family? Strangers? Have you ever heard people complain about thin/large bodies?

Q3: How do you feel being around other people with thin/large bodies? Does it make you feel comfortable? Uncomfortable? Do you ever avoid people with thin/large bodies?

Q4: When you see a stranger in public that is very thin/large, what is the first thought that runs through your mind? Do you ever feel like there are places people with thin/large bodies shouldn't go?

Q5: If someone is overweight (or underweight?), whose responsibility is it?? Follow up: Do you think it is important for society to be concerned about people's weight?

Paraguay: What kind of body would you be proud for your [husband] or [son/daughter] to have? Would it be embarrassing for them to have a body that is bigger than [the one described]? Why - how - can you think of an example?

Rural GA: What if you ran into a friend who had gained a lot of weight since you last saw them?

JPN: Sitting on the train; at the public bath.

Samoa: Where do you hear disparaging or positive statements about fat? What kinds of things do you think other people associated with weight?

Finally, I'd like to ask you about who you talk about weight with.

Now, I'd like to talk about how some of these ideas connect to you:

5. GENERAL OWN-BODY CONCERNS

Q1: Do you ever notice other people's body shapes/sizes? When do you notice other people's body shapes?

Q2: Do you ever notice your own body shape or size? Can you tell me a time when you felt good about/proud of your body? How about a time when you remember not feeling good about your body? Like, do you remember ever feeling embarrassed by your body size or shape?

Q3: Does your body cause you any anxiety or embarrassment when you are around other people? What about when you are alone? Follow-up: Are there spaces where you feel more comfortable about/in your body than others? Less comfortable?

Q4: Are you happy with your body - how and why? Has any of your family or friends ever suggested that you should reduce your body size (lose weight)? Can you tell me about that.

Q5: Can you think of times when someone else, like a stranger or acquaintance, has commented on your body size? How did you feel? [Prompt: Have you ever felt you were treated differently (better or worse) due to your body size?]

Q6: Do you think this would be different if you were younger/older, male/female, pre/post reproductive?

Q7: Are there times when you have been proud or felt good about being big? Can you tell me about those?

Q8: If you could change your body in any way, what would you want to change? And how would you like that to be done? (e.g., surgery, exercise, diet). [What is stopping you? etc.]

Paraguay: Reproduction v agriculture. [agricultural labor] What do bodies that can do these jobs well look like?

Rural GA: Do you dress for your body? When do you make the most effort to do this?

JPN:

So now I'd like to ask a little bit about your body…

- How much do you think you weigh? Has that changed over time? When was the last time you were weighed?

- How tall do you think you are?
- Would you classify yourself as underweight/about right/somewhat overweight/extremely overweight? OR,
- How would you classify yourselves in terms of weight? What about body shape?

6. FAT TALK (if questions seem too direct, please go directly to prompts listed below).

Q1: Do you ever talk to family members about your body weight or how your body looks? Do they talk to you? Tell me about these conversations. Are they different from the way conversations go with your friends?

Q2: How do you think girls talk about weight and body vs. boys?

Q3: Do you think people who are older/younger than you talk about their weight differently? Do you ever have conversations with people about weight who are not your age?

Potential FT Prompts depending on situation:

Does your daughter/son (sister/brother, wife/partner if appropriate) ever ask you if s/he looks fat? How do you respond?

If you see a good friend who has recently gained/lost a noticeable amount of weight, what do you say about the weight gain/loss?

Do you complain that your pants are too tight?

Do you complain about hair loss?

Who do you complain to?

Do any of your friends or family complain to you about these kinds of issues?

Do you worry that you are too small/big for xyz activities?

What kind of sports did you enjoy in high school? Do you still occasionally play/engage in that sport?

Finally, can you share a fat joke with me. (We need one from each site.)

APPENDIX D

PROJECT 1 THEMATIC CODEBOOK

Project 1 Thematic codebook:

1. ***Health as a process*** – Black women feeling as though their health is a journey (not something gotten over night, it's a struggle to survive)

    - ***Key words:*** journey, struggle, prevent, process, preparation, cook our foods, change the process, taking care of myself, know what to do for your own body,

    Inclusion criteria – Any mention of becoming healthy as a continuous process or that it's a day to day walk in life.

    Exclusion criteria – Absence of becoming healthy as a continuous process (such as medicine being the cure)

    Exemplar(s):

    - *"I might not be at the weight that I need to be at, but, health, yes"*
    - *"Um, and, uh, losing weight, it's a good feeling, a real good feeling. Uh, to lose weight and to be* able to control *your own body. Because as long as you got the weight on you, your weight is controlling your body."*
    - *"but in order to eat healthy, you need to be very intentional"*

    Atypical:

    Close but no: *"I love watermelons. And watermelons affect people with diabetes. But I learned to drink a lot of water, too, and that flushes the sugar out."*

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2. ***Trusting my gut instincts*** –women feeling as though the medicines that they have been prescribe harm their bodies as it treats their symptoms or that tools used define their disease are not inclusive of their bodies or experiences. **Not believing**

in medical stats and instruments – Statistical measures that 'they' came up with does not work for Black women's bodies. **Over and under diagnosis**. **Trusting in God to heal versus** medicine and medical practitioners.

- **Key words**: trust, not trusting, they/them, distrust, they don't know, faith, not taking everything from doctors, medicine, sick

Inclusion criteria – Any mention of not trusting in or having faith in medical systems, practitioners, or tools (e.g., BMI chart or medicine)

Exclusion criteria – Trusting in medical systems or medical tools to treat Black bodies

Exemplar(s):

- *"but uh I think that medical people, or medical statistics – Are not dealing with us as a black people. I think that they are basing everything on us from white studies."*
- *"I've lost this weight, but it hasn't taken me off any medication…"*
- *"Uh, certain things, I ain't too quick to take everything from the doctor. I don't do the drugs, the narcotic drugs at all."*

Atypical:

Close but no: *"I've lost this weight, but it hasn't taken me off any medication…"*

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3. ***Self-care of body and mind*** – health of the body is extended to the mind.

- ***Key words***: loving self, mental health, mental, stress, stressed, depressed

Inclusion criteria – Any mention of self-care of the body extending to the mind, this also includes decreasing stress and depression.

Exclusion criteria – Rejecting that self-care of body and mind is an extension of whole health.

Exemplar(s):

- *"Girl what happened to you? Okay, I know you ate, but what else went on with you?". It's always something mentally went on with them."*
- *"You know, considering in shape and healthy being able to do physically, you know, mentally what you need to be able to do.*
- *"And I think a lot of the hypertension comes from stress. And, um, in the black community what I've seen, especially down south, women carry a lot of the weight."*
- *"You look like you've gone through something."*

Atypical:

- *"Now, it's just her making peace with herself that she's okay."*

Close but no:

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4. ***A large body not meaning an unhealthy body*** – being thick does mean that you're diseased, there are skinny people with diseases that are attached to obesity (e.g., type 2 diabetes and high blood pressure)
   - ***Key words***: big boned, big, thick, fluffy, healthy, good shape, loving me regardless, I love me, statistics, commodity racism/showing Blacks on commercials about diseases, inner beauty, criticize, size, sexy, health issues, being the right weight, medicines

Inclusion criteria – Any reference to larger Black women's weight not being attached to health.

Exclusion criteria – Mention of skinniness being an indicator of healthiness.

Exemplar(s):

- *"Um, yeah, and that, well you can still be pretty heavy even if you are eating on the healthy side."*

Atypical:

- *"The ideal body weight it not, what's in, people are starting to accept that being bigger is okay.*
- *"I love me regardless. And a lot of people don't love themselves, they haven't arrived at that point, so."*

Close but no:

- *"I'm serious! We didn't have any fat kids in my class, in the school, hardly ever you might see one or two."*
- *"I see a lot of my age peers, you know, it's like, they're working out because they're not really working out to get healthy. They're working out to gain the body."*

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5. ***Support network*** – other Black women around me keep me grounded and focused on my health (mentally and physically).

    - **Key words:** I need help, without her, without them, support, love, help, encouragement, let's go walk,

Inclusion criteria – Any mention of Black women's support, love, sisterhood, and nurture as a tool for other Black women to become healthier.

Exclusion criteria – reference to other Black women not being supportive or being "crabs in a barrel" pulling other Black women down intentionally.

Exemplar(s):

- *"But she only has been a big help. She motivates me, she cooks for me, actually she prepares my food, so I don't go out and get my lunch. So, she checks on me, my mother's retired, she doesn't have things to do, I'm the only child, and so, um, she, she, she's the mother. She plays that role, uh, very well in my life. Um, she's kinda like a personal assistant, so, without her help, I would be absent from any of this, so, it would just be, I wouldn't take the time to do it."*

Atypical:

Close but no:

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6. ***Black MS women's ways of knowing how to heal their bodies*** – Black women knowing their bodies and understanding that there are natural things to heal it. Also knowing how medicine may need to not be taken because of it not making them "feel right." Self-healing.

    - ***Key words****:* herbs, grandma/big mama, back in the day, garden, heal, home remedy(ies), tree(s), tea(s), mom/momma/mama nem/them, certain foods, food, we take better care of ourselves, certain foods aren't made for us, we used to know what was in our food, exercise, diet, cooking your own foods, poor areas, poor quality food

Inclusion criteria – Any mention using alternative medicine or foods to heal the body or discontinued medicines.

Exclusion criteria – Mention of prescription medicine as healing.

Exemplar(s):

- *"You're going to pull all of that away. I mean, it's, it's everything this is about. It's about pulling us away from original."*
- *"Because… us as blacks, even though they downgrade us, like we are nothing, we take better care of ourselves. Um… uh… some might not go to the doctor, but they try to use home remedies."*

Atypical:

Close but no:

Thought of **(rejecting) the deficit theory of health in Black women** – weaknesses and shortcomings of health in Black women rather than trauma associated with structural and systemic barriers.

APPENDIX E

PROJECT 2 INFORMED CONSENT FORM SUMMER 2020

Project 2 Consent form:

Informed Consent for Participant

Conversational Peace: The role of a community-engaged conversation in producing a more meaningful conversation on health with Black women living in Mississippi.

The Conversational Peace project is a part of my Global Health PhD dissertation research. The purpose of this project is to draw on the community of Brookhaven Black women to find ways to facilitate meaningful and resolution driven interactions with medical practitioners. One goal of this project is to co-create with you and your ways of knowing something tangible that will be useful in producing more meaningful conversations in medical encounters that directly increase health equity for Brookhaven Black women.

Voluntary participation:

You must be 18 years or older to participate in this project. As a participant you will be asked to engage in a 3-step process: 1) pre-talk survey, 2) sister-girl talk (conversation), and 3) post-talk survey. I am interested in learning about your experiences around health including interactions with medical practitioners, feeling judged for body size, feelings of personal responsibility around health, and self-care. Participating in all 3 phases combined is expected to take about 2 hours. If you consent to participate, you can withdraw your consent at any time without penalty (even after completion). In addition, you can skip questions or refuse to answer some of the questions without penalty.

There are no expected risks or discomfort to you for your participation in this project. In addition, there may be no direct benefit to each individual. However, the project aims to

develop tangible outcomes that will result in better understandings of Black women and their health. These results will be shared with all participants.

All participants will be compensated with $20 in cash. If the sister-girl talk session is held face-to-face, light snacks will be provided. If face-to-face interaction is not possible, compensation will be provided through a mobile payment service such as Venmo, Zelle, or PayPal or through the service specified by the participant. I recognize that each participant's time and knowledge is invaluable and that the $20 serves merely as a token of my appreciation.

All steps of the project will take place in person if the COVID-19 situation allows. If not, we will be using virtual technologies to facilitate the project:

1. For pre-talk surveys and post-talk surveys, participants will be emailed a secure link to an ASU Google form to complete the surveys.

a. If pre and post surveys are taken online, participants will receive via email a secure password protected link to the surveys.

b. IP addresses will not be collected. Email addresses will not be stored with any participant identifying information. Each participant will be assigned a pseudonym.

2. For participants who prefer filling out the surveys on paper, mailed paper-copies of surveys along with a pre-addressed, pre-paid return envelope using USPS Priority Mail, UPS, or FedEx.
    a. All information will be kept anonymous using an assigned code and pseudonym for analysis purposes. All data will be stored in a locked file cabinet in a locked data storage area. Only those directly involved in the research project will have access to the data.

3. Zoom Video Communications will be used to facilitate secure video communication for the sister-girl talk and be recorded. Zoom has an automatic consent function to alert anyone participating in the Zoom meeting that they are being recorded (both voice and face). If you don't want your face recorded there is an audio-only option. The recording will be stored on an ASU password-protected secure cloud storage and erased once those data are analyzed. You will be provided step-by-step instructions on how to use Zoom, including how to change your name to the fake name that will be assigned to you.

Confidentiality:

The information that you share in this project will be confidential. This means that the surveys and the sister-girl talk will not have your name or any other information that can identify you (e.g., phone number or physical address). However, due to the group nature of the sister-girl talk, total individual confidentiality cannot be guaranteed. The sister-girl talk will be conducted in a group setting (in-person or virtually.) The information you provide will be used in two ways: 1) to assist in increasing the healthiness of Black women living in Brookhaven; and, 2) to form part of my dissertation in Global Health.

Access to Data:

Only the research team will have access to the audio recording that will be stored in a password protected file and deleted once the recording has been transcribed. Any quotes used in the project will use a pseudonym (fictitious name) to protect your identity. There are fourteen pseudonyms (i.e., Beautiful, Intelligent, Nice, Understanding, Self-controlled, Reliable, Hard-working, Achieved, Kind, Peaceful, Focused, Happy, Thoughtful, and Concerned.) I have chosen these pseudonyms they resist and counter the

humiliating and dehumanizing stereotypes that precede Black women, such as lazy, ugly, and loose. Also, I ask that to protect your identity further that during the sister-girl talk that you refrain from using any information to identify yourself or the other women participating in the project. Please let me know if, at any time that you feel uncomfortable during the project, you may choose to leave and terminate your participation in the project without penalty. Before the sister-girl audio recording starts, you would have confirmed "YES" to an email that had the consent attached to it. Confirmation of that email serves as a legal agreement that you have read the consent form, agree that you are participating in this three-phase research project at your free will. In place of a physical signature, your email "YES" response will serve as its substitution. I will need an email with "YES" because, again, during the sister-girl talk, complete confidentiality cannot be guaranteed due to it being a group discussion.

Please note that a unique ID using the pseudonym assigned to you at the recruitment of the research project. The unique ID will be used to link the pre-talk and post-talk surveys by the individual. The unique ID will consist of one the randomly assigned fourteen pseudonyms mentioned above. The unique ID will include the state the data is collected in (Mississippi/MS), and the number that indicates the numerical order in which the survey was collected and use "a" or "b" for pre(a) or post(b) test (e.g., Beautiful_MS001a). The unique ID will be prewritten on each survey, whether the pre and post-tests are facilitated in-person or mailed to the participant.

If you have any questions or concerns about the project, please contact the research team, Charlayne Mitchell, cfmitche@asu.edu, Dr. Alexandra Brewis Slade, alex.brewis@asu.edu, or Dr. Cindi SturtzSreetharan, csturtzs@asu.edu. If you have any

questions on your rights as a participant in this project or feel that you have been placed at risk, please contact the Chair of the Human Subjects Institutional Review Board, through the Arizona State University Office of Research Integrity and Assurance at 480.965.6788. I appreciate your time if you do choose or do not choose to be a part of this project.

You email reply of “YES” serves as consent to send you links to the pre- and post-surveys as well as to record the Zoom sister-girl talk conversation.

Thank you.

APPENDIX F

PROJECT 2 SISTER-GIRL TALK (FOCUS GROUP) PROTOCOL

Project 2 Sister-girl Talk (focus groups)Protocol :

Project Name:

Sister-girl talk: Black Mississippian Women and Health: Collaborating to Build Conversational Peace

Participants:

Age
Young (44 and below), N=6
Mature (45 and older), N =8

Goal: Build something tangible to create a more meaningful conversation between Black Mississippian women and their medical practitioners regarding their health concerns.

Instructions to Participants: During the sister-girl talk (focus) group please refer to each other as the pseudonym that each participant is wearing as their name tag and/or that appears as their Zoom meeting name (e.g. Beautiful).

Below are the questions and prompts that the sister-girl talk facilitator will use to guide the conversation.

1. **We cannot talk about the medical system and trust without talking about Blacks and COVID-19.** With the current situation of COVID-19 and Blacks in Mississippi representing *46% of confirmed cases *55.9% of deaths, and *25% of the deaths being Black women, who do feel you that Blacks trust to test them, and do they trust the test? *msdh.ms.gov information as of May 08, 2020.

2. Do you feel as though the medical system that you participate in assigns blame and responsibility for your health to you?

Prompt:

"for example, the other day I went to see my doctor, and they told me that I needed to exercise more if I wanted to keep my heart healthy." OR you say "For example, if you tell your medical provider that you don't feel healthy, do they ask about your recent behaviors (food, exercise, etc.)"?

2a. Why do, do not, or maybe you feel this way? Are there historical ties/connections to the way that you feel? Exploitation?

If maybe is provided as an answer remember that this is a hedge (almost hesitant), prompt the participant by asking what does "maybe" as an answer mean?)

3. Do you feel that you've ever been medically misdiagnosed?

3a. If 'yes' tell me about it. Prompt: 1). Is there someone you know that has been misdiagnosed? Did you talk to your doctor or practitioner about you feeling that you were misdiagnosed?

4. Have you every ignored things (instructions) your medical provider gave you? Like, didn't take medication, didn't get a special lab test or other exam?

4a. If 'yes' tell me about the symptoms you had and how did you manage your diagnoses?

5. How is your well-being now, since deleting those medications?

Prompt:

Are there returned symptoms and how are you managing them.

5a. Have you spoken with someone about your health-related concerns? If so, how did you decide who you would talk to?

Prompt:

What was the conversation like? Did the person give you advice or just listen? Did the person tell you about their own health concerns? What was your response to their own health concerns?

6. What would help you feel more comfortable in having a more fulfilling conversation with your healthcare provider?

Prompt:

Would having more conversations with other supportive Black women help (maybe outside of your close network?) Do you feel as though you just do not have the needed words to have a meaningful conversation with your health provider? Do you fear telling your medical provider that you don't agree with their diagnosis of your health?

APPENDIX G

PROJECT 2 THEMATIC CODEBOOK

Project 2 Thematic Codebook:

<u>Codebook II (Sister-girl Talk):</u>

7. **Being honest about body concerns to doctor (sometimes others/non-health system individuals) leads to judgement or blame** – Telling doctor about how one experiences of living in their body leads to harmful responses.

    - ***Key words***: weight, don't feel comfortable, judgement, judge, not open, listening, compassion, support

    Inclusion criteria – Any reference to feeling as though discussing one's body leads to belittlement and causes them to shut down.

    Exclusion criteria – Mention of being honest about body concern leading to positive feelings.

    Exemplar(s):

    - *"Just because that answered the question correctly about "Do you have sinus problems?" And I said, yes. And so they told me that was a symptom of the COVID-19. I was like, well, then I been had it for years. If it's the symptoms of COVID-19, which come to find out it was just what it was it was your sinus draining that was causing me to cough sometimes or to get hoarse, you know, and I just didn't like how my doctor's office handled the situation when I... And I couldn't go into the. I could go nowhere because it's like your name flag now. You can't go. They wouldn't let me go into hospital to see what was going on with my foot. I had to wait until my test results before I could see a doctor concerning my foot because it was just terrible. And then when I did go into the doctor's office, they standing*

back like they scared to touch you…" (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 96)

Atypical:

- *"Somewhat comfortable but certain things not comfortable with talking to anyone."*

Close but no:

- *I do encourage my patients to exercise and things like that and eat right. But at the same time, you know, I understand that because of finances and things like that you're not able to eat what you should eat. But you know, the blame was on the patient.*

8. I think that they do somewhat put the blame on the patients and it's hard for me to answer these questions because I am a provider... I do now, um, I do encourage my patients to exercise and things like that and eat right. But at the same time, you know, I understand that because of finances and things like that you're not able to eat what you should eat. But you know, the blame was on the patient. (Group 1 MS_Young Blk Wm_7_20_2020_otter.ai, Pos. 92

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8. **We know but you [practitioners (mostly white) refuse to listen.** Black women's knowledge of their body is just as good as any book's or doctor's (belittled knowledge of self) .

    - ***Key words***: control, understand, it couldn't be that bad, don't agree, agree, prescribed, pill, medicine, offended, make my mind up, mind, professional, no love, love, respect, I'm the doctor, underestimate, strong, preyed upon, under diagnosed, guinea pigs, mental issues

Inclusion criteria – Any reference to Black women speaking-up regarding concerns of medical treatment or rejecting medical intervention because of them noticing that the intervention being used to "help" or improve their health is in fact working and they want to understand more on how to maintain their health status without medicine and instead feel "pushed" to continue the medication OR the medication is not working and they would like to know their options for other treatments, but instead feel as though they are being ignored and that they don't know what they are talking about.

Exclusion criteria – Stating that the doctor knows best and that their knowledge is subordinate to the doctor's.

Exemplar(s):

- *"And I'm taking a pill now, about two years ago, I went to pick some blueberries, and I picked the blueberries. I came back home my mouth was tingling and all that and I felt like whew something is wrong. And so I went to the doctor, doctor Burtock. He gave me put me on three, two vitamins. And one, I think blood thinner looking thing or something and I've been on it ever since they've been putting on and I asked about it and they say I think you need to keep taking it. You know and it makes no sense, but I'm not a doctor, you know...I do. I feel that way I feel like they, for my blood sugar to be like it is now for my A1C to be 5.0 Mm It couldn't have been that bad, you understand? it couldn't be that bad..." "you know cause like now, the reason there's this doctor for my insurance they call me, doctor from WellCare. And he called they do me once a year. And he*

was talking he said, Well, did you sure you had it? I say yeah, I had it they say I had it. But he's saying like certain things I should get off of. Now that's what he's saying. But hey, I asked the doctor [primary doctor] about and they don't think so…" "But see and been had, I don't think I had a stroke I think I had I think I had he said, these are mini strokes and he said, Everybody have them your age, mini strokes. Everybody don't have no mini strokes I don't understand…" "Then I went to pick Blueberries the next year same thing happened to me. you know it just." (Group 2 MS_Older Blk Wm_7_27_2020A_otter.ai, Pos. 388,392, 396, 408, and 412)

- *"Ah, no, just mostly with the COVID-19 find me I'm trying to think back of a doctor that I had went to she I think she was more on the pills kind of her ownself. I don't know do any kind of painkillers they have have to be something that is non-narcotic because I choose to take medicine like that it seems like sometimes that when I do go to a doctor like it's a problem, you know, I'm like don't give me any narcotics. I don't want anything that's gonna have me sleep all day cuz I'm too nosy I need to see what's going on. And they want to give you this medicine and I just won't take it and and then she'll say you got this problem? Did you go to another doctor? And I'll have the same problem. It's just I have the problem with the medicine. At one time I was having problems because I refuse to take those painkillers that have people addicted." (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 126)*

- *And then I stop taking it because it only messes up the lining of your stomach. So, if I can get this information why my doctor nem don't have this information and they prescribe these pills to people. So quick fix the other thing. I mean, I just feel like sometimes they don't give you the best in certain situations as far as the color of your skin, maybe they don't go to that extra mile to make sure you will straight with your meds and that these pills don't interfere with this pill that this doctor has given you. You asked for this when we come in your medicine when we when we come in to ask for a list. But then they give you something. They don't agree with this when you wind up going to another doctor, why did they have you on this pill? It's just like that pill? It's like you was taking and overdose? (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 172)*
- *“And then I stop taking it because it only messes up the lining of your stomach. So, if I can get this information why my doctor nem don't have this information and they prescribe these pills to people. So quick fix the other thing. I mean, I just feel like sometimes they don't give you the best in certain situations as far as the color of your skin, maybe they don't go to that extra mile to make sure you will straight with your meds and that these pills don't interfere with this pill that this doctor has given you. You asked for this when we come in your medicine when we when we come in to ask for a list. But then they give you something. They don't agree with this when you wind up going to another doctor, why did they have you on*

this pill? It's just like that pill? It's like you was taking and overdose?" (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 172)

- *"Well, they seem like they easily to get offended when you say something to them about them. They're giving you like, you're not a doctor. I'm the doctor, you know, so I don't say anything. I just leave and I make my mind up if I'm gone take it or if Imma go get it or not you know you know the way we living now life is a gamble every day that you really go out it is really, really, really dangerous. So you gamble either way it go." (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 180)*
- *I tried to go...I tried to tell my doctor get personal with my doctor and tell him what was really going on with me. I got to this stage that I'm in where I became homeless where I didn't have any income it's because I got sick. I lost everything. (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 470)*
- *"I tried to go...I tried to tell my doctor get personal with my doctor and tell him what was really going on with me. I got to this stage that I'm in where I became homeless where I didn't have any income it's because I got sick. I lost everything." (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 470)*

Atypical:

- *Right. I'm not a doctor, he, he has the training. I'm not a doctor, but some somethings I would refuse you know, if it If they told me that I needed this or that or the other, I would say, Well, you know, Imma wait on that or*

you know. I wouldn't let them push me into something I didn't want. (Group 2 MS_Older Blk Wm_7_27_2020A_otter.ai, Pos. 548)

- *"Oh, yes. They definitely, medical misdiagnosed me with that [COVID-19]. I mean, they could have came and checked my temp. I didn't have a fever I didn't have anything. And I told them why I was coming. But yet, when you check in, you have to check in with the question on that tablet and something that I don't like um okay if COVID-19 is out here and people come up to you I'm trying to give a good example of something that I don't get like okay like them... you get your have their tablet are your do your phone do it by phone, but if they give me something from them they're supposed to be so clean but you let me look at this tablet to check off all of this why not COVID-19 is not connected to what you just passed me from the office on and what I gave back to you if you thought that I was so contagious that I need to go over here. You understand?" (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 102)*

Close but no:

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9. **Black women need each other but there is breakdown in sisterhood/support network** – Black women need other Black women simply because they can relate to their ways of knowing, experiences, struggles, challenges, road to achievement, and bravery to stand in her own understandings even if the experiences are from a different perspective they still intersect. However, there is a breakdown in the bridge of sisterhood that has historical ties (e.g., light skinned versus darker skinned and the politics of respectability) that

continues to be a wedge in between them at times. A wedge that causes them to be silent and still amongst each other instead of vocally unfiltered and actively pushing one another out of the stereotypical, gendered, racial, and classed barrels that they have been thrown into.

- ***Key words***: sisterhood, support, support network, relate, struggles, together, change, thoughts, judgement, iron sharpens iron, fight, criticizing, jealous, envious, teaching, I'm releasing, go through so much, tired, conversation, suppress, leaning on, weak, afraid, angry Black woman, trust, hurting, offended, apologies, let stuff go, hold on, defensive, vulnerability, exposed, feedback, intentions

Inclusion criteria – Any reference to feeling that Black women share a special bond and need each other to keep moving forward in an oppressive world that does not respect them, makes them hypervisible and invisible, invades their bodies and minds, hates them, misleads them, and excludes them. Also, any reference to Black women feeling that this special bond has been cracked, broken, disregarded because of distrust or jealously.

Exclusion criteria – Belief that Black women do not have a special bond and have no oppressive intersections in life that unite them or that Black sisterhood is not a thing.

Exemplar(s):

- *"…We fight each other so hard." "They fight each other so and when they say straighten a sister's crown..." "And it's because they don't know how*

to straighten that sister's crown." (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 356, 360, and 364)

- *"Yes, yes. Yeah, we are our worst enemy. We are our worst enemies because we hate to see a lover of women of color, or any of color of us move up the ladder. That's why they call us crabs because we will try to find a way most of us, not everybody to pull the other one back down. There is a is saying "the Indian and the white man and the Black man. The white man had a rope white, the Black man had a stick, and the Indian man had a blanket and they had the example the white man would pull his brother's up with the rope. The Black man would beat his back down with the stick and the Indian would cover his friends, his his family with the blanket so that means that we always want the crab to beat each other back down." So we hate, most of us we are jealous hearted envy. They are the ones they won't say "oh girl you look good." They would rather not say anything and know that you look nice. They won't say Oh, your hair look beautiful today or Good morning. Well, how much? How much energy does it take to say good morning or to put a smile on your face. It takes more muscles in your face that make a frown and to make a smile. Oh and I always smile" (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 368)*
- *"I like what we're doing now. I think it need to be did more than once a year. Maybe I don't know how to say, Well, yeah, maybe this is the*

beginning. You know? If something is going to become we need to help each other." (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 372)

- *"It is something different has to come from the Black woman and like I said, I believe this is a start I'm praying that it is. To someone that will just listen a group that will just start listening to hear. Sometimes you have to listen to hear the things that are not being said." (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 380)*

Atypical:

- *"Somewhat comfortable but certain things not comfortable with talking to anyone."*

Close but no:

10. **Cultural assumptions** – feeling as though stereotypes attached to Black people/ women proceed them. They are not treated right no matter where they are. And that there are assumptions of what their bodies mean before their experiences are heard.

- ***Key words:*** lazy, fat, obese, overweight, overeating, bad eating habits, eat bad, exercise, taking care of myself, know what to do for your own body, stupid, dumb, serve right, listen, greet

Inclusion criteria – Any mention of negative preconceived notions of Black women's bodies being the way that they are because ideologies of Blackness and ideal health based on whiteness (e.g., stereotypes, such as lazy).

Exclusion criteria – Absence of negative descriptions attached to Black women's bodies that where established in slavery, medical, anthropological, and sociobiological to dehumanize and discredit Blackness.

Exemplar(s):

- *"I do think there's some providers think that Black people, all they do is eat, you know, they're lazy, they don't work this and that so I do think that some providers have their preconceived notion that because you may be overweight though, all you do is sit at home, eat all day, you know, so there are some preconceived notions and I know this from just from some of my patients…"*
- *"Okay, I think like I said, the blood pressure, the diabetic, the cholesterol, as far as the Black women how we are treated in certain stores or things that you places that you go out to, you know. You know, they just don't. They don't do right. They don't serve right. They don't give right…" "They don't listen right. That's the number one thing. They don't listen right." (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 248 and 252)*
- *"You get frowned on, you get disrespected, you get talked to like you you stupid or you don't know. I might not pronounce certain words especially with medicine you just, they just too big but they they act like you stupid but I say well I took a picture of my medicine here it is there go the name of it right there. But they do something sometimes you get that at the doctor's office. I have been to a Nurse Practitioner the was mean. I reported em. Then when I got back to go back to the doctor I reason why I*

didn't go back to the doctor because I knew I had reported them and I knew that when I reported them the people told them who said something." (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 260)

- *"Typical Black female based on a white man belief, Black woman opinion on what they heard how you look when you came you ain't been able to go to no doctor... (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 478)"*

Atypical:

- *"That makes you don't even want to go back to church because I done gone to a whole lot of churches and they have invited me when I go there. Treat me like I'm on a piece of mud on the bottom of their feet. That they don't even like, won't acknowledge that I'm not even a church. And so I feel some type of way and I don't go back. That's just like the doctor's office. If I feel a type of way if they treat me this kind of way at the doctor's office, I don't return I go to another office...to get some kind of respect." (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 278)*

Close but no:

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11. **Black women's bodies being patched up (controlling the body through medicine) versus healed** – experiencing health a la cart, where preventative measures, health maintenance, and treatment are being pieced out by medical practitioners versus facilitating health practices that 'see' the whole body and not pieces of it.

- ***Key words***: just trying to get a dollar, money, $1, trying to get to the next person, trustworthy, best interest, patched up, diagnosed, over diagnosed, under diagnosed, at the top

Inclusion criteria – Any mention of feeling as though Black women's health is being pieced together through prescriptions (e.g., prescribing medicine, but not diagnosing the disease). Black women feel as though their bodies houses for medication and not healing.

Exclusion criteria – reference to Black women's bodies benefitting from taking multiple medications.

Exemplar(s):

- *"Well, I feel like a lot of pharmacists and doctors are connected. I feel like they want people to take their medicine more than anything else. I feel like you know, if you doctors get a break on, on this or that, pushing this kind of medicine, because I've been on Betacar. I've been on... I think I'm on Losartan now. I'm been on the Sinopril. I've been on like three or four different blood pressure pills or whatnot. And now I'm on I think about Losartan and the Flodipine and they are working, I can tell a difference. They're working real good with my blood pressure. Because if I don't take them I'm sick. If I don't take them I'm feeling really really bad. But take them once a day and I feel pretty good. But I think that push pills on you more than they do anything else. And then when it comes to eating and comes to food, really we don't have very much of a choice when it comes to food.*

Because you know pork is will be so bad for you, but they have so many pork items and and beef is supposed to be bad for you, but they have so many beef items, you know, that everything else is always you know if they do Have Turkey. I did try turkey bacon once. They only had one brand. And it was too salty." (Group 2 MS_Older Blk Wm_7_27_2020A_otter.ai, Pos. 362)

- And then she's saying about the food and everything. She's right. And then a lot of Black people cannot afford the food they want them to eat, you know, they say that's good for them. But like she's saying when I'm talking to my doctor has never told me anything about you know, and I was weighing 258 pounds, and I was diabetic. And every time I did something to improve, I said, Nobody corrected me. You know what I mean by correcting me, like, praise the other race and when they would lose weight they [the doctor] would take them off the pill. They never took me off, you know, never [big emphasis] to this day. And I went to the day then I've been exercising and doing all this and now my a one sees [A1C] 5.0, 5.0 I shouldn't be having to take any pills, but they told me that well you take them as you need them, you know 150 and over if you 150 over, if you're diabetic numbers 150 and over, you take the pill. Well, I haven't taken pill in almost a year now. I went down, from 258 now I'm 183 they didn't offer to take me off. Or nothing. (Group 2 MS_Older Blk Wm_7_27_2020A_otter.ai, Pos. 364)

- *“And by me. What is it, medical experience? I don't know who to believe. They want you on that medicine they want you there because...” “I don't think they trying to heal you. I don't think they trying to get you healed. I think they're trying to maintain.” (Group 2 MS_Older Blk Wm_7_27_2020A_otter.ai, Pos. 420 and 424)*
- *“Patch you up...” “N'all I said patch you up You know how you patch up like a car [referring to Black women’s bodies] or an outfit or something. Just patch it up so I can get on you know down the road a little bit Patch the car up but not really fix it but just patch it up...” “And keep you coming back.” (Group 2 MS_Older Blk Wm_7_27_2020A_otter.ai, Pos. 426,430, and 432)*

Atypical:

Close but no:

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12. **My health is my responsibility/politics of health responsibility –** Concluding that it is one’s own fault as to why their health is the shape/condition (e.g., obese, diabetic, high blood pressure) that it is in. And if the person would “do better” and assimilate to white behaviors their health condition would improve.

- ***Key words***: diet, exercise, well-being, care, self-care, responsible, eat healthier, eat, compassion, support, die, I’m gonna die anyway, no insurance, insurance.

Inclusion criteria – Any reference to feeling as though no matter what is done to improve health there is no props or implications of improvement. The person feels that because of the stereotypes attached to their bodies that practitioners feel that they are going to die anyway so not as much attention is paid to their health or work to improve their health. No matter what they do even following the doctor's "orders," for example, taking medications, diet, and exercise changes there are no physical change in body or mention from a medical practitioner that the person's health is improving.

Exclusion criteria – Mention health improving after taking medications or following doctor's advisements. And life experiences don't pertain to health it's more about lifestyle behaviors. You live because you do as you are told.

Exemplar(s):

- *The doctors are because they don't tell you what's going on with your body. They want you to be sick because of the pharmaceutical companies. If you don't ask questions they want tell. Like when I had breast cancer, I had just gone to my gynecologist who had asked me about why my knuckles were so dark, but I didn't ask why she asked me that and she didn't tell me either. Two weeks later I discovered a lump in my breast. Then I went to another doctor who asked if I wanted a partial lumpectomy but didn't tell me why he was asking that.*
- *"And then she's saying about the food and everything. She's right. And then a lot of Black people cannot afford the food they want them to eat, you know, they say that's good for them. But like she's saying when I'm*

talking to my doctor has never told me anything about you know, and I was weighing 258 pounds, and I was diabetic. And every time I did something to improve, I said, Nobody corrected me. You know what I mean by correcting me, like, praise the other race and when they would lose weight they [the doctor] would take them off the pill. They never took me off, you know, never [big emphasis] to this day. And I went to the day then I've been exercising and doing all this and now my a one sees [A1C] 5.0, 5.0 I shouldn't be having to take any pills, but they told me that well you take them as you need them, you know 150 and over if you 150 over, if you're diabetic numbers 150 and over, you take the pill. Well, I haven't taken pill in almost a year now. I went down, from 258 now I'm 183 they didn't offer to take me off. Or nothing." (Group 2 MS_Older Blk Wm_7_27_2020A_otter.ai, Pos. 364)

- *Life, stress, and the daily responsibilities has a way of getting in the way of your health and cause one to stop focusing on what's really important in your daily life.*
- *"there are a lot of providers that have that preconceived notion in their head that because you may be overweight or out of shape that all you do is sit at home and eat every day."*
- *"I feel like when I go to a doctor, they just give you some medicine for it is like, I've never went to a doctor. He told me that I need to exercise I used*

to exercise more, but I don't exercise as much as I used to. But I've never went to the doctor, they tell me you need to lose weight. You need to exercise. I'm about 190 pounds, five, five. And they've never told me that they said I was a little obese. But they've never asked me about my diet. They've never asked any questions." (Group 2 MS_Older Blk Wm_7_27_2020A_otter.ai, Pos. 358)

Atypical:

- *"Wow. That's something. So I'm 72 and if I catch it, then they're gonna send me home to die. Because they thinking that I'm not gonna live…" "I believe age and color matters." (Group 2 MS Older Blk Wm_7_27_2020A_otter.ai, Pos. 346 and 350)*
- *I believe that. And see some people don't have insurance. And average Kovac [COVID] stay is over 30 days. So if my son... my son does not have any insurance, if he gets it, are they gonna let him in the hospital or are they just gonna send him home to die? (Group 2 MS_Older Blk Wm_7_27_2020A_otter.ai, Pos. 354)*
- *I believe that. And see some people don't have insurance. And average Kovac [COVID] stay is over 30 days. So if my son... my son does not have any insurance, if he gets it, are they gonna let him in the hospital or are they just gonna send him home to die? (Group 2 MS_Older Blk Wm_7_27_2020A_otter.ai, Pos. 354)*

Close but no:

- *"I do encourage my patients to exercise and things like that and eat right. But at the same time, you know, I understand that because of finances and things like that you're not able to eat what you should eat. But you know, the blame was on the patient."*

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13. **Black women trusting in God and themselves to heal them versus a doctor** – Relying on God's guidance for my health has been the sole reason that I am here "why I survive."

- ***Key words:*** Lord, blessing, prayer, praying, trust in the Lord, it's in God's hands, God is good,

Inclusion criteria – Any mention of God, Jesus, or the Lord bringing someone of out their health situation versus a medical practitioner or medical care.

Exclusion criteria – Absence of depending on God and instead on medical treatment(s).

Exemplar(s):

- *"She told them to my husband just died of this. When he first got it. She said my husband has COVID and what happened with the husband, the husband, his brother and some more people were at a card game and two of the people at the card game came down with Kovac [COVID]. And she said the Lord blessed and her and her children have not gotten sick from it or anything." (Group 2 MS Older Blk Wm_7_27_2020A_otter.ai, Pos. 338)*
- *"Yeah, so you know those were my thing with the COVID-19 I don't know sometimes hearing it airborne and then you don't but you know you just*

live day by day and as they say Apply the blood of Jesus and go out and trust if he will tell you because this is the time where where people with doctors are not not coming forth and giving the patient what they need." It (Group 3 MS_Older Blk Wm_7_28_2020_otter.ai, Pos. 122)

Atypical:

Close but no:

APPENDIX H

PROJECT 1 PARTICIPANT AGE CHART LINCOLN, COUNTY MISSISSIPPI

Project 1: Participant age chart (Lincoln County, Mississippi, 2019)

Participant ID	Age
MS001	34
MS002	37
MS003	64
MS004	54
MS005	58
MS006	64
MS007	58
MS008	34
MS009	54
MS010	23
MS011	38
MS012	89
MS013	59
MS014	34

APPENDIX I

PROJECT 2 PARTICIPANT AGE CHART LINCOLN, COUNTY MISSISSIPPI

Project 2: Participant age chart (Lincoln County, Mississippi, 2020)

Participant ID	Age
Kind	65
Hardworking	35
Achieved	35
Thoughtful	35
Beautiful	55
Focused	60
Peaceful	57
Understanding	38
Concerned	72
Happy	27

APPENDIX J

PROJECT 1 HUMAN SUBJECT IRB APPROVAL

EXEMPTION GRANTED

Alexandra Slade
Human Evolution and Social Change, School of (SHESC)
480/727-9879
Alex.Brewis@asu.edu

Dear Alexandra Slade:

On 2/26/2016 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	Living Large: A Study of Obesity in Cultural Context
Investigator:	Alexandra Slade
IRB ID:	STUDY00003997
Funding:	Name: Piper (Virginia G.) Charitable Trust, Funding Source ID: internal award
Grant Title:	
Grant ID:	
Documents Reviewed:	• Living large , Category: Consent Form; • Verbal recruitment script, Category: Recruitment Materials; • Piper internal ASU award (not a regular proposal), Category: Sponsor Attachment; • Interview Q exemplars, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Living Large protocol, Category: IRB Protocol;

The IRB determined that the protocol is considered exempt pursuant to Federal Regulations 45CFR46 (2) Tests, surveys, interviews, or observation on 2/26/2016.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

IRB Administrator

cc:
Amber Wutich
Cindi SturtzSreetharan

APPENDIX K

PROJECT 2 HUMAN SUBJECT IRB APPROVAL

ASU Knowledge Enterprise Development

EXEMPTION GRANTED

Alexandra Slade
CLAS-SS: Human Evolution and Social Change, School of (SHESC)
480/727-9879
Alex.Brewis@asu.edu

Dear Alexandra Slade:

On 5/12/2020 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	Conversational Peace: Building a community-based and culturally grounded conversation centered around the health of Black women living in Mississippi to create more meaningful interactions with healthcare professionals
Investigator:	Alexandra Slade
IRB ID:	STUDY00011745
Funding:	Name: (Unspecified)
Grant Title:	
Grant ID:	
Documents Reviewed:	• IRB Social Behavioral 2019_Protocol_05062020.docx, Category: IRB Protocol; • Pre_Post-talk survey- Black Mississippian Women and Health_05092020.pdf, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Recruitment_Methods_04132020.pdf, Category: Other; • Research Award Mitchell.pdf, Category: Sponsor Attachment; • Sister-girl talk_Guiding Questions and Prompts_05112020_CM.pdf, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Su20_Informed Consent for

	Participant_05112020_CM.pdf, Category: Consent Form; • Su20_Recruiting Script_03172020_CM.pdf, Category: Recruitment Materials; • Supporting Documents_04042020.pdf, Category: Other;

The IRB determined that the protocol is considered exempt pursuant to Federal Regulations 45CFR46 on 5/12/2020.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

If any changes are made to the study, the IRB must be notified at research.integrity@asu.edu to determine if additional reviews/approvals are required. Changes may include but not limited to revisions to data collection, survey and/or interview questions, and vulnerable populations, etc.

Sincerely,

IRB Administrator

cc: Charlayne Mitchell
Charlayne Mitchell
Olga Davis
Cindi SturtzSreetharan
Ersula Ore
Amber Wutich