I decided to minor in Women’s and Gender Studies after realizing that I wanted to be a women’s health nurse practitioner. I was drawn to the women’s health specialty because I wanted to find a tangible way to address disparities in teenage pregnancy, maternal mortality, and breast cancer mortality that I witnessed affect Black women in my high school and family. Initially, I thought the goals of the women’s health specialty and my minor would be directly aligned, but I found this wasn’t exactly the case. My WGS classes have not been, fortunately, as limited in focus as I naively thought they would be when I first declared my minor. My experience in WGS has provided me with a toolkit of theory, history, and general knowledge that I know I will be able to apply to impacting my future institution and my community as a women’s health nurse practitioner. Therefore, for my final project I have created appendices composed of definitions, resources, history, and terminology that I believe is essential to keep with me and potentially continue editing for the rest of my career and life.

It is formatted as a resource that I can turn to while in class, while studying, or while at work when I need to refer to the non-medical response to situations I’m facing. Therefore, it consists of more direct quotes and paraphrasing than an essay or typical academic piece. For example, I start off by defining the nurse practitioner role and Women’s Health specialty using the definition provided on my future school’s website. For other definitions and explanations, I used class notes. However, what makes the appendices my own work is the inclusion of modifications to make these definitions more inclusive and feminist. I am not completely deconstructing the gendered health system or what it means to be a health care provider for gender related needs. Rather, I am giving myself a foundation for learning how to effectively work within a system with which I currently have very little experience; I am preparing myself to be able to combine skill with more equitable care, compassion, and humility. We’ll see where my determined Black feminist mindset takes me once I start working, but for now this is what I have.
Appendix A
Defining the Field and Relevant Concepts Within the Feminist Context

**Nurse Practitioner/Advanced Practice Nurse (NP)**
According to my future school of nursing and my understanding of inclusive care, this is a health care provider and educator committed to the delivery and study of high-quality, evidence-based clinical care that works to shape health care systems *through understanding social determinants of health and practicing cultural competency*. It is an *alliance with patients or health care system using a holistic and contextual perspective*. Additionally, it involves specialization in an area, identification of signs/symptoms/behaviors that demonstrate vulnerability and the selection of interventions to promote health and prevent illness, *disability, and complications.*

*Prevention of disabilities can be facilitated but remember that individuals have varying levels of ability that should be respected and supported.*


**Women’s Health Nurse Practitioner (WHNP)**
According to my future institution and my understanding of inclusive care, a WHNP is a patient-centered primary health care provider, focusing on gender-related health care needs. Responsibilities include caring for women from adolescence through old age, with expertise in gynecology, prenatal care, and primary care. Practitioners are also prepared to address sexual and reproduction related health care for men and patients across gender identities, *despite the emphasis on women in the name of the role. Given the diversity of the potential patient population, it is important to remember that all patients in need of routine “women’s health” primary care may not consider/prefer to consider these forms of prevention and care as pertaining to sex or reproduction.*


- **Patients may identify as:**
  - Cisgender- describes or relates to an individual whose gender identity and/experience aligns with their sex assigned at birth
  - Transgender/Trans*- umbrella term that may mean various things to different individuals but generally describes gender identity and/expression that does not correspond with one’s sex assigned at birth
    - Some “women’s health” patients who may not seem to fit into the “women’s health” category of healthcare are trans* men/female-to-male (FTM)/individuals on the FTM spectrum. However, these
patients should not be considered as atypical patients; practitioners should be prepared to tailor care to their needs as they would with all patients.

- Nonbinary- umbrella term that describes someone who doesn’t identify as exclusively male or female
  - Some “women’s health” patients who may not seem appear to fit into the “women’s health” category of healthcare may identify as nonbinary. However, these patients should not be considered as atypical patients; practitioners should be prepared to tailor care to their needs as they would with all patients.

*DO NOT assume, attempt to determine, or inquire about a patient’s specific gender identity. Instead, affirm the patient’s gender by asking if they have a preferred name or preferred pronouns. This could easily be incorporated into standard procedures by incorporating space to include this information on forms and documentation for all patients.

**Health**

Not the absence of illness and disease, but the presence of complete well-being.


www.who.int/about/who-we-are/constitution

- **Wellbeing** is how individuals and communities experience and evaluate their lives, physical health, mental health, and ability to have meaningful futures
  
  

**Health Disparities**

Unnecessary and avoidable differences in health outcomes that affect populations who have historically and systematically experienced disadvantage due to race and/or ethnicity, religion, socioeconomic status (SES), gender identity, age, sexuality, mental health, ability, or other factors


https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

- **Sex Assigned at Birth**
  
  Classification given at the time of birth, based on one’s anatomy, hormones, and chromosomes
  
  - Commonly denoted as male, female, or intersex (within Western context)
  
  - Some forms/documentation may conflate this with gender, but it should not be assumed that one’s gender identity is based on this label

- **Gender**
  
  Gender identity is someone’s internal sense of gender and gender expression is the way one’s gender identity manifests. Gender exists on a spectrum, or as Maia Kobabe views it, a landscape.
This category has been a source of disadvantage and unfair treatment for individuals including women, nonbinary folks, trans* individuals, and people of other gender identities, with the exception typically being white men.

A study entitled *Barriers to Care for Transgender Individuals* argues that more research needs to be conducted to fully understand and explain disparities in health outcomes experienced by trans* individuals. However, some known barriers faced disproportionately by trans* folks within the healthcare system include:

- Lack of access to care
  - Lack of providers with adequate expertise
  - Lack of in-depth and adequate medical curricula on trans* health care
- Discrimination
- Low income/lack of income due to other issues like discrimination within the workforce
- Lack of insurance
- Additional socioeconomic barriers
  - Housing
  - Transportation


**Sexuality**

One’s sexual desires, needs, and expression; or the absence of these

- Different individuals’ sexuality can vary greatly, with sexual identity ranging anywhere from homosexual to pansexual to straight and beyond.
- It is important to remember that individuals can also be asexual, meaning they may not have sexual desires. However, this does not imply the absence of romantic needs or desires and this also does not mean that they have never engaged in sexual activity.
- This category has been a source of disadvantage and unfair treatment for individuals, generally speaking those who do not identify as straight/heterosexual.

**Race**

A subjective social construct, based on physical characteristics, that changes over time; maintains a socially significant meaning.

- Although related, race is not the same as *ethnicity, which is based on cultural factors like language, origin, history, traditions, values, and food*. Ethnicity can be self-defined and fluid; furthermore, it does not imply physical characteristics.
- Variety of racial identities varies globally.
- NOT a proxy for genes; racism and discrimination are responsible for poor health outcomes prevalent in certain racial minorities.
- Racial disadvantage often correlates with socioeconomic disadvantage; however, the two are capable of factoring into health independently
Still, note that race is an antecedent to class
- This category has been a source of disadvantage and unfair treatment for individuals, within the US context, especially African Americans and other racial minorities.

- **Ability**
  Individuals’ varying levels of physical, mental, cognitive, sexual, and emotional functioning
  - Unspoken “norms” have been used to describe certain levels of function as disabled
  - Society is less accommodating to levels of ability that are perceived as falling within the disabled category
    - This lack of diverse accommodations plays as much of a role, if not more, in individual’s abilities to function in the world as individual capability
  - According to Alison Kafer, the medical model of disability describes differing bodies and levels of function as deviant, pathological, and defective; the necessary approach is treating the condition and the person with it, rather than addressing social processes and politics that create barriers for people with disabilities. Kafer notes that according to disability studies scholars and activists the disability category can only be understood in a binary relation to able-bodied or able-minded.
    - Kafer provides a **political/relational model** which situates disability within built environments and social patterns that exclude or stigmatize particular kinds of bodies, minds, and ways of being.
    - Kafer mentions being hesitant of the complete rejection of the medical model and medical treatment, while advocating for the hybrid political/relational approach

- **Class/ Socioeconomic status**
  - Means of stratifying people in the US, based on median income, level of education, poverty, net worth, and occupational prestige
  - Although class and SES factor into health independently from race, class-based analyses should not be considered without factoring in race.
  - Black Americans are overly represented in lower SES groups.

- **Intersectionality**
  - Term coined by Kimberlé Crenshaw and historically explored by Patricia Hill Collins, Combahee River Collective, and Deborah King to understand the way multiple assumed and/perceived identities overlap to shape individuals’ experiences. Initially, the term was applied within the judicial context to describe multidimensional discrimination faced by Black women in the workforce.
  - Strong ties to Black feminism
  - Be sure to move beyond simple use as a buzzword
**Equitable Care**
Commitment to reduce and eradicate health disparities and the related determinants of health.

- Gives everyone a fair opportunity to achieve their full health potential
- Social justice approach to health care


- **Blankenship’s Structural Interventions**
  - **Availability**
    - “Access, physical environment, and behavioral factors that affect health promotion and outcomes”
    - Grocery store and clinic location
    - Access to accurate and timely health care information
  - **Acceptability**
    - Surrounding community and peers’ views, values, culture, and social norms
    - Perceptions of therapy
    - Prioritization of health
    - Beliefs about what is considered appropriate given one’s gender, ethnicity, religion, and age
  - **Accessibility**
    - Tangibility of resources based on social, economic, and political factors
    - Racial and economic stressors
    - Community organization
    - Discrimination
    - Local politics

Appendix B
Relevant History and Literature

A number of historical events have occurred that continue to contribute to disproportionate rates of adverse health outcomes within disadvantaged and underserved populations today. As a practitioner, it is not always possible to address systematic issues within a single appointment. However, it is important to be mindful and engage patients in conversations about what social, financial, and cultural influences are impacting their experiences and health care. This brings to mind a peer who told me that she heard a practitioner tell Latinx patients “no mas Coca Cola” in response to them having elevated BMI. This response was inappropriate for many reasons, but it clearly indicates a lack of understanding this country’s history of injustice and other social determinants of health that impact patients’ health outcomes. Below are some examples of historical events and resources to remind you of the historical realities and social factors that may be affecting patients’ attitudes towards their health and health care.

Medical Experimentation
- Medical experimentation and Slavery
  - Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present by Harriet A. Washington
- Henrietta Lacks and HeLa Cells
  - The Immortal Life of Henrietta Lacks by Rebecca Skloot

Reproductive Rights
- General Women’s Rights History and Movement History
  - A History of US Feminisms by Rory Dicker
- History of Sterilization and Black Women’s Role in Advocacy
  - Intimate Justice: the Black Female Body and the Body Politic by Shatema Threadcraft

Sexual Assault Response and Care
- The Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention by Sameena Mulla

Gatekeepers
- Medical History of Trans* Care
  - The Erotic Drive to Cross Dress by Magnus Hirschfield
    - Read with critical approach
  - Transgender Liberation: A Movement Whose Time Has Come by Leslie Feinberg
    - Read with critical approach
A "Fierce and Demanding" Drive by Joanne Meyerowitz
  • Read with critical approach

Health Disparities and Health Equity
  • History of US Racial, Ethnic, and Religious Minorities Health Histories
    o Racism: Science and Tools for the Public Health Professional by Sandra L. Ford and Derek M. Griffith
  • Racism and Sexual Oppression in Anglo-America: A Genealogy by Ladelle McWhorter

Pandemics/COVID-19
  • Articles about abortions as essential medical care during pandemic
    o The Guardian article about attempt to ban abortions in Tennessee
  • Articles about midwives and doulas during pandemic

Advocacy
  • Coalition Work, Organizing, and Grassroots Movements
    o Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of Law. By Dean Spade
Appendix C

Inclusive Terminology for Pelvic Exams & Pap Smears

First a Reminder

Pelvic exams and pap smears are often described as being uncomfortable for many individuals. They are exams used to screen for disease and cervical cancer, which may affect individuals who have a uterus, cervix, fallopian tubes, ovaries, vagina, and/rectum. These exams are often described as being specific to women and their reproductive health. However, these screenings may also be important for individuals who identify as trans*, non-binary, on the FTM spectrum, or some gender identity other than woman. When this is the case, these exams may go beyond simply being uncomfortable to being excessively painful, psychologically trying, and emotionally distressing. For this reason, it is important to employ appropriate language, gestures, and interactions to try your best to keep your patient as informed and comfortable as possible. Additionally, during, pre-, and post-exam it is important to assess the patient’s level of physical and emotional discomfort. Incorporating some of these strategies into all appointments is an easy way to develop and solidify your own confidence using inclusive practices.

*Side note: All patient-provider conversations in a women’s health clinic do not have to be about the patient’s children or gendered subjects. Practice having non-gendered filler conversations with ALL patients. Talk about events going on in the community, books patients are reading, or really topics patients want to discuss not subjects you think are relevant based on your assumptions.

Facilitating Screenings

Pre-exam:

- Re-examine necessary and helpful resources
  - Stay informed and educated on caring for all patients
  - Learn about insurance, Medicare, and Medicaid policies that may affect patients
  - Re-read and edit these appendices
  - Attend relevant conferences and volunteer to engage in relevant continued education
- Share what you know and learn/have trainings with colleagues, including fellow WHNPs, midwives, front desk and clinic staff
- Encourage use of inclusive Electronic Medical Record Software/Forms
  - Does program provide options for preferred pronouns and names
- Determine if patient has a preferred name and pronouns
- Assess patient’s familiarity with the exam
  - If necessary, explain the process, gauging how much patient is looking to understand
- Be mindful of time patient spends in waiting room
o Invite patient to share satisfaction, dissatisfaction, or discomfort with waiting room experience
• Assess preferred terminology
  o “Are there any words you would like me to use to refer to specific body parts during this screening?”
  o Refer to Table 1 if necessary
• Provide gender-inclusive, non-gendered, and trans*-specific health education
  o This can be brochures, posters, flyers
  o Talk about HPV risks and Pap screening as non-gendered cancer prevention
  o Make and provide a community-based lgbt-inclusive resource list
• Assess and respect trauma history
• Ask about past experiences with the screening
  o Invite patient to explain how the experience can be more comfortable for them
• Affirm patient’s ability to voice needs at any time during the exam
• Remember that it is okay to make a mistake
  o Apologize and learn from the experience
• Try to remember/document patient’s preferences for future appointments
  o Remember that these may change and that’s completely normal and acceptable

During Exam:
• Allow patient to undress from the waist down only, if possible
  o Respect patient’s privacy while undressing
    ▪ Close curtain, leave room, wait until after they are undressed to communicate with them
• Respect preferences discussed pre-exam
• Consider using diagrams, rather than “anatomically correct” terminology to discuss process or results
• Be aware of your own facial expressions and reactions
• Be mindful and clear about your verbal reactions
• Be aware of any signs that the exam needs to be stopped or paused
• Use strategies to mitigate pain or discomfort
  o Smaller speculum
  o Moderate amount of lubricant
  o Use health care training to consider using appropriate medication
• Balance patient comfort with attempts to get sample

Post Exam:
• Allow patient to dress and sit in a chair, rather than exam table, before discussing anything
• Give positive reinforcement
• Discuss how results will be communicated
• Discuss patient’s post-exam self-care plan
  o This is especially important if the patient experienced any distress due to the exam
• Use preferred terminology when discussing results
• Help advocate to insurance company if necessary
*Reflect:
Following all of these steps can help ensure patient’s have better experiences during pelvic exams and pap smears. However, there may also be times where you do all that you can, and the patient still experiences distress during the process. This is not necessarily your fault; remember, in all that you do lead with care, patience, empathy, and humility. Keep learning and improving.

<table>
<thead>
<tr>
<th>Gendered/Sexual/Violent Terminology</th>
<th>Inclusive/More Neutral Terminology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive Organs</td>
<td>Internal Organs</td>
</tr>
<tr>
<td>Vagina</td>
<td>Genital Opening, Frontal Pelvic Opening, Internal Canal</td>
</tr>
<tr>
<td>Uterus/Ovaries</td>
<td>Internal Organs</td>
</tr>
<tr>
<td>Vulva</td>
<td>External Pelvic Area</td>
</tr>
<tr>
<td>Breasts</td>
<td>Chest</td>
</tr>
<tr>
<td>Pap Smear</td>
<td>Cancer Screening</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>Cancer, HPV</td>
</tr>
<tr>
<td>Bra/Panties</td>
<td>Underwear</td>
</tr>
<tr>
<td>Pads/Tampons (for post pelvic exam/screening)</td>
<td>Suggest Depends or absorbent material patient is comfortable with</td>
</tr>
<tr>
<td>Period/Menstruation</td>
<td>Bleeding</td>
</tr>
<tr>
<td>Blades of Speculum</td>
<td>Speculum Opening</td>
</tr>
<tr>
<td>Sensations: “poke” “brush” “scratch” “prick”</td>
<td>“Inserting speculum now” “You may feel some pressure”</td>
</tr>
<tr>
<td>Stirrups</td>
<td>Foot holders/ Footrests</td>
</tr>
<tr>
<td>“Open your legs”</td>
<td>“Let your legs drop to either side”</td>
</tr>
</tbody>
</table>

Table 1