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Author

Spencer-Walters, Dayo

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Q&A with Jessica Gipson

CSW Faculty Research Seed Grant Recipient investigates women's choices regarding prenatal and delivery care in a rural area of western China



JESSICA GIPSON is an Assistant Professor of Community Health Sciences in the School of Public Health at UCLA. She received a CSW Faculty Research

Seed Grants for 2010-2011 for a project titled "Investigating Tibetan Women's Pregnancy Care Preferences in Rural China: A Collaborative Pilot Study to Promote Safe Motherhood." Investigating women's choices regarding prenatal and delivery care in rural, western China, an area with high maternal mortality and morbidity, the project will also develop a clinic data collection system to track women's knowledge, perceptions, and use of a newly constructed Tibetan

Birth Center in this area. Recently, Professor Gipson very kindly responded to some questions about her career path and research activities.

What led you to your academic career? How did you become interested in public health and reproductive health?

I first discovered public health while pursuing my undergraduate degree here at UCLA. I started out as a biology and pre-med major but felt a deeper need to blend the biological processes with the realities of human lives and behaviors. I switched to medical anthropology and stumbled upon public health, as several courses were cross-listed with anthropology. I was enraptured by my first public health course — CHS 100. That course set me on a whole new path.

I interned with a community organization working with Asian-American/Pacific Islander adolescents, then after college worked at a non-profit community clinic in East Los Angeles and then with RAND in Santa Monica. While there, I decided to pursue more intensive and hands-on experience in public health. I enrolled in the Masters Internationalist program with Tulane University School of Public Health and Tropical Medicine, completed my Master's in Public Health coursework, then spent 2+ years in the Dominican Republic (DR) with the Peace Corps.

While in the DR, I was able to both broaden and focus my public health interests. I was assigned to work with a non-governmental organization on HIV prevention on the Dominican-Haitian border;

however, I soon learned after settling in to my new town that HIV wasn't on the top of their health priority list. A clean and safe place to go to the bathroom was...so, we built latrines!

Simultaneously, though, I saw how access to basic reproductive health information and services could significantly alter the health and well-being of women and their families. I was also faced head-on with the realities of working in the reproductive health field. In my attempts to collaborate and work with a variety of community members on reproductive health issues, I came across many opinions, as well as myths and misconceptions. One particularly memorable incident was a disturbing conversation with a nun in my town in which she indicated that condoms were ineffective in preventing HIV due to "microscopic holes." The next time I was able to access a computer with an Internet connection, I rounded up all of the scientific literature I could to bring back to her to show her the scientific evidence. In spite of the mound of studies I showed her, there was no convincing her otherwise. This was one of my first insights in to how challenging working in this field could be. Unfortunately, throughout the world, reproductive health is one of the most contentious areas of research and one in which politics and ideology sometimes trump science.

What are some advantages of basing your research in community health science?

Where do I start? I really appreciate the vast experience and varied backgrounds of my colleagues and the students in CHS. My fellow faculty members include policy experts, clinicians, mental health specialists, demographers, sociologists, and anthropologists. Exposure to and interaction with colleagues representing different disciplines and perspectives has been really gratifying and, I think, contributes to a more holistic approach to the health issues we address. Despite the variety of interests and populations with whom we work, I also appreciate that there is a unifying passion and dedication to the improvement of health from a social justice perspective—that health and well-being is a basic human right.

Since you teach a course on mixed [research] methods, could you elaborate on using mixed methods in health research? What is the benefit of this approach in highlighting the complexities of gender?

Mixed-methods research, or the integration of more exploratory, in-depth qualitative methods with more structured, quantitative methods, is extremely helpful in public health research. In addition to providing numerical estimates on the prevalence of, or trends in, particular health beliefs or practices, one can also explore the nuances behind the numbers: Why is this health outcome so prevalent? How did it get to be that way? How do people think about and make decisions about

this health outcome? What are the broader social influences that affect this health outcome?

Gender is one of the most pervasive and powerful social influences—in this country and in all of the global settings in which I work. I am fascinated by how different men's and women's health-related perceptions and experiences can be, even when they live within the same household. Mixed-methods research allows us to build on simple categorizations of sex and gender to understand why and how being male or female contributes to these perceptions and experiences at a personal and a societal level.

How do different contexts of gender dynamics influence your research methods and program design?

This is one of many areas in which I greatly value and rely on the input of senior colleagues and in-country collaborators. This is also an area in which in-depth qualitative methods are also very useful, if not absolutely necessary, to determine the most culturally appropriate and ethical way in which to conduct a research investigation or intervention.

One of the key issues I face, especially when attempting to work with male-female couples in various settings, is to determine to what extent women can independently and safely participate or not participate in a health intervention or research project, regardless of their husband's or male partner's wishes. I have found that it depends on the issue at hand. For example, during my study on fertility preferences and pregnancy in

Bangladesh, I was warned by colleagues that husbands may need to be approached first and to be asked for permission for their wives' participation before the wives themselves are asked. However, when we tried, many of the husbands questioned why we were asking them about such issues when this was a "woman's domain."

This statement reflects another issue that I grapple with—the historical exclusion of males in sexual and reproductive health interventions, policies, and research. This practice has changed drastically in the past decade or two, and in many cases is a pragmatic decision based on resources and time. If there is only enough money to gather pregnancy data from 2,000 people, doesn't it make sense that we would focus on women? However, in most situations, the male partner is integral to decisions related to the occurrence and outcome of a pregnancy—if/when to have sex, if/when to use contraception, if/when to have a child, if/where the baby will be delivered, and how scarce resources will be allocated within the household once the child is born. In my work, I have tried to include the male perspective not only to learn more about men's perspectives and health issues but also to learn how males' perspectives influence the health and well-being of their female partners and families.

Why do you think it's important for public health professionals and researchers to genuinely consider and attempt to engage with gender and sexuality?

Gender and sexuality are such important elements

of health—not just reproductive health. Gender norms and sexual and gender identity impact how we view the world and how the world views us. How does our biology or our gendered experience impinge on how we view health, our ability to manage our health, and our access to health care and services? Another area of public health importance is the assessment of potential social, psychological, and physical repercussions when individuals challenge the predominant notions of sexuality and gender in their communities and societies.

Your current projects are located in the Philippines and Tibet. Can you tell us about the research?

The Philippines is a setting where reproductive health information and services are severely restricted. In addition to a ban on modern contraception in Manila in 2000, the most recent President, Gloria Macapagal Arroyo (2001–2010), restricted the provision and funding of modern contraceptive methods throughout the country. Meanwhile, young adults have an even greater need for reproductive health services given earlier ages of sexual debut and later ages at marriage. Given these changes, we conducted an in-depth, qualitative study to explore situations in which young adults are faced with a pregnancy that they weren't expecting and may not have desired. Although traditional ideals persist regarding the "proper" timing and order of courtship, marriage, and childbearing, the current reality is often different. Many of the young adults we spoke to had

pregnancies before marriage or in the context of unstable relationships. In a setting where abortion is illegal, some women who were desperate to terminate an unwanted pregnancy ingested toxic or unregulated substances and/or self-inflicted injury. Findings from this study provide insight into the realities of young adult lives and highlight the need for comprehensive reproductive health services for Filipino young adults, especially amidst intense national debate on the Philippine Reproductive Health Bill to be voted on later this month.

Thanks to a Faculty Development Seed Grant from the Center for Study of Women and to the UCLA Council on Research, I am also working on a project with colleagues at UCLA and with the Tso-Ngon University Tibetan Medical College. We will be working in the Malho Tibetan Autonomous Prefecture, a remote area which is undergoing rapid social and cultural change. We are examining the role of sociocultural factors and logistical constraints on choices made by rural women and their families about whether to deliver their babies at a new, innovative Tibetan Birth Center, in a local hospital, or at home, where babies in this region are generally born. We are also hoping to lay the groundwork for a larger, regional study by developing a population-based data collection system for the purpose of monitoring maternal morbidity and mortality, as well as other health outcomes.

Dayo Spencer-Walters, who prepared the questions for this interview, is a MPH student in the Community Health Sciences in the School of Public Health at UCLA and a Graduate Student