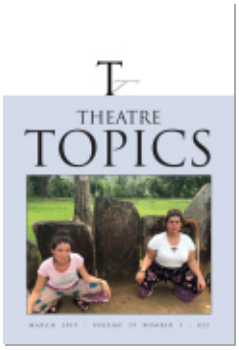
# Normalizing Disruption: Advocating for Reproductive Health in Academia

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# Normalizing Disruption: Advocating for Reproductive Health in Academia

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## Introduction

In March 2018, we shared a roundtable, "Spin Cycles: Issues of Women's Reproductive Health and Wellness in Academia," at the Mid-America Theatre Conference (MATC). The robust response to the roundtable encouraged us to share our experiences in the pages of *Theatre Topics* as a continuation, not conclusion, of the conversations begun at MATC.

The abstract of our roundtable read as follows:

> The decision to grow one's family as a woman in academia brings with it a number of logistical and conceptual challenges, from timing parental leave and managing new financial obligations to wrestling with anxieties over scholarly productivity, degree completion or promotion, becoming a parent, and the overall balancing of personal goals with professional ones. Recent books like *Professor Mommy*, *Mama PhD*, and *Academic Motherhood* provide helpful advice on family planning, tenure clock stoppages, and how academic mothers can achieve a satisfying and effective work/life balance. But what if not everything goes as planned for the aspiring or new parent? What is it like to teach, write, and make art in academia while dealing with the physical challenges and psychological fallout of reproductive issues including infertility, miscarriage, birth complications, infant loss, premature births, breastfeeding troubles, and postpartum depression? This roundtable seeks to initiate a dialogue on dealing with reproductive trauma while studying or working in academia, a topic largely unrecognized by even the most parent-friendly institutions due to its relative invisibility in the eyes of students, peers, and administrators; the diversity of medical issues it encompasses; and the enduring stigmatization of non-normative or undesirable outcomes in women's reproductive health, from miscarriages to caesarian sections.

The language used in the abstract reflects our self-identifications with the term *woman*, not our belief that one must identify as such in order to reckon with these challenges. Indeed, we are glad to see capacious discussions of caregiving emerging in the field, including a panel at the recent ATHE conference on "Care in the Academy: Revolutionizing Our Experiences and Access," convened by Janet Werther, and the formation of the Parent Artist Advocacy League (PAAL). Both in our roundtable and in our collaborative writings, we are struck by the language politics around describing reproductive health issues, and the worthwhile difficulties of using language that is precise and also inclusive. In the individual essays, many of us choose to use the term *mother* to refer to our experiences with gestational parenthood; where it appears, it is a reflection of each of our self-identifications with the term and is not meant to be a universal or prescriptive descriptor.

Here, we focus our essays on exploring somatic experiences of fertility, pregnancy, birth, recovery, and the postpartum period. They document experiences with conception, assistive reproductive technologies, birth trauma, premature birth, and lactation. While sharing our experiences, an omnipresent tension emerged between wanting to make these experiences visible so as to expand or perhaps eliminate altogether "normative" expectations and policies around reproductive health, and the profound vulnerability we feel at disclosing what are, for many of us, deeply private and often traumatic moments from our personal lives. We strongly urge others to join us, if they feel able, in sharing their experiences and continuing these conversations in public forums to aid in the de-stigmatization of reproductive health and wellness within the academy.

This sense of vulnerability is linked as well to a feeling that, in sharing our experiences, we are complaining. It is no accident, as Sara Ahmed points out, that "complaint" (from sharing a dissatisfaction to filing an official complaint) is often framed by institutions as contagious, "as a bodily condition, an ailment, an illness" that can infect the operations of the institution (n.p.). In our essays, we are indeed complaining about complaints. We are registering our dissatisfaction in the pages of this journal with how our disciplines and institutions create understanding and policy around a particular set of reproductive health complaints. We are rallying around Ahmed's ("fragile . . . feminist and furious") definition of complaint: "when we transform what we do not cope with into a protest at what we are supposed to cope with."

We also note that our experiences inevitably intersect with power differentials of race, class, gender, sexuality, and the labor conditions of higher education in the United States that shaped how we were able or unable to secure accommodation, rights, and understanding from our peers and institutional administrations. The personal essays conclude with a list of resources for further investigation and dialogue.

## Adanma Onyedike Barton, "*Lost & Found*: Using Solo Performance for Social Change"

> "If you are silent about your pain, they will kill you and say you enjoyed it."
>
> —Zora Neale Hurston

After teaching my very first year of my first tenure-track job, I turned 30 years old and got married. My husband and I were very happy—we both had jobs in the fields of our advanced degrees. The happiness was short-lived once I was diagnosed with severe endometriosis. Endometriosis is a condition in which elements of the lining of the uterus grow outside of the uterus. This condition causes severe pain, especially during the menstrual cycle. We were encouraged to try to start our family as soon as possible, because the condition, a degenerative disease of the uterus, will worsen over time.

In six years, my husband and I suffered twelve miscarriages.

Linda Layne says, "the liminality of women who do not complete wished-for pregnancies and the superliminality of the dead embryos/fetuses they bear helps to explain why pregnancy loss is a tabooed subject in our society. The silence that surrounds this topic does not result from its lack of consequence; on the contrary, taboo status signals the importance of these events" (62). Working for a small liberal arts institution has been very rewarding for me professionally, yet personally there were issues that I had to overcome. Our campus is a forty-five-minute drive from the advanced healthcare I needed to receive. After the fourth loss, I broke my silence and shared our struggles with my department chair. Thankfully, we were able to shift my teaching schedule to afternoon classes. So in the mornings I would wake up, drive to the doctor, drive back, teach class, and direct rehearsals in the evening.

It never occurred to me to take any type of break or to keep in mind what Kerry Ann Rockquemore says about African American faculty service: "there is a limit to what you can provide without putting yourself at risk by taking on more than you can reasonably handle (which quickly leads to burnout and resentment) or turning students away (which generates guilt)" (19).

I did not want to seem "weak" by asking for a medical leave. Plus, recurrent miscarriage is an invisible condition. It is understandable that a woman takes medical leave when she is successfully pregnant, but there is no language in most faculty manuals that specifically pertains to pregnancy loss. Also, I was throwing myself into my work, because I felt that it was something I could control. With each miscarriage I was losing control and could feel the pit of grief and despair growing, and I had to find a way to put a cap on it. Creating art kept me from losing my mind. When directing a play or teaching an acting course, I attempted to escape from my own reality. However, escape is not the answer for pregnancy loss. Grief is a circle, not a straight line, and one should ask for the help needed in order to make it through.

I found that I needed to build a community—a sister circle—around me, and used Gabriella Gutiérrez y Muhs and coeditors' *Presumed Incompetent* to do so. Thankfully, my dean agreed to purchase the book for any female professor who was interested, and I was able to be the lead facilitator of some fantastic conversations. Feelings of despair eased once I shared my struggle with others. It was from meeting with that sister circle that I was then inspired to take things a step further. After receiving tenure by unanimous vote, I wanted to do something important with my first sabbatical. I teach a course called "Feminist Solo Performance," and it is truly one of my favorites to teach. So I created a solo production titled *Lost & Found* and toured it to six states. During the day I taught a solo performance workshop, and afterward completed a cue-to-cue for my show in the evening. With each performance, the host college would provide a local OB/GYN and a grief counselor to join me for a talkback with the audience after the show. The response was overwhelmingly positive. Fraternity brothers at Birmingham Southern College asked sincere questions about the timing each month when a woman can get pregnant. A professor at Newberry College in South Carolina confessed out loud for the first time her struggles with Polycystic Ovarian Syndrome. At Coker College, also in South Carolina, the talkback was extremely informative due to the coordination of my performance with its Women's Health Week. At Davis and Elkins College in West Virginia an elderly couple spoke eloquently about their earlier struggles to have a family, which led to the adoption of their son. One of the strongest responses came from the audience at Sweet Briar College in Virginia, where the students felt empowered to begin researching why reproductive services are so expensive. As bell hooks says,

> to commit ourselves to the work of transforming the academy so that it will be a place where cultural diversity informs every aspect of our learning, we must embrace struggle and sacrifice. We cannot be easily discouraged. We cannot despair when there is conflict. Our solidarity must be affirmed by shared belief in a spirit of intellectual openness that celebrates diversity, welcomes dissent, and rejoices in collective dedication to truth. (33)

Theatre, even more than essays and lectures, has the power to be transformative. As theatre artists we learn and grow from examining conflicts. The creation of my solo performance project gave my audience immediate access to doctors and therapists, when some may not have had the economic opportunity to do so. Live theatre has always been and will always be the more immediate and effective way to connect with people. What worked for me may not work for others. However, I found it to be extremely rewarding/healing in breaking the taboo/stigma of silence surrounding miscarriage through art. Department chairs and administrators should be made more aware of these issues. If one-in-ten women in the United States has endometriosis and one-in-four experiences miscarriage, surely there are more in academe who are suffering in silence.

My husband and I are now childless by circumstance, not choice. Yet, I remain grateful because my marriage is stronger than ever due to how we supported each other through shared trauma. I now have built-in trust with my department chair and dean. Most important to me was the creation of a sister circle—a tribe of strong academic women—because we all need mentorship and safe places, especially when on the tenure track. From the success of *Lost & Found*, I am now in the process of curating other work, because I fully believe that theatre can be used as a tool for community development and social change. My solo performance created a safe space in which the audience learned not only about the female reproductive system, but also about grief, loss, and moving forward after painful experiences. Audience members were able to share stories with one another and address questions to medical professionals. I benefited by finding community within my audience and also from teaching solo performance workshops to theatre students on each campus. Overall, *Lost & Found* was a successful example of creating art from pain, and using that art to help and empower others. It is my sincere hope that other women in academe will feel empowered enough to express whatever is needed without repercussions.

## Meredith Conti, "The Myth of Effortless Labor"

In a nondescript bathroom in a campus building, I am executing what amounts to a pit stop. But instead of readying a car to reenter the racetrack, I am a postpartum doctoral candidate and instructor with only a few minutes before my students return to the classroom for the second half of our weekly evening class. The bag I brought to the bathroom is filled with pads of every kind—sanitary pads, breast pads, gauze pads—none of which is particularly comfortable, but all of which are necessary to avoid the sort of embarrassing incident that ends up on the internet. Somewhere below, in Pittsburgh's darkened streets, my grad-student husband and five-week-old infant are joyriding in the family car in the hopes that the gentle rocking supplied by the city's numerous potholes pacifies the baby until mama returns. I glance in the bathroom mirror and see a face drained by exhaustion, jaw clenched against the abdominal pain being inflicted by the high-waisted tights helping to hold various pads in place. I swipe on lip gloss and head for the door.

When I met with members of my dissertation committee the previous spring to announce my pregnancy, they were wonderfully congratulatory and encouraging. My own conduct in these meetings was guided by an acute desire to assure the faculty that, come pregnancy and motherhood, I would be the same ambitious and conscientious "me" that they had come to know through my graduate work. I shared my plans for completing my dissertation as scheduled and requested that I be assigned a once-weekly course to teach in the fall of my due date. When my advisor asked what types of resources I sought, I hastily replied, "Oh, I'll look for information on the website." What I found was a freshly approved set of accommodation guidelines for grad-student parents that provided six weeks of leave without interruptions in funding and benefits. I secured substitute teachers for five successive class meetings, checked costs with my health insurance, and sketched out a hospital birth plan.

I made all these arrangements, of course, before I had gone into labor, before a number of medical complications, including a rare placental abruption, intervened in what I had envisioned to be a fairly standard birth. Instead, the baby arrived via a protracted, distressing labor and a caesarean section. Five days later, as a medical student with shaky hands removed the surgical staples, a small segment of the incision pulled apart. Fluid was tunneling under the skin's surface; to release the fluid, doctors reopened half of the incision. I was discharged from the hospital hours later with an infant and an open abdominal wound that would take six weeks of home healthcare to close. Each day, a nurse visited our apartment to debride the wound by pulling salt-infused gauze strips out of my abdomen's open cavity and gently inserting new ones while my newborn nursed or slept in the bassinet, a ritual that evolved from agonizing to tranquilizing as the wound slowly relinquished its

fascial and dermal real estate. A comment from my mother during my first days as a parent communicated what I was reluctant to voice aloud: "You've been through a trauma, honey."

My story of giving birth as a doctoral candidate, then, is not a story of intolerant advisors, a contentious cohort, or a student handbook barren of accommodation policies for new parents. It is the story of a pregnancy, difficult birth, and lengthy recovery made more challenging by being a graduate student. Of the many cumulative, entangled effects of this experience, a few takeaways can be articulated here. First, it is important to acknowledge that even the most supportive departments cannot neutralize the overlapping outcomes of what scholars call the "mommy tax," the "baby penalty," and the "leaking pipeline"; nor can they eradicate the messaging, circulating within the US academy, that cautions women to conceal their reproductive lives in order to remain "in competition" with their male counterparts (Castañeda and Isgro; Mason et al.; Mirick and Wladkowski; Tower and Latimer). Second, academic women take on more invisible labor and unpaid service than men, while attempting to make their work as multi-hyphenate academics appear easy, or risk being called quarrelsome, fragile, or any number of other gendered (and career-jeopardizing) labels (Childers; Guarino and Borden). These twinned directives felt particularly pressing to me at the graduate level, where, like many other women, people of color, and LGBTQIA+ individuals in higher education, I engaged in a paradoxical performance of "effortless labor" that, while certainly not disingenuous, was curated with the goal of foregrounding my professional successes and masking any accompanying struggles. This approach to studying and working in academia, of hiding process and celebrating product, informed how I navigated becoming a mother in graduate school in both positive and negative ways.

When I reentered the classroom with my wound not yet fully healed, I did so without formally notifying the department that my child's birth had been a complicated affair or that I was still physically dealing with its repercussions. The whole ordeal felt too raw and personal (and somehow unprofessional) to put into words, especially given that the faculty to whom my health update would be addressed was largely male. Moreover, I was not yet able to mitigate my feelings of guilt over what had transpired, nor recognize that I was now performing an unsustainable version of effortless labor—that of a new mother. Beyond adhering to the optimistic postpartum schedule I had set, there were other reasons I returned to teaching that evening. First and foremost, I wished to inconvenience as few people as possible. Those who guest lectured for me—all graduate students with their own teaching assignments, coursework, and research projects—were not being financially compensated. I was also eager to make academic motherhood visible to my students, a goal that ironically required masking my somatic trauma. Finally, I hoped that perhaps being back in the classroom, my second home, would help symbolically reintegrate my fractured parts. You see, a temporary though perplexing consequence of my birth trauma was that I felt somewhat dissociated from my body. The open abdominal wound served as a constant, gnawing reminder of my body's deficiencies rather than its resiliency. Being a doctoral candidate and new mother on the brink of entering the job market felt vulnerable enough; I also hated feeling physically vulnerable, in pain and at risk of infection. And I desperately wanted to feel grounded in and at ease with my body again. To my relief, reengaging with teaching and research—now as the mother of a wondrous little human—proved instrumental to the re-knitting of my body and mind.

Birth is messy. A traumatic or complicated birth can be even messier. And graduate students often do not like showing mess. Accustomed to being under near-constant evaluation by their mentors (and peers), graduate students are especially susceptible to the notion that acknowledging their struggles exposes an inadequacy of character, intelligence, or work ethic. For new student-parents, this can be a damaging misapprehension. Graduate faculty must help to dispel the myth of effortless labor, which can be done without lowering standards or making inequitable allowances. Offer university resources for families and expectant/aspiring parents before students request them; recognize and strive to accommodate the needs of mothers recovering from traumatic births, while respecting their personal boundaries; and, for faculty with children, please model the messiness of academic parenting. Your students need to see your labors.

## Kristi Good, "Performing Motherhood without a Village"

I was in the middle of a big move across the state to begin a three-year visiting assistant professor position at a small liberal arts college at around week 28 of my pregnancy. This was the first time I heard that there was a problem. My placenta was attached via the umbilical cord directly over my cervix, a condition I would find out much later was called "placenta previa." When I told the doctor that I was moving in a couple of weeks, his only response was, "[i]f you start bleeding, go to a hospital immediately." He put me on "pelvic rest"—a step up from bed rest—to prevent a rupture.

I was already having a stressful pregnancy. In planning for a family, I had never considered that my identity as a genderqueer individual would play such a large role. No one in my LGBTQ community had been pregnant or ever talked about the issues I might encounter. The ensuing pregnancy resulted in typical physical changes: a rounded belly, widening hips, and fuller breasts, features ascribed to a maternal, feminine body. I suffered from gender dysphoria, distressed that my outward appearance read as the epitome of femininity when I understood my gender identity to be fluid. I avoided reflections, photographs, and shopping for maternity clothing; I dreaded the inevitable baby shower.

I went through a rigorous orientation for my new position, interspersed with frequent doctor appointments, and began the semester teaching three courses. At thirty-two weeks and two days my husband and I drove forty-five minutes to a second-opinion ultrasound, and the doctor immediately admitted me to the hospital. My first response was, "[b]ut I have to teach tomorrow," so ingrained in me was the resilience expected of women in academia. This is when she explained that a rupture would cause the baby to hemorrhage fatally within a minute or two. Not only would the baby's death be guaranteed, but if I was not already prepped with an IV catheter for an immediate blood transfusion, my death was also a near certainty. This was the first time my condition had ever been explained in such primal terms—I was horrified, to say the least.

The doctor's intention was to keep me stabilized at the hospital until week 36, when they would perform a caesarean section. I asked my husband to call the chair of my department to explain what I simply had no words to convey. At 7:00 AM the next morning, a new doctor expressed concern about continued contractions. By 10:00 AM she had decided on an emergency C-section and asked how quickly my husband could be at the hospital. By 11:02 AM our baby was born.

I could normalize the experience and say that in the end, everyone was fine. But what that really means is that no one died. The baby was born eight weeks early, weighing 3 pounds 15 ounces, and stayed in the NICU for three weeks. During that time I lived alone at the Ronald McDonald House, a shuttle ride across the hospital campus, because my husband was not eligible for leave from his new job.

It was only a day or two after the C-section that the provost at my new institution called me. He was as cordial as he could be under the circumstances, but his purpose was clear: How do we deal with this situation? We ultimately decided that a colleague would take over my teaching load, but that I would continue writing assignments and grading, in order to retain a portion of my salary. I would return at full capacity in January. I hope most people recognize that three months of paid family leave, albeit with modified duties, is an improbable boon for a new parent. Rather than question the ultimate deficiencies of family-leave policies across the nation, I gladly accepted these terms.

I terminated my visiting assistant professor contract after two years, however, due to a toxic work environment. During my first year I attempted to renegotiate directing the mainstage, but my chair would not consider it. He reassured me that he loved "having kids in the theatre space," and I was welcome to bring the baby to rehearsals. His offer appeared supportive, but how could I devote the necessary time, care, and resources to both the production and my newborn simultaneously? I had legitimate concerns about performance evaluations and their effect on my contract

renewal. At the start of my second year, the chair provided me with an impromptu review, in front of a colleague, which was wholly negative in tone and content, claiming that I was failing to fulfill departmental expectations. When I asked what those expectations were, he refused to give specific departmental standards; he said I should have received that information early in the semester, but then—referring to my emergency C-section—"the shit hit the fan." I reported his behavior to three people—a department colleague, my faculty mentor, and the dean—as well as detailing it again in my resignation letter. He received tenure in 2018.

I spent that year on the job market, but became disillusioned. I was suffering from undiagnosed postpartum depression and anxiety and knew I had to leave my current position. I went through one on-campus interview pretending that I did not have any children, because no one in that department had a family. I was afraid it might make the current faculty question how good a fit I was for their community. At the end of the interview I was terrified that they might actually offer me the job, and I would feel obligated, due to the state of the job market, to accept. This was when I ended my search for a tenure-track career.

Three years later, we are all legitimately happy and healthy. I am in therapy and teach in a supportive, family-positive community. However, *family positive* is a vague phrase that does not always guarantee tangible resources for parents. Academia, theatre departments in particular, would benefit from investigating the resources and national support network curated by the PAAL. From childcare grants to a best practices handbook, the league supplies actionable resources that advocate for "work–life balance interventions, healthy work culture, stable protocols, and accessible pathways to employment" ("Mission"), all of which I sorely needed during my postpartum struggle. I hope that by telling my story department administrators will recognize what shifts in policy and personal behavior are necessary to become active, supportive members of the village it takes to raise a child.

## Ariel Nereson, "Breastfeeding in Academia: Boundaries and Bodily Autonomy"

What I want to make visible in this essay are a few of the difficulties of being a lactating parent in academia, as well as practices that can support lactating individuals. I acknowledge that there are many layers of privilege, not the least being the relative time autonomy of a faculty position and my private office, that made it possible for me to continue breastfeeding while also working. Breastfeeding is a political topic (at the time of this writing the United States bafflingly opposed a breastfeeding encouragement resolution from the United Nations–affiliated World Health Assembly), and while I do not feel I was treated with bias, it is true that breastfeeding limited my participation in a variety of activities. This limitation was sometimes perceived as voluntary, as though because I elected to breastfeed I also made a deliberate choice not to participate "fully" (an irony that anyone who has been late to a pumping session will painfully recognize). I had a baby who refused any and all bottles. Thus my anxiety around her feeding was high, because if I was not there to feed her she would not eat. As I write, I am aware of potential readers thinking I did not try hard enough to get her to take a bottle, just one of many parenting choices where others' opinions and judgments echo loudly, except that this choice is also about my body and how I choose to use it. Thus nursing became a Venn diagram of refusing, ignoring, or persevering beyond others' assumptions about how to parent a child, and about how a working woman should use her body. In this respect, I think issues of lactation are distinct in their inter-animation by general parental judgment and views of women's bodily autonomy.

Becoming a mother has been a strangely liberating experience. I now note how some of my past behaviors were aligned with gender socialization around women serving in nurturing, caring, and often people-pleasing capacities, particularly in professional environments. As Rachel Connelly and Kirsten Ghodsee note in their book *Professor Mommy*, becoming a primary caregiver often results

in fewer resources of time and energy to perform the "care labor" (or "academic housekeeping") expected of women in academia (99). I felt I "owed" colleagues a detailed reason why I would be late, or have to leave early, or need to Skype in to a meeting, or generally not fulfill external expectations of an academic mother because I chose to breastfeed. That first semester back at work, I often blamed my daughter as I rushed out of meetings, hoping my breasts were not announcing ahead of me the reason I had to run. I regret this. Not because it was not true—it was, my baby would not eat if I was not there to nurse her. But there was a larger truth at play for me about my own identity and desires: I wanted to be nursing my baby. In the first half year of her life, nursing was more important to me than working. Were I to do it over again, I would practice the advice I now give when asked by expecting parents: to be clear, brief, and firm in requesting accommodation and managing your time. Childbearing years notoriously tend to coincide with years of junior status, and establishing boundaries around time and energy can be fraught with the realities of precarious employment, underemployment, and other professional vulnerabilities. When breastfeeding is added to the equation, boundaries around bodily autonomy are heightened. In my experience, the institutional level can be the most glacial in terms of changing policy and language around any issue; as we agitate for institutional change, we must lead to the extent possible at the departmental level and in developing best practices at the organizational level, perhaps the most nimble site for intervention.

Field dynamics can operate differently among these levels. My daughter attended the ATHE (at three months old) and ASTR (at six months) annual meetings because I was breastfeeding. Many of the folks who regularly attend these meetings also read this journal, so allow me to thank you here. While I am a sample size of one, my baby was welcomed at both of these conferences and made many a friend bouncing in her baby carrier in the book exhibit. So while I juggled the time and energy demands of nursing, I was not made to feel unprofessional for bringing my baby to our meetings—the casual smiles and glances of support from folks I did not know were much appreciated. Keep them coming. For those parents considering bringing a nursing infant to this kind of professional engagement, I encourage you to think about the opportunities for networking as just as, if not more, important as the panels and plenaries. I tried to time nursing around the panels, which resulted in missing almost all of the more informal opportunities to connect with new and old colleagues that, in the already-isolating days of early parenthood, were critically missed.

Our large conferences are complex economic creatures; however, I would like to see more opportunities for virtual engagement in our professional meetings that would make it more feasible for people with all kinds of caregiving responsibilities to participate. Further, not all conference attendees have the financial means to secure a room in the conference hotel, therefore lactating individuals may be without an onsite, private location to breastfeed or pump. Establishing lactation rooms would help even the playing field. Lastly, from my own observations, at professional events (conference sessions, workshops, institutional meetings, and so on) that are tailored to the concerns of a specific group (diversity, mental health, caregiving, and so on), many of the folks who show up have a personal stake in the issue. I believe the chances are better for more equitable and just policies when all of us demand them in support of one another, and not solely the people whom they immediately affect. Recruitment and retention of underrepresented populations should be a shared priority across our field's academic and other settings, and recent research suggests that even in resource-rich environments, the invisible-care labor that women perform both in professional and personal settings is a detriment to their career advancement (June). Directors of graduate studies, editors, chairs, deans, colleagues: if you do not have significant caregiving responsibilities, please attend those conference sessions anyway.

## Suggested Practices and Resources

In proposing a short list of best practices for departmental leadership, staff, and colleagues wishing to support faculty and students experiencing reproductive health issues, we appreciate the

considerable variances in institutional systems and structures, including those governing promotion and tenure. While the recommendations below directly address reproductive issues related to fertility, childbirth, and postpartum maternal health, we urge that they be only a part of comprehensive parental and caregiver accommodation policies and practices applicable to and inclusive of adoptive parents, foster parents, surrogates, nonbinary and trans parents, and family caregivers. It is also imperative that policies attend to the disparities in financial need, health insurance coverage, teaching and research expectations, and job security across all instructional faculty: graduate teaching fellows and assistants, contingent faculty, and tenured or tenure-track faculty. Policies written with only the latter group in mind neglect 70 percent of the academic labor force (AAUP).

- Create departmental policies concerning reproductive health issues, in conjunction with university human resources and Title IX offices. As you work toward a set of guidelines, be aware that, as Rachel Hile Bassett notes, most "family-friendly policies benefit privileged and visible caregivers only" (see Twombly 123). Such policies should include
    - — Streamlined points of contact for the employee experiencing reproductive health issues (rather than requiring that they notify five separate offices).
    - — Parameters and protocols for taking additional absences/accommodations beyond those guaranteed in university parental-accommodation guidelines, including any documentation requirements for leave extensions. Keep in mind that different reproductive health issues will require different lengths of recovery or treatment time; any decisions on leave periods should be made in concert with the employee's healthcare providers.
    - — Options for partial return to duties; that is, returning to teaching or production work, but postponing service responsibilities until a later date.
    - — Campus resources for employees who are lactating; recovering from birth complications, miscarriages, and other medical procedures; or returning to work following an infant death. These should include the locations of lactation and pumping rooms and contact information for parking and transportation, human resources, disability services, and the counseling center. As a sign of commitment to the well-being of your faculty and graduate student employees, you may want to include the contact information for the university ombudsperson and the dean or provost of student affairs.
    - — Language throughout that avoids categorizing vaginal births of live babies as "normal" or "natural" and all other outcomes as "medicalized" or "nonnormative." This also goes for language addressing fertility and infertility.
- Provide *all* incoming students and new faculty (regardless of age, gender, sexuality, ability, or relationship status) with departmental policies concerning reproductive health issues. These policies should be distributed alongside other parental and caregiving policies.
- Encourage support across instructional faculty divides through reading and discussion groups (although participation should be recommended, not mandatory).
- Be aware that many reproductive health issues are invisible and unforeseen. Chairs should not press "healthy appearing" employees to justify their requests for accommodations. Instead, assure employees experiencing such issues that while they are welcome to confidentially share their stories, departmental and institutional support is not dependent on how much of their conditions they disclose.
- Recognize that some major or chronic reproductive health issues may require leadership to seek solutions beyond departmental resources. Relying exclusively upon departmental employees to "cover" their ailing, recovering, or grieving colleagues for extended periods of time without additional compensation is an abuse of their positions and has the potential to breed resentment. Consider offering overtime pay or a course release (for the semester

immediately following or a semester of the covering employee's choosing), hiring additional faculty and staff, or even canceling a low-enrollment course in order to restructure teaching or production assignments.

- Be aware that reproductive health issues can also emerge from or exist alongside traumatic experiences with seeking or receiving medical care. There are significant racial disparities in maternal and fetal healthcare in the United States, with mother- and infant-mortality rates three times higher for black women than for white women (Villarosa). Trans and nonbinary patients are often denied gender-affirming healthcare, reproductive or otherwise (National LGBT Health Education Center 8).
- Finally, as Susan Twombly urges, rather than applying accommodations to present academic labor structures—structures that often deemphasize or penalize those who try to conceive, reproduce, or caregive, it is perhaps time to think toward a reconceptualization or reorganization of academic work (123). Although such a seismic shift would be impossible to generate at a departmental level, leadership should still consider the formation of a task force charged with analyzing current practices in accommodating reproductive health issues and parenthood with an eye toward potential improvements.

Higher education institutions ideally should anticipate that instructional and research faculty of all ranks may desire to start or add to their families, just as many may not, and recognize that reproductive health issues are not uncommon.

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