

Living Between Two Cultures:  
A Reproductive Health Journey of African Refugee Women

by

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## ABSTRACT

Most studies on refugee populations tend to focus on mental health issues and communicable diseases. Yet, reproductive health remains a major aspect of refugee women's health needs. African refugee women in the United States continue to experience some difficulties in accessing reproductive health services despite having health insurance coverage. The purpose of this study was to understand the reproductive health journey of African refugee women resettled in Phoenix, Arizona. This study also explored how African refugee women's pre-migration and post-migration experiences affect their relationships with health care providers. The study was qualitative consisting of field observations at the Refugee Women's Health Clinic (RWHC) in Phoenix, verbally administered demographic questionnaires, and semi-structured one-on-one interviews with twenty African refugee women (between the ages of 18 and 55) and ten health care providers. The findings were divided into three major categories: pre-migration and post migration experiences, reproductive health experiences, and perspectives of health care providers. The themes that emerged from these categories include social isolation, living between two cultures, racial and religious discrimination, language/interpretation issues and lack of continuity of care.

Postcolonial feminism, intersectionality, and human rights provided the theoretical frameworks that helped me to analyze the data that emerged from the interviews, questionnaire and fieldnotes. The findings revealed some contrasts from the refugee women's accounts and the accounts of health care providers. While refugee women spoke from their own specific social location leading to more nuanced perspectives, health care providers were more uniform in their responses leading to a rethink of the concept of cultural competency. As I argue in the dissertation and contrary to conventional wisdom, culture per se does not necessarily translate to resistance to the American health care system for many African refugee women. Rather, their utilization (or lack thereof) of health services are better conceived within a broader and complex context that recognizes intersectional factors such as gender, racialization, language, displacement, and class which have a huge impact on the reproductive health seeking patterns of refugee women.

## DEDICATION

To my husband, Anene Ezeukwu. You have been a true companion. Thank you for believing in my ability to complete my dissertation. I wonder what I would have done without you. Your constant words of encouragement kept me focused and reminded me of the beautiful things in life.

To my family, Jatau-Emeagha, I appreciate your phone calls, support and prayers.

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Studying in the United States brought a great deal of new experiences for me and raised untold consciousness in me. My memories include having to embrace a new social identity, Black/African woman, in the U.S. This consciousness created an intellectual hunger in me to understand the experiences of my fellow Black/African women living in the U.S. Hence, my study of African refugees continues my intellectual curiosity about the Black/African woman. Completing this dissertation has allowed me to bring to life the need to recognize the complexity of experiences of Black/African women, particularly African refugees resettled in the U.S.

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## **Chapter 1**

### **INTRODUCTION**

The forced migration of people across regional and international boundaries is an important and highly complex global problem with dire consequences. Encompassing political instability, ethnic conflicts and wars, social disruption and lack of basic health and social infrastructures, forced migration poses several risks that strongly affect personal well being. Martin (2004) noted that about 25-30 million people would be refugees if they migrate outside their countries but are displaced within their countries. By the end of 2010, there were 43.7 million displaced people worldwide, the highest number in fifteen years. Of these, 15.4 million were refugees, and 10.5 million were receiving protection or assistance from the United Nations High Commissioner for Refugees (UNHCR, 2010a).

Most refugees are victims of political instability, civil unrest, human rights abuses, and conflicts. Because formal refugee status depends on movement of people across borders, it involves a joint responsibility of national governments and international organizations such as the UNHCR. The primary responsibility for protecting and assisting refugees rests with the UNHCR. Other United Nations (UN) agencies and international organizations such as United Nations Children's

Education Fund (UNICEF), United Nations Development Program (UNDP), World Health Organization (WHO), International Rescue Committee (IRC), and Catholic charities also provide services to refugees.

The global refugee crisis has significantly contributed to demographic changes in the United States. Approximately 28 million individuals in the United States, or 10.4% of the U.S population, are immigrants (Schmidley, 2001). About two million of these immigrants are those considered involuntary immigrants or refugees of natural and man-made disasters (Office of Refugee Resettlement Annual Report, 2004). The reproductive health needs of individuals new to the United States are often difficult to discern due to a lack of literature focused on their needs (Hovey, 2000; Pernice, 1994) and due to the cultural and language barriers (Fan, 1999). In order for healthcare providers to provide appropriate interventions for these populations, it is important that they understand their culture, their pre-migration and post-migration experiences and how these experiences affect their daily lives. This study explored the reproductive health experiences and perceptions of African refugee women resettled in Phoenix, Arizona, and their relationship with health care providers.

Globally, many people have been displaced in large proportions due to invasion, oppression, persecution, famine, and economic challenges (Cole, Espin,

& Rothblum, 1992; Hackett, 1999). These challenges have driven millions from their homes and have displaced them within their own countries or across borders (Cole, Espin, & Rothblum, 1992). The 21<sup>st</sup> century refugee phenomenon is unique to the history of refugees, due to the “massive and prolific weapons of destruction that have changed the scale of displacement and the movement of people.” (Hackett, 1999, p.9). Over the past decade, the number of refugees has doubled in the world, and these numbers are expected to increase (Cole, Espin & Rothblum, 1992).

There are currently 15.4 million refugees globally, with Africa being the second largest producer of refugees after Asia (UNHCR, 2010a; Taiwo, 2006). The UNHCR (2010a) estimates that there are 3.6 million African refugees across the globe and an additional 2.2 million are being hosted in Africa. They have been displaced internally on the continent of Africa, some having been displaced several times or confined to refugee camps for numerous years. Millions of African refugees have been killed, disabled, and rendered homeless due to wars and political conflict (UNICEF, 1996). The 2004 Refugee survey by the U.S. Committee on Refugees reported that two-thirds of almost thirteen million refugees worldwide have been confined in a segregated settlement for more than ten years without basic rights. Seventy-five percent of refugees in Africa have

been confined in refugee camps (a condition known as “warehousing”) for more than twenty years. These individuals have been severely scarred by the trauma of war, detention, sexual assault, long-term settlement in poverty stricken and violent refugee camps, and the brutal murder of their family members (Canadian International Development Agency, 2005). Many await relocation by the United Nations Commissioner for Refugees, which takes a while to process the necessary documents (UNHCR, 2005).

As refugees are resettled in developed countries amidst anti-immigration sentiments, they encounter a negative reception due to prejudice and discrimination (Bryce-La-Porte, 1993). Refugees of African descent, in particular, often encounter more problems and difficulties than are typical of any new refugee group, as they are “triple minorities” (Bryce-La-Porte, 1993, p.34). Not only are they foreigners who speak a different language, but they are also black (Bryce-La-Porte, 1993; Pierce & Elisme, 2000) and mostly of lower socioeconomic status. For African refugee women, they have become “multiple minorities” post-migration due to their race, ethnicity, language, religion, culture, gender, and class locations. African refugee women’s intersectional discrimination will be discussed later in this dissertation.

Over eighty percent of the adult refugee population is female. Consequently, the “human face of refugees is female” (Cole, Espin, & Rothblum, 1992, p.xii). Little is documented on how to support and address the reproductive health needs of African refugee women who have fled countries being ravaged by civil war (Neuner, Schauer, Klaschik, Karunakara & Elbert, 2004) or who have endured violence and poverty in long-term refugee camp life. Understanding how pre-migration and post-migration experiences influence the reproductive health perceptions of African refugee women warrants the attention of health care providers. A study by Morris et al (2009) reveals that lack of language and communication skills were major barriers to African refugee women’s access to health services. Similarly, Cole, Espin, and Rothblum’s (1992) study on the experiences of refugee women from Asia, Europe, Central and South America found that these women faced daily struggles as well. The loss of stability in these women’s lives is evident as “communities are impermanent, resources are unreliable, and neither women nor men have real control over basic conditions” (Cole, Espin, & Rothblum, 1992, p.304). Refugee women also struggle to redefine their identity and gender roles during migration and many experience reproductive health complications, pregnancy in particular.

A review of literature reveals that studies devoted to the understanding of reproductive health experiences and needs specific to African refugee women in the U.S are few. There is a general perception among healthcare providers that African refugees are at risk for serious pregnancy complications based on pre-existing health issues and diseases, such as malaria, which are common in Africa but uncommon in the United States (WHO, 2008). Moreover, the real reproductive health issues of African refugee women in developed countries are, as yet, unclear. These women constitute a relatively small subset of Blacks in America and currently there is little literature available that explores their pre-migration health status or reproductive health needs post-migration. Therefore, healthcare providers may be called upon to provide reproductive health care for African refugee women without a clear understanding of their medical history pre-migration as well post-migration health issues. The importance of providing culturally appropriate care to African refugee women who have been circumcised has been addressed (Johnson, Ali, & Shipp, 2009; Kim, Torbay, & Lawry, 2007; Banks, Meiriki, Farley, et al, 2006; Lax, 2000). A variety of language, cultural skills and knowledge of the needs of these populations and culturally and linguistically appropriate care are also recommended (Nelms& Gorski, 2006; Burgess, 2004). However, the relationship between African refugee women and



their healthcare providers in regards to seeking reproductive health is sparsely addressed in the literature.

Researchers of refugee health have found that many humanitarian agencies rush into regions to provide services to refugees, but that few are adequately prepared to serve these heterogeneous populations that are ethnically, culturally, linguistically, and religiously diverse (Gozdziak, 2004; Bracken, Giller, & Summerfield, 1997). Health care providers working with refugees tend to have limited knowledge of the country and cultural practices of the displaced population (Summerfield, 1999; Bracken, Giller, and Summerfield, 1997) and may therefore be unprepared to offer culturally appropriate services. Thus, there is a great need for health care providers to be adequately prepared (Gozdziak, 2004). Providers working with refugee patients require special skills such as cultural knowledge and linguistic abilities of people they are working with, and training to provide effective services (Gozdziak, 2004). It has been argued that Western medicine is ill-equipped to serve refugees due to the tendency to medicalize every issue because the biomedical model in Western medicine generally views illness as biologically mediated (Pavlish, Noor, & Brandt, 2010), and tends to disregard cultural difference in response to health issues and adversity (Summerfield, 1999; Gozdzia, 2004; Pupovac, 2002). Additionally,

spiritual and religious precepts are often insufficiently taught in health training programs and thus the programs fail to adequately prepare providers to understand religious beliefs or to treat beliefs sympathetically (Ong, 1998).

A qualitative approach to refugee health issues has been encouraged (Ahearn, 2000; Gozdzik, 2004) as a means to enhance cultural competence. This approach helps us to understand the participants' point of view, their pre-migration and post-migration experience, their relation to health care providers, and their worldview on reproductive health. The current study examined the reproductive health experiences and perceptions of African refugee women and their relationship with healthcare providers. The National Black Women's Health Project's position statement on women's health asserts that "Black women are the only appropriate and best qualified individuals to define the nature of their health issues and the research, programs and services necessary to address them" (Ruzek et al, 1997, p.68). The knowledge gained from this study will enhance health care providers' understanding and awareness of the reproductive health needs of refugee women and it will also provide information that may improve the response to refugees by the receiving communities.

Many public, private, and voluntary sector organizations have helped refugees access services related to housing, employment, counseling, training and

health care. Federal funds were made available to help refugees become self-sufficient, and for a period of time in the mid –eighties, refugees were able to access a broad range of federally supported and locally sponsored activities. Now, with the economic recession and philanthropic dollars shrinking, refugees struggling with unique cultural adjustment issues and with employment, housing, education, and health issues may find themselves in need of special services which are no longer available. Federal funding for refugee programs has existed since the passage of the Refugee Act of 1980. The elimination of much of this federal funding over the next few years and competing demands on overburdened state and local budgets are forcing refugee resettlement agencies serving refugees to rethink their postures toward partnership and collaboration. Helping refugees enter the mainstream system is now a major issue for health care providers.

### **Statement of Problem**

While the basic health care is a priority for refugees, reproductive health care has often received little attention. Yet refugee women, as do all other women, require basic reproductive health care for pregnancies, childbirth, birth control, and other facets of reproductive health. Research on African refugee women’s perspectives is scant (Matlou, 1999; UNHCR, 2003). Furthermore, Indra (1999) reviewed research on refugees and noted that women have been predominantly

represented in research studies pertaining to family life and socialization. Very few studies have focused on the reproductive health experiences of refugee women (Indra, 1999).

In spite of their reproductive health needs, African refugee women remain a shadow population in the United States- only partly visible and only partially understood. Health care providers must face the challenge of providing services to largely unknown people with very special needs. The resettlement of 4320 refugees in Arizona by the U.S Resettlement Program (USRP) in the fiscal year 2009 (October 2008-September 2009) brought over 700 African refugees to Arizona. Arizona ranks fourth in the nation, after California, Texas, and New York, in refugee resettlement, with 5.79% resettled in the state in 2009 (Office of Refugee Resettlement, 2010). Of course, this reflects only arrival and does not account for secondary migration in and out of state. Most of the African refugees resettled in Arizona come from Somalia, Sudan, Burundi, Liberia, and Congo. This results in heterogeneity of the refugee population. Hence, resettlement of African refugees in U.S. communities presents a variety of clinical and cross-cultural challenges for healthcare providers and refugee patients (International Rescue Committee News, 2004).

## **Purpose/Goal of Study**

Very few studies have focused on the reproductive health experiences of refugee women. This study aims to make a positive contribution to refugee women's health in general and reproductive health in particular. The major purpose of this study was to understand the reproductive health journey of African refugee women. This study explored the reproductive health experiences and perceptions of African refugee women, and the nature of their relationship with healthcare providers in order to provide information that will enhance the clinical encounters of refugees and health care providers.

The goal of this study is to improve the health and reproductive healthcare outcomes for refugee women by providing a forum for the voices of African refugee women to be heard. Also, this study explored the reproductive health experiences of African refugee women in the context of their pre-migration and post-migration experiences to broaden providers' knowledge of and awareness on the experiences of African refugee women.

## **Rationale of Study**

The demographics of the U.S. continue to shift as individuals voluntarily and involuntarily move to this country. Health care providers face the challenge of understanding experiences and reproductive health needs of these new

populations. There is limited knowledge and a paucity of literature devoted to the impact of pre-migration and post-migration experiences on African refugee women's reproductive health. A thorough investigation of the experiences of African refugee women who are now resettled in Phoenix was conducted utilizing a qualitative research approach. Qualitative research offers a unique opportunity for feminist health scholars and activists to identify themes important to improving the refugee women's reproductive health conditions and promoting better patient-provider relationships.

Knowledge of refugee women's experiences enhances health program planning and implementation and allows refugee women to assert themselves in their own words. Mohanty (1991) has argued for the relevance of women's social agency by focusing on women as people who can tell their own stories. This study contributes context-specific knowledge regarding African refugee women and health care providers' perspectives and experiences on reproductive health care in Phoenix, Arizona. The findings increase awareness and understanding of African refugee women's reproductive health needs and provide insight into how healthcare providers can provide culturally appropriate care to this population.

## **Significance of Study**

As forced migration continues to grow (Massey, 1995), it behooves healthcare providers to develop a comprehensive knowledge base about factors that inhibit reproductive health during pre-migration and post-migration. There is no comprehensive theoretical framework about how displacement affects refugee reproductive health, and specifically how women's experiences shape their relationship with health care providers. Most of the literature about African refugee women is focused on their pathologic responses to forced migration. Very little is known about their perception of the reproductive health services they receive post-migration and ways they communicate with health care providers.

This study takes into account the complexities of forced migration experiences of African refugee women and situates them within the larger environment to understand their impact on reproductive health. An understanding about what the post-migration experiences are like for refugee women will provide contextual information to develop strategies that are helpful and relevant for refugee populations. Refugee women's efforts to support and sustain themselves and their family members are likely to be successful if they build on common experiences as well as familiar cultural values and practices. Minimizing barriers to refugee women's post- migration experiences allows them to gain

access to those resources, such as culturally sensitive reproductive health services that contribute to their general health and well-being.

The knowledge derived from this study broadens theoretical understandings of African refugee women's reproductive health needs. These new understandings can help change the world-view from epistemologies centering on Western medical interventions on reproductive health to frameworks that value the cultural context of African understandings and health models. This study also shows the non-medical factors that influence the reproductive health of refugee population. Additional knowledge gained in this study will add to the literature base and feminist texts by expanding reproductive health discourse and guiding future research with African refugee women. This work underlines the value of utilizing a qualitative research method with refugees as it offers an opportunity where the voices of refugee women can be heard.

### **Conceptualizing Reproductive Health**

The World Health Organization (WHO) defines reproductive health as the condition in which the reproductive process is accomplished in a state of complete physical, mental, and social well-being and is not the mere absence of disease or disorders of the reproductive process. That is, reproductive health implies that people have the ability to enjoy sexual relationships. It further implies that



reproduction is carried to a successful outcome through infant and child survival, growth and health development. It finally means that women can pass through pregnancy and childbirth, that fertility regulation can be achieved without health hazards and that people are safe in having sex. In other words, reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how to do so (WHO, 2004). For this study, reproductive health is not limited to sexual freedom and healthy pregnancy outcomes. Rather, reproductive health refers to all processes that have to deal with women's reproductive systems. These include abortion, infertility, and menopause services, among other issues.

The concept of reproductive health was first developed in the 1980s by feminist scholars and women activists, but did not gain widespread acceptance until the International Conference on Population and Development (ICPD) in 1994. The ICPD Plan of Action states that: migrants and displaced persons in many parts of the world have limited access to reproductive health care and may face specific serious threats to their reproductive health and rights (ICPD 7.11). The ICPD was an international response to reproductive health and rights and pledged to achieve the goal of universal access to reproductive health for everyone in all countries by 2015. Following the ICPD, UNHCR and UNFPA

spearheaded international efforts to address the issue of reproductive health in refugee situations.

Reproductive health is a critical component of women's general health. It is a prerequisite for women's social, economic and human development. When women lack access to safe, comprehensive health care the consequences can be damaging. An individual's reproductive health is influenced by many factors such as age, lifestyle habits, genetics, use of medicines and exposures to environmental toxins (National Institute of Health, 2011). This study examined how pre-migration and post-migration experiences shape African refugee women's reproductive health experiences in Phoenix, Arizona.

Reproductive health care covers a wide range of issues: pregnancy and childbirth; the protection of women, children, adolescents and men from emotional, physical and sexual abuse; family planning counseling and services to prevent unwanted pregnancies and the sequelae of unsafe abortion; the treatment and prevention of sexually transmitted diseases including HIV/AIDS; and the discouragement of harmful traditional practices (WHO, 2000). The provision of reproductive health services should be based on the needs of the population, with particular attention being paid to vulnerable groups, such as African refugee women.

Reproductive health care needs provide an important example of the gendered needs of refugees. The reproductive health issues refugee women face are similar to those of other women in their home countries, but many are compounded by the refugee experience. Martin (2004) points out that during the pre-migration and migratory phases, refugee women suffer from septic abortions, unsanitary conditions during birth, poor lighting during deliveries, and infections from unsanitary instruments. A study in the United States has identified four areas that need to be addressed to help improve refugee women's reproductive health. These are safe motherhood, family planning, prevention of HIV/AIDS and other sexually transmitted diseases prevention, and the prevention of sexual and gender based violence (U.S. Committee for Refugees, 2000). In addition, some ethnic groups face specific problems in a new country, such as Somalis with their customary practice of female circumcision (Meares, 1995). In cases such as these, issues of cultural and racial sensitivity need to be balanced against women's rights issues.

### **Who is a Refugee?**

The legal definition of refugee status following World War II has been that of the 1951 United Nations Convention Relating to the Status of Refugees. The convention defines a refugee as:

Any person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it (UNHCR, 2010b).

This convention was augmented in 1967 to accommodate the new flows of refugee populations particularly in Africa. The United States is a signatory to the 1951 United Nations Convention and the 1967 Protocol Relating to the Status of Refugees.

Within the United States, the definition of refugee and refugee needs, as well as the responsibility of the international community, have been and continue to be controversial at both the popular and policy levels (Simcox & Jenks, 1992). For some Americans, only those fleeing unfriendly regimes all over the world should be considered for refugee status. For other Americans, some interest groups in the legislative arena have widened the gate and exploited American generosity to admit more people, whether they fled persecution and human rights

abuse or not (Simcox & Jenks, 1992). There are yet others, and this is true in Africa, who think that anyone fleeing natural disasters, famines, or political unrest should be considered a refugee and deserves assistance from other countries (Arthur, 2000).

An asylee is a person who enters the U.S. under a distinct visa, having applied for and obtained asylum status in the U.S. Drachman (1995) explains that an asylee is basically a refugee, the difference being that the asylee applies for asylum status from within a U.S. territory, whereas a refugee applies for asylum while in another country. The service benefits of an asylee are uncertain, although such benefits should mirror those of refugees, as their political statuses are the same. The person who applies for asylee status waits a long time before his or her status is determined; during that time the individual is ineligible for any services (Drachman, 1995).

There is a distinction between refugees and voluntary immigrants. While refugees are forced migrants fleeing from catastrophic situations, voluntary immigrants intentionally leave their home country to start a new life in another country. Voluntary immigrants decide where and how to migrate, whereas refugees have to depend on humanitarian agencies to resettle them in a new country. For the purpose of this dissertation, the term “refugee” will be used in its

specific U.S. context as someone who has been brought into the U.S through a refugee resettlement program.

### **United States Refugee Policy**

The U.S refugee regime emerged out of the post-World War II period. This period was the first time the U.S formally approved a refugee resettlement program through legislation (Gibney, 2004). As a key element to the political and economic reconstruction of Europe, the 1948 Displaced Persons Act was designed to assist the hundreds of thousands of people persecuted and left without homes after the war. This was necessary as the countries under reconstruction could not support the populations they had much less hundreds of thousands of refugees.

While the 1948 Act allotted space for resettlement in the United States, the act was not a total victory for humanitarian efforts because it was still under the 1924 National Origins Act restriction. This meant that refugees admitted from certain countries were subtracted from the state-designated annual immigration quota for that country. And if the refugees exceeded the annual allotment, the spaces were taken out of future annual quotas of that country, but only fifty percent of that country's quota could be mortgaged (Gibney, 2004). The Act also codified into law U.S. racist fears of non-Whites, as only Europeans displaced before 1945 could legally be resettled. In other words, while the refugee

resettlement program was publicized as humanitarian, it strongly privileged certain subjects, mostly white males, in actual access to resettlements as displaced persons. By the end of the Act's tenure in 1952, over 340,000 displaced persons had been resettled in the United States as well as 80,000 other Europeans who were driven from their countries (Gibney, 2004).

During the Cold War (1940s -1980s), U.S. refugee policy came to favor those fleeing communist regimes. Consequently, the U.S began to accept Cuban refugees fleeing Fidel Castro's rise to power. As Gibney argues concerning this period, "the grant of asylum was seen as a way of hastening the regime's rapid demise. The departure of refugees was seen as a hemorrhaging the country's best and brightest that would prove fatal to the regime" (p.148). The policy concerning Cuban refugees shifted continuously between 1960s and 1980s as different administrations used the program to make symbolic statements about democracy and capitalism, as well as their relationship to communism. And although there were many refugees around the world who were not fleeing communism as recognized in the 1967 U.N Protocol relating to the Status of Refugees, the U.S. employed a definition of refugees that included a stipulation that refugees be fleeing communism. Thus the primary refugees admitted during this period were recognized as fleeing communism. Presidents Ford and Carter used the parole

provisions to admit approximately 430,000 refugees fleeing Vietnam (Gibney, 2004). Interestingly, there was no mention of women refugees during this period, a time known as the second wave of feminism.

The 1980s witnessed a policy shift in the U.S refugee resettlement program. This shift gave the U.S Congress control of the refugee admittance cap. The U.S Congress saw this policy shift as a way of reducing the social burden of non-U.S citizens on the state. This happened through a number of processes. First, the President was granted the right to establish annual refugee ceilings under advisement from the Congress concerning which groups to be resettled as well as the number of refugees to be resettled (Gibney, 2004). The Act also aligned with international refugee protocol, adopting the UNHCR definition of refugee along with the 1967 UN Protocol for determining the status of a refugee.

The incorporation of the 1967 UN Protocol in the 1980s meant that individuals could enter U.S. borders, make a claim for asylum, and legally not be turned away. The refugee system became a matter for the courts. Gibney explains that this had the effect of smoothing out the national preference often present in large refugee resettlements (Gibney, 2004). Even with the 1980 Refugee Act, which created a humanitarian basis for refugee admissions in line with the U.N definition, the U.S continued to accept mainly refugees from communist (or



former communist) countries, mostly in Europe and Asia, along with Cuba. The Office of Refugee Resettlement (ORR) estimates that, for the twenty-year period between 1983 (when they began keeping their own numbers) and 2003, refugees from five countries represented 77 percent of all arrivals: the former Soviet Union (25 percent), Vietnam (23 percent), Cuba (13 percent), the former Yugoslavia (9 percent), and Laos (6 percent).

The privileging of Europeans accounted for the high flow of European refugees even after the 1989 collapse of the Soviet Union leading Lennox (1993) to argue that “no longer can communism serve as a proxy for racial selectivity” prevalent in the refugee admission program. Haitians and Africans were disproportionately underrepresented. For example, in spite of Haitians’ claim for political asylum, the Reagan administration was not sympathetic to their claims, and viewed them as “economic migrants”. Haitians who crossed U.S. borders were detained, subjected to harsh treatment, and their asylum cases were denied.

In spite of the “racial selectivity” and preferences mentioned above, the United States has officially accepted for resettlement roughly 2.9 million refugees from strife-torn countries around the world since 1975, making the U.S the leading country for refugee resettlement. About 74% of refugees resettled in developed countries worldwide are in the United States followed by 7.99% and

7.75% in Australia and Canada respectively. Also, the U.S. continues to actively support efforts to provide protection, assistance, and durable solutions to refugees, as these measures meet its humanitarian objectives and foreign policy and national security interests. Combined with humanitarian diplomacy, the United States' financial contributions to international and non-governmental organizations are vital to achieving these goals. Under the authority in the Migration and Refugee Assistance Act of 1962, as amended, the United States contributes to the programs of UNHCR and other international and non-governmental organizations that provide protection and assistance to refugees and other vulnerable migrants. These contributions address the legal and physical protection needs of refugees as well as basic assistance needs for water, health care, shelter, and other services. The U.S monitors these programs to ensure the most effective use of resources, maximizing humanitarian impact for the beneficiaries.

After the September 11, 2001 attacks on the United States, modifications in the resettlement criteria were made to protect its security. The Department of State, Bureau of Population, Refugees, and Migration (PRM) became directly responsible for coordinating and managing the United States Refugee Admission Program (USRAP). A critical part of this responsibility is determining which

individuals or groups from among the millions of refugees worldwide will have access to U.S. resettlement consideration. The ultimate determination as to whether an applicant can be admitted as a refugee is made by Department of Homeland Security (DHS) /United States Citizenship and Immigration Services (USCIS) in accordance with the criteria set forth in the INA. Applicants who are eligible for access within the established priorities are presented to DHS/USCIS officers for interview.

Under current U.S. refugee policy, there are three main components of the U.S. refugee program:

Priority One (P1) brings individuals “with compelling persecution needs or those for whom no other durable solution exists”, who are referred by UNHCR or identified by a U.S embassy or non-governmental organization (NGO). Under Priority Two (P2), members of designated groups facing persecution, often religious or ethnic minorities, are accepted. P2 groups, who are of “special concern” to the United States, are selected by the Department of State, with input from USCIS, UNHCR, and NGOs. Under Priority Three (P3), already settled refugees who are 18 or older- called “anchors”- can request their immediate refugee relatives (parents, spouses, and unmarried children under 21) be considered for refugee admission.

The immediate relative is the primary applicant on P3 case and is allowed to include his or her spouse and children under 21, who are the derivative beneficiaries. While the primary applicant must establish a refuge claim, the derivatives are joining in the application and do not need to show persecution. The P3 program is only open to those that their nationality groups designated in the annual Presidential Report to congress on Proposed Refugee Admissions (Esbenshade, 2010).

African refugees are mostly admitted under the P1 and P3 category. Between 2004 and 2007, Africa was the ceiling region from which the largest number of refugees came (Esbenshade, 2010). But, African refugees came at a time of relatively few refugee arrivals, never reaching the levels of European and Asian refugee arrivals. Furthermore, Africans have less access to the Priority Two, which makes it difficult for many Africans to gain access to the U.S even though they might qualify for religious persecution.

The family reunification available under category P3 was halted in 2008 by the PRM on the grounds that there was high fraud in the program (Esbenshade, 2010). The PRM claims that there is especially “high fraud” in the family reunification applications of African refugees. The U.S. cited instances of “high fraud” whereby refugees claimed familial relations with non-relatives

(Esbenshade, 2010). Consequently, the PRM proposes to use mandatory DNA testing to prove claims of family relationship (Esbenshade, 2010). The prospect of DNA testing is of concern to refugees themselves, and various agencies providing and protecting them such as the UNHCR. The DNA testing will provide an insight into other issues that come into play in refugee admission policy, such as how family relationships are proven. Once again, non-Europeans are the target of refugee policy designed to shut more people out as opposed to bringing them into the country. The fact that the U.S accepts for resettlement few Africans means that it will be more difficult for their loved ones who were separated from them during their displacement and flight to join them.

The pilot DNA test was conducted in Kenyan refugee camps targeting mostly Somali and Ethiopian refugees. The refugees were not pre-informed about the test. Rather, refugees were asked during interviews to provide a DNA sample. The PRM has extended the program to Ghana, Ivory Coast, Ethiopia, Uganda, Guinea, and the Gambia. These DNA tests do not take into cognizance the definition of family across cultures. What constitutes “high fraud” in the family reunification application is highly contestable, since in most African cultures the understanding of family is much more expansive. It is well documented that fostering of children by non-parental kin is prevalent in Africa (Oppong, 1992). In

some countries the tradition is that, if a parent dies, the father's brother or mother's sister substitutes as the parent. Thus, the term "child" can be used to refer to nieces and nephews, "father" to an uncle, and "mother" to refer to an aunt. Hence, some refugees probably genuinely did not understand the difference between parent/child relationship and the definition being used by the interviewers (Esbenshade, 2010). Also, polygamy is still practiced in many African cultures and considering the mass loss of lives that occur during conflict, any surviving wife of a deceased man generally assumes the role of legal parent of the children regardless of whether they are biologically her children.

Once resettled in the country, the United States' policy allows refugees to be lawfully employed upon arrival. After one year, a refugee is required to apply for adjustment status to lawful permanent resident. Five years after admission, a refugee who has been granted lawful permanent resident status is eligible to apply for U.S. citizenship. While the U.S. refugee policies and procedures are determined at the federal level, the burdens of addressing the unique needs of refugees after they arrive are passed on to local communities, often without their consent. Under current practice, the Federal government works with voluntary organizations, including faith-based groups, to decide where to send refugees for resettlement.

Refugees resettled in various U.S. communities place demands, sometimes significant, on local schools, hospitals, and social services. The refugees are often overwhelmed by their lack of English language skills and the cultural differences. Consequently, refugees in the United States and persons assisting them often face challenges in addressing the needs of refugees after they arrive in the U.S. However, the Department of State has made some changes to meet the increasing needs of refugees. For example, there has been an increase from \$900 to \$1800, effective January 1, 2010, in the reception and placement per capita grant administered by the Department of State for the initial weeks after a refugee's arrival (United States Department of State, 2010). This grant ensures that refugees have shelter, food and basic assistance in their first 30-90 days in the U.S. This grant also reduces the burden of providing for refugees on states and local communities.

### **Gender and the Refugee System**

The early 1980s saw an increasing awareness of the gendered nature of the refugee experience (Barnett, 2002; Callamard, 1999). Beginning with the UN Decade for Women, activists and organizers dedicated to women's rights began to address the gap in humanitarian efforts in relation to women. Though no political or legal change occurred during this time, Baines (2004) asserts that the

conferences that took place during the decade were central for the prominence of refugee women's visibility on a global scale.

The first formal UNHCR report concerning gender emerging from this decade documented the challenges of women in exile including gender-specific and sexual forms of violence. At the Copenhagen conference where the report was delivered, representatives were divided in defining the gender disparity as well as the causes for that disparity:

Western states wanted to focus the agenda on sexual discrimination of women. Delegates from Latin America, Africa, the Soviet Union, and Asia rejected the term "sexism" itself on the ground that it did not translate easily to other languages...More poignantly, delegates were divided over root causes of women's subordination. Many Third World delegates firmly stood behind the movement towards a New International Economic Order (NIEO) and were opposed to the West's disproportionate share of global wealth at the expense and exploitation of the rest of the world (Baines, 2004, p.25).

In making these connections, Third World delegates saw women's experiences and subordination in local contexts as highly impacted by the limited economic and political choices their nation-states had in providing social services and



promoting development (Lake, 1987). Despite acrimony, Copenhagen ended with a global declaration including the rights of women refugees, though the UNHCR did little to enforce or comply with these suggestions. However, this conference initiated other conferences and groups to consider the politics of gender in the international refugee system. For example, in 1983, the Dutch Refugee Association (DRA) formulated the first known recommendation for gender-related violence to be recognized as persecution and grounds for asylum (Baines, 2004, p.25).

Two years later at the 1985 Nairobi Conference organized by the UN, activists articulated concerns about gender inequity within the refugee system more comprehensively. Unfortunately, there seemed to be a discursive shift from the previous conference in the positioning of refugee women. Baines (2004) reports:

I was struck by the constant location of refugee women in the private sphere. For instance, women's gender roles were largely identified by their reproductive or unpaid domestic labor. Moreover, their protection or assistance needs were defined by their position within the family. The gender-related root causes of displacement – a continuing point of tension among delegates- were not addressed anywhere in the report (p.26).

Additionally, the sentiments from the conference were that the UNHCR definitions and protocol, the international refugee and asylum laws as well as humanitarian efforts were devoid of gender bias. Instead, it was women's culturally defined roles and dependence on men that caused inequity within the refugee system. However, this conference was a success in the sense that it opened up the space for feminist dialogue in the 1990s about a state's complicity and obligation to women who experience gender-related violence in privately recognized spheres. For example, women could make gendered claims based on Female Genital Circumcision (FGC). This created the opportunity for micro level claims for asylum. It also implicates refugee women's pre-migration experience by providing the context to analyze their reasons for fleeing their home country. My own analysis in this dissertation is related to this conceptual mode as I explicate refugee women's pre-migration experiences in the context of reproductive health.

### **Self Disclosure**

I believe it would be helpful to situate myself as a researcher in this research and provide a context. That situatedness and context is based on my belief that as researchers we bring knowledge, skills, and personal attributes to the research setting. I have been particularly interested in studying African

populations, being an African myself. My experience working among vulnerable groups in Nigeria has made me particularly sensitive to the plight of those displaced by adverse circumstances in Africa. A year ago, I became involved with the Refugee Women's Health Clinic (RWHC) in Phoenix. I participated in the quarterly community meetings as a means of gaining access to refugee women. I continued attending these meetings which became not only a place to gain access to African refugee women, but also an opportunity for me to become familiar with the challenges of healthcare providers as well.

Over the course of six months, I was able to establish a close working relationship and to develop a significant level of trust and mutual respect with the director of the clinic, social worker, and interpreters. My participation in the quarterly and scheduled meetings became helpful in drafting my semi-structured interview questions with participants. As I began interacting with participants, I realized that many of these women have not been heard, nor does feminist literature extensively address the needs of this population. My involvement with this group has given me the opportunity to understand their worldviews about reproductive health and offer valuable information to health care providers. As a feminist researcher, I am aware of the fact that my personal views, my assumptions, my biases, and my epistemological position regarding the study

have influenced the data collection and interpretation process. However, I made sure to listen deeply to the interviewees to ensure that their views are fully understood and represented in the data.

My research was also influenced by my understanding of postcolonial, intersectionality, and human rights theories. These theories influenced my perception of the struggles faced by the refugee women and my identification of themes such as living between two cultures in the midst of adversity. My personal Christian beliefs made me sensitive to the religious themes that emerged from the data. I was particularly sensitive to statements made concerning the women's religious practices and their view of God as the great healer. I was touched by the statement of one of the participants who stated, "I did not drink the medicine because it is only God that can heal me." These telling words evidenced the significant coping mechanism of prayer. Similarly, my interviews with healthcare providers were influenced by my understanding of patient-provider relations, which also influenced my identification of themes such as cultural competence and trust. The language barrier between me and some of the African refugee women, particularly Burundian women, meant that I had to use an interpreter who speaks both Kirundi and English to conduct interviews.

I operated under the assumption that a qualitative design is an effective way of discovering the experiences and perceptions of my participants and that by conducting a small number of detailed interviews, I would uncover valuable information needed to improve the reproductive health services for refugee women, and African refugee women in particular. I assumed that the participants would answer the interview questions truthfully and to the best of their ability.

### **Limitations of Study**

The limitation of this study involved the time constraint and my lack of multilingual skills. Hence, I utilized the services of two interpreters to conduct interviews with seven African refugee women. I depended on the interpreters to accurately explain the study to the participants and to translate accordingly. However, there were issues of power differentials that existed between all of us who participated in the study. For example, one of the interpreters declined to ask six participants from Burundi a question about their ethnicity, which was part of my demographic questionnaire. The interpreter claimed it was inappropriate to ask such questions due to Burundi's history of ethnic violence, and did not give the participants the opportunity to state their opinion. Thus, my inability to speak the same language as some of my refugee participants was a major challenge for me as a researcher.

Another limitation of this qualitative study concerns the role of the researcher within the research itself. In qualitative research the researcher is an integral part of the research process and influences the results with his/her past experiences, views, beliefs and values. Despite these limitations, the data that emerged and the conclusions drawn from the study have important implications for feminist health research, policy and future research.

### **Outline of Chapters**

This chapter serves as an introduction to the study of African refugee women's reproductive experiences and relationship with healthcare providers in Phoenix, Arizona. I have provided the purpose, significance, and rationale of the study of the target population. I have provided the definition of the key terms of interest to this study. In conclusion, I have clearly described my interest and presumptions about the topic. Chapter 2 discusses the qualitative methods used to collect data and analysis. Chapter 3 provides the theoretical framework regarding forced migration as part of the review of literature. Also included is a review of empirical studies. Together these will provide a frame of reference about refugee experiences thereby pointing to the gaps in the literature which serve as a justification for this study. Chapter 4 provides a historical context of African refugees. Chapter 5 provides biographical sketches of the refugees and health care

providers who participated in this study. The pre-migration and post-migration themes that emerged in the data will be the focus of chapter 6. Experience and perceptions of African refugee women regarding reproductive health is the subject of chapter 7. Healthcare providers' responses and views on providing reproductive health services to African refugee women are the focus of Chapter 8, which delves into the difficulties associated with providing care for refugee women. Chapter 9 continues the discussion within a postcolonial feminist framework. The last chapter, chapter 10, is the conclusion, advancing the claim that this study generates a new knowledge about refugee women and their relationship with healthcare providers.

## **Chapter 2**

### **METHODOLOGY**

This qualitative study used interviewing methods to explore the African refugee women's reproductive health experience, and their relationship with health care providers. Qualitative research is a method inductive inquiry used to develop a body of knowledge about an area where little is known (Morse & Field, 1995) or when a cultural perspective is important to understand a phenomenon. As mentioned in the previous chapter, little is known of African refugee women's reproductive health experiences. The literature also fails to address the relationship between refugee women and health care providers and the strategies they use to communicate.

According to Morse and Field (1995), the goal of qualitative research is theory development (p.17). Theory serves as a guide to actions and is used to organize and direct thoughts and observations (Sidani & Braden, 1998). One of the goals of this qualitative study was to extend postcolonial, human rights, refugee, patient-provider, and socio-ecological theories to African refugee women and uncover aspects of pre-migration and post-migration that influence their reproductive health experiences and perceptions as well as their relationship with health care providers. One of the major reasons for using qualitative research was



to understand the phenomenon from the participants' point of view and to uncover the meaning of their experience.

One basic assumption of qualitative methods is that “no single interpretive truth exists” (Denzin & Lincoln, 2000, p.23). Truth or reality is contextual and is created by an individual or group of individuals. This is distinct from quantitative research which has an underlying assumption that the researcher can employ methods to be a detached and unbiased observer. The subject or research participant is considered the expert in qualitative research, and the researcher is considered a co-participant. The truth or reality in qualitative studies is co-created by participant and researcher. Another aspect of qualitative research is the ability to capture the cultural context in which the experiences can be situated for a full understanding of the phenomenon under study. Qualitative research is the world of lived experience where individual belief and action intersect with culture (Denzin & Lincoln, 2000).

### **Study Participants**

A purposive sample of twenty African refugee women resettled in the Phoenix area and ten health care providers who have experience providing care to refugee women participated in this study. The women in the study were 18-52 years old with an average age of 34.4 years. At the time of study, eighteen of

these women had 1 to 7 children ranging from 6 weeks to twenty-eight years old, while two women were pregnant with their first babies. A diverse group of African refugee women from different countries was chosen for this study to capture the unique experiences associated with migrating across international borders. These women have been living in the U.S from 1 to 10 years, with an average time living in the U.S of 6.5 years. Seventeen of the women in the study were married and living with their husbands, two were single parents, and one was widowed. The inclusion criteria was that the participants must be African refugee women living the Phoenix area, while the healthcare providers must have direct professional experience with refugee populations.

The educational level of the women varied from no formal education whatsoever to twelve years. Two of the twenty women had some college/associate degree but the majority had no more than eleventh grade when they left Africa. Fourteen of the women were Christians and six were Muslims. Thirteen of the women were able to speak understandable English during the interviews. Two interpreters were used for seven of the interviews.

The healthcare providers who participated in the study were one obstetrician/gynecologist, two social workers, two certified nurse midwives, and five registered nurses. All the providers were female. Eight of the ten providers

were white, and the remaining two were Indian-Immigrant and Asian-Immigrant. All the interviews with the providers were conducted in English. All the providers had between two and ten years of professional service with refugee populations. Two health care providers spoke a second language, eight of them spoke only English. However, none of the healthcare providers in this study spoke the same language with the African refugee women. They normally use the services of live interpreters or telephone interpreters when interacting with African refugees who have limited or no English skills.

### **Research Questions**

The research questions are critical components of research in that they help to determine the method to be used. These questions also provide the framework around which the conclusions of the study are constructed (Strauss & Corbin, 1990). This study was guided by the following questions:

- 1) How do African refugee women describe their pre-migration and post-migration experiences?
- 2) How do pre-migration and post-migration experiences affect the reproductive health experiences of African refugee women?
- 3) What challenges do healthcare providers face with African refugee women?

- 4) How do healthcare providers provide culturally appropriate care to African refugee women?
- 5) What is the nature of the relationship between African refugee women and healthcare providers?

To help answer these questions, one-on-one interviews were conducted with each refugee woman and healthcare provider using a semi-structured interview guide (Appendix A) to understand their personal experiences with the phenomenon.

### **Recruitment**

I had originally planned to also recruit women for the study from two refugee resettlement agencies in Phoenix metropolitan area- International Rescue Committee (IRC) and Catholic Social Services. However, I learned that there were very few African refugees still receiving services from these agencies since the resettlement programs only provide direct services to refugees during the first 8-18 months after arrival in the U.S. Therefore, the majority of the participants were recruited from the Refugee Women's Health Clinic (RWHC) and by word of mouth from refugee women participating in the study, whereas all the healthcare providers were recruited from the Maricopa Medical Center. The main recruitment site was the Refugee Women's Health Clinic and the Department of Obstetrics and Gynecology both located at the Maricopa Medical Center,

Phoenix. However, I visited a Liberian church in Phoenix where I recruited two women. Recruitment began in August 2010 and continued until October 2010. I contacted health care providers and some of them responded and we scheduled interviews based on their work schedules. The refugee women recruited at RWHC were interviewed once they consented to participate in the study. I would walk up to them while they are waiting to see the doctor, introduce myself and tell them about my research. I would end the discussion by asking them if they want to be part of the study and if they say yes we will arrange to either meet after they have been seen by the doctor or at a later date. The women I recruited from the church gave me their phone numbers to contact them to schedule interviews. Since the study was anonymous, none of the participants were required to sign the informed consent letter, instead informational letter was used to explain the study to participants, after which verbal consent was used.

*Gatekeepers:* It was necessary to align with gatekeepers to gain access to the African refugee women in Phoenix. A gatekeeper is someone who acts as a liaison between the researcher and participants. The African refugee community is fairly spread out in the area and it would have been impossible to access potential participants without gaining the trust of those people/community members who have direct access to these women. The director of the RWHC and

social worker provided me with access to African refugee women. The director of the clinic also helped me to send word out to healthcare providers and I was contacted by those interested in taking part in the study. The social worker was invaluable as a gatekeeper to the African refugee women. She was well-respected and trusted by the refugee women. As a healthcare provider who was also an African refugee resettled in the U.S., the social worker holds a Masters Degree in Social Works and is a certified social worker and provides interpretation services for some of the African refugee patients at RWHC.

### **Procedures**

After I obtained approval from the Institutional Review Board (IRB) at Arizona State University (Appendix B), I also applied for and obtained approval from the Institutional Review Board at Maricopa Integrated Health System (Appendix C) - the responsible authority for reviewing researchers' proposals at the Refugee Women's Health Clinic and Maricopa Medical Center to allow me to recruit study participants from the Refugee Women's Health Clinic. I generally sat at the reception area of the clinic waiting for African refugee women to show up for an appointment or as new patients then I approached them and explained the study to them using the information letter (Appendix D) and then arranged for the interviews with those who gave their consent. Sometimes, the interviews will

take place after they had consulted with their physician or they would give me a different appointment. The clinical staff was aware of my presence and did not interfere with my recruitment since I had received the official IRB clearance to conduct my study at the clinic.

I emailed the information letter (Appendix E) to health care providers and arranged for interviews at various locations in the hospital. Most of the providers accepted to be part of the study once they received my email. I also maintained observational notes of the clinic which were added to the description of the participants and noted common themes that emerged from the data. The duration of the interviews varied from one participant to another, between thirty minutes to one hour and thirty minutes. For the non-English participants, I used an interpreter. Each question was asked in English, and then interpreted into the refugee woman's language. The participants responded in their native language. This response was then interpreted into English.

*Materials:* A demographic questionnaire (Appendix F) was completed by each refugee participant at the beginning of the interview. The questionnaire was read and completed by me for those who were not able to write. The demographic questionnaire inquired about the participant's age, marital status, number of children, pre-migration and post-migration educational attainment, occupation,

health insurance status, country of origin, zip code, religious affiliation, when they migrated to the U.S. The healthcare providers were asked years of service with refugee patients. Thirteen interviews were recorded and labeled with the participant's assigned code number. The recording were transcribed onto a word document and kept in a locked cabinet. For the participants who did not want to be recorded, I took copious notes to capture all that was said.

*Interpreter:* The interviews were aided by a Burundian woman, Janet (not real name), who is fluent in English and Kirundi. My initial plan was to skip non-English speaking refugees due to my lack of multilingual skills, but after my proposal defense my committee suggested that it was important to include non-English speakers in order to have a representative sample. I met Janet at the Refugee Women's Health Clinic where she is an intern. After I discussed my research with her, it became evident that she was the best person to interpret for me. I also used a refugee (from Togo) participant's brother-in-law as an interpreter. The participant was comfortable using her brother-in-law as an interpreter. Both interpreters were apprised of the study and I explained the goal of my study and asked them to be as direct and clear as possible in their interpretation and translation in order not to lose relevant data and to avoid misrepresenting the participants' views.



## **Conducting Research with Refugee Women**

The refugee women in this study were considered to be an extremely vulnerable population (Dunn & Chadwick, 2002). Therefore stringent measures were taken to insure they were protected from any undue harm or coercion as a result of the study. The rights of the vulnerable are fiercely protected by new rules implemented by the government as a result of past exploitation of minority groups (U.S. Department of Health and Human Services, 2005). As a student researcher, I am bound by the Institutional Review Board's ethical principles to insure that no harm would be caused to this population of refugee women as a result of this research.

The anticipated benefits and risks of inclusion in the study were shared with the participants. The anticipated benefits included being able to tell their stories and share the hardships and challenges they experience with someone who cares. Another potential benefit was that by participation the healthcare providers would provide information that will be helpful in recommending better ways of serving refugee populations. All participants were compensated for the time and contributions to the study. Each participant was either given cash or a gift certificate of \$15 to compensate them for their time.

In preparing for the study, it was acknowledged that a participant's signature could be an identifiable marker. Therefore, to protect their identity, none of the participants were required to sign the consent form. Instead an information letter (Appendix E) was distributed and verbal consent was obtained before each interview. I was aware that some of the participants may not have understood the purpose or aims of the research and might have been suspicious of a researcher coming to talk to them about their reproductive health experiences. To allay this potential suspicion, it was necessary to continuously articulate the purpose of the study throughout the data collection process (Germain, 2001).

In working with participants that have been traumatized it is important to account for the effects associated with retelling a traumatizing story on the researcher as well as participants (Ahearn, 2000). Many of the refugees in this study have lost a family member, and experienced atrocities associated with forced migration (Gozdziak, 2004). I was prepared to refer them to the mental health division at the Maricopa Medical Center for counseling or follow-up care if needed. Several of the refugee participants became sad as they shared their stories during the interviews. Participants were told that they could stop the interview process at any time and were not required to share any information with the

researcher they chose not to share. None of the participants dropped from the study, they were all able to complete the interviews.

### **Setting**

Although, the RWHC was the primary data collection site, other locations were used as needed. The interviews were conducted at a secluded place at the RWHC. All the healthcare providers were interviewed at the Maricopa Medical Center. Some refugee women were interviewed at their homes. Two women requested to be interviewed at the church after fellowship on a Wednesday evening. Women were observed in the clinic for their comfort level and interaction with providers. Those women interviewed at home were observed for their interaction with their children, spouses, and other family members. The RWHC was used as a site for observation as well as recruitment. This clinic is well known as the only clinic in the state of Arizona that provides culturally and linguistically competent services for refugee women specifically. I have chosen to use the name of the clinic in this study because of the requests of those in the Department of Obstetrics and Gynecology who permitted me to base my study in the clinic and who wished for its real name to be used.

Refugee Women's Health Clinic proved to be an ideal site on which to base a study of African refugee women's reproductive health experiences and

perception, as well as patient-provider relationships for a number of reasons. First, because of its reputation as the only clinic of its kind in the Phoenix area, RWHC serves as the most popular care center for refugee women with various reproductive health needs including pregnancy care, infertility, family planning, abortion, and cancer screenings. The hospital also serves as a primary care center for women's all-well examination. Thus, the clinic attempts to serve the reproductive health needs of a large population of mostly refugee women, including a rather significant population of African refugee women. It is these women and healthcare providers in the clinic who served as informants for my study.

In each of the settings, my role as a researcher was made explicit and privacy was considered and accounted for to insure confidentiality of subjects. It was necessary during the consent process to clearly communicate with the participants that their participation in this study had nothing to do with the services they received from the RWHC, and that they understood that their participation in the study was completely voluntary.

### **Data Collection**

The hallmark of qualitative research is the use of multiple methods to collect data and ongoing analysis (Omidian, 1999). Data were collected three

ways: 1) demographic questionnaire; 2) in-depth semi-structured interviews; and 3) observation. Data from each method were analyzed separately and then triangulated to arrive at common themes. I asked participants information on the demographic questionnaire as soon as they gave their verbal consent before proceeding to the interviews. Most of the interviews were recorded using a digital audio recorder. Fidelity was achieved with the use of recorder as data was reproduced exactly as the data became evident to me. I took extensive notes to record interviews when the participants declined being recorded. I also took notes on all participants to capture the non-verbal behavior or insights that occurred during the interviews. These notes were included in the data findings when relevant.

*Demographic Questionnaire:* was designed to elicit information sequentially according to three phases of forced migration: pre-migration, migration, and post-migration. The questionnaire elicited information about the country of origin of participants, if they arrived in the U.S unaccompanied or with family, age, and number of years they had spent in refugee camps or asylum. This information was important as it provided a context for their post-migration experience and provided information about the background and the experience of these women at each phase of the forced migration. Information was elicited

about which city in the U.S. the women were first resettled in, length of time there, and their experiences and the other resettlement locations prior to coming to Phoenix metro area. The questionnaire also elicited personal information such as number of years of formal education, language, ethnicity, employment, religion, health insurance status, and marital status, all of which are considered influential in women's health seeking pattern post-migration. The questionnaire was not used for the healthcare providers. Instead only their years of professional service and job title were needed.

*Observation:* According to Hammersley and Atkinson (1983; 2004), all social research takes the form of participant observation. It involves participating in the social world, in whatever role, and reflecting on the products of that participation. There are various ways to describe the roles that researchers take in the field. Hammersley and Atkinson (1983, p.93) define the different levels of participation corresponding to the amount of involvement and engagement of the researcher in the field. The different levels are: complete participant, participant observer, observer as participant, and the complete observer (Hammersley and Atkinson, 1983, p.93). These levels range on a continuum from complete immersion in the lives and culture of the participants to a more detached and outside role. The complete participant functions covertly as a researcher

completely immersed and subjectively involved in the world under study. Participant as observer is the more common term used by ethnographers who spend a considerable amount of time in the setting with informants in order to gain an “insider” perspective, yet they are open about their role as a researcher. The observer as participant is more detached and engages in selected activities. There is usually no confusion in the researcher’s role in observer as participant, as it is clear that the researcher is an “outsider” in the setting. The last category is the complete observer. This is the most objective and detached role for a researcher (Hammersley & Atkinson, 2005, p.104). However, there can never be a detached observer since we bring our perceptions and assumptions into the field.

In as much as I believe there is no such thing as completely objective detachment research, it must be kept in mind that when feminist researchers use conventional research methods, they adjust them to fit into the emancipatory stance of feminism. To this end, my role as an observer participant is used to denote the limited involvement of the researcher in the world of the participants under study. I made this distinction since my role as “observer participant” was considered to affect the behavior and interactions of the participants under study. In each setting my role as a researcher was made explicit. This was to avoid any suspicion about why I was observing and participating in events and activities and

also to clarify that my role had no effect on the services they receive at the Refugee Women's Health Clinic. The fact that participants' identity was confidential made it easy for them to express their views.

The following is a listing of specific sites and particular activities that were observed in this study.

*Refugee Women's Health Clinic:* The clinic is supported by the Maricopa Medical Center and is located in downtown Phoenix, Arizona. Observations at the clinic included watching the interaction between the refugee women and healthcare providers, the comfort level of the participants and whether they were unaccompanied. Observations of dress, body language, language skills, and where the women chose to seat were made and recorded in the field notes.

*Africa Faith Expressions Church:* The church is located in downtown Phoenix. This church is a religious and social center for many of the Liberian refugees that have been resettled in Phoenix metropolitan area. In addition to religious observances, it is used for many social events in the Liberian community. Observation at the church included women's social interaction with their family and community members. Observations of dress and songs from Africa were made.



*Women's Homes during the Individual Interviews:* I used an interpreter for all the interviews that were conducted at the women's homes because the women reported lack of English language skills. Observations were made of family interactions and relationships which contributed to an understanding of roles and cultural factors that were considered to influence reproductive health perceptions. The children were often present in the homes during the interviews, but were usually instructed by their mothers to remain in an adjacent room during the interviews. On some occasions, the women's husbands would come into the living room and say hello to me before proceeding outside. On different occasions, friends/neighbors of the participants would visit during the interviews and the interview session had to be interrupted until they left. This unexpected interruption provided an opportunity to observe the women in a social role in their homes. Observations in the home also included furnishings, decoration, and family pictures. Most of the living room decorations reflected their modest background.

*Field notes:* Notes were kept to document observations, my own feelings about what was being observed. Field notes were made of observations of participants' interaction with healthcare providers, interaction with friends at

home and church, and situations that existed in the site. The field notes reflected behaviors that could not be captured by interview questions.

*In-depth Semi-structured Interviews:* Participants' perceptions and beliefs are at the heart of qualitative research and this was the main motivation for conducting interviews. The refugee women and healthcare providers' perspectives were gained by conducting in-depth, semi-structured interviews with each participant. The interview questions were designed to reflect both the women's reproductive health experiences and healthcare providers' views on refugee patients. Examples of the questions that were asked are presented in the Interview Guide. The refugee women's interviews began with questions related to their pre-migration. Then information was sought about their experience in the U.S and how all these affect their reproductive health experiences. The healthcare providers interviews focused on them listing the challenges they have providing care for African refugee women. During the interview, it was important not to restrain the participants but to give them time to talk about how they understood and described their experience of reproductive health. These interviews lasted between thirty minutes and one hour and thirty minutes depending on how much the participant is willing to say.

I personally transcribed each interview, and the data from the demographic questionnaire and observation notes were added to each narrative. Word-for-word transcription was conducted “in order to allow the voices of the participants to speak” (Groenewald, 2004, p.14). A file for each interview was kept with the following documentation:

1. The completed demographic questionnaires
2. Notes made during the interview
3. Field notes made subsequent to each interview
4. Notes made during the data analysis, for example grouping of units of meaning into themes.

### **Data Analysis**

The researcher consulted with her faculty advisor in an ongoing manner to discuss the information as it was unfolding for data analysis purposes. Data analysis is considered both a rigorous and creative process in qualitative research. Data analysis involves interpretation that takes the data to a level of abstraction different from the original data (Morse, 2001). Data were analyzed during the process of collection. The data used for the analysis included direct quotes from participants whose beliefs, views, experiences and perceptions were revealed in the interviews. A distinctive feature of qualitative research is that understanding

from the data emerges as the analysis proceeds (Morse & Richards, 2002). Each source of data was analyzed separately and then triangulated for patterns, themes, and thematic linkages:

- Demographic Questionnaire: Information from the questionnaires was analyzed using descriptive techniques of reporting frequencies and averages of ages and number of years since resettlement, number of children, and education.
- Observation field notes were coded according to type, whether at the clinic, church, or participants' homes.
- Individual interviews- Data collected from each of the 30 personal interviews were grouped into two-refugee women and healthcare providers, explored and compared for recurring themes and meanings. The goal of the personal interviews was to compare the information obtained with that from other participants to arrive at shared meanings so that themes could be generated in the development of theory.

Data analysis proceeded according to the four steps laid out by Germain (2001). The first step was coding the data. Codes are labels assigned to units of meaning (Germain, 2001, p.296). The data were reviewed and designated by certain codes to identify categories of data that were relevant to answer the

research questions. This was accomplished by breaking the interview text and field notes into discrete segments by assigning units of meaning. Coding was important because it provided direct links to the original data.

The next step in the data analysis was to group the codes by combining similar codes into categories. Conceptual categories were developed from recurring patterns that emerged from the data and were used as a way of clustering the data for easier analysis. Development of conceptual categories is considered a central step in the process of analysis (Hammersley & Atkinson, 2005). Categories were then reviewed for emergent patterns or themes.

Data from all three methods, demographic questionnaires, interviews, and field notes, were triangulated to arrive at a cohesive whole that answered the research questions. Triangulation is a term borrowed from the nautical sciences to describe a process of “finding a position or location by means of bearings from two points” (Merriam-Webster, 2004, p.1335). In this study, triangulation refers to using two or more data collection methods to arrive at conclusions that could not be obtained using only one method (Duffy, 1987). After the data from the three different methods were analyzed separately, they were then triangulated and explored for recurring patterns or themes that contributed to knowledge about African refugee women’s reproductive health experiences and their relationship

with healthcare providers. The final analysis of the data and the conclusions reached were informed by the researcher's theoretical perspectives (Germain, 2001). In the final analysis, I attempted to avoid imposing my views on the data.

### **Data Security**

Identification of participants was done by assigning each participant a pseudonym. The digital recorder and field notes were kept in a locked file cabinet in the researcher's home. Once the data were transcribed, and checked for accuracy and analyzed, the other documents were destroyed. The transcript was stored in multiple locations- flash drive, CD-ROM, and online account.

## **Chapter 3**

### **REVIEW OF LITERATURE**

Previous feminist critiques have rendered problematic many aspects of refugee discourse and scholarship, and called for more attention to women and gender-based human rights violations. Today, the global image of the refugee is female, in part because there are currently more women refugees across the world, but also because a victimized female refugee plays into certain western tropes of feminizing the “other.” (Collins, 2000). There are currently more women refugees across the world. In this review of literature, I articulate the relevance of feminist theories in refugee scholarship. Feminist scholars from different intellectual traditions have approached refugee scholarship in terms of its gendered inequalities. The first strand of feminist writings is about the foundational in recognizing gender-based violence for asylum claims. The second strand of feminist engagement with refugee scholarship concerns the concept of women’s rights as human rights. This focused on addressing specific situations of women’s rights violations. Finally, feminist postcolonial and intersectionality scholarship focused on the myriad gendered exclusions and patterns of discrimination that are the legacy of colonialism in Africa and elsewhere.

Some feminists have been critical of universalization of human rights in the context of women's rights. Nivedita Menon (1996) argued that human rights were being universalized by the "rich and powerful countries of the North," that rights evolve in specific contexts and "any universalization is bound to reflect the interest of dominant groups rather than marginal ones." Yet the campaign for women's rights as human rights raised an international consciousness with women from many nations, colonial and postcolonial, participating, although hierarchically, in transnational connectivities that created a "common" goal (Grewal, 2005). The struggle to keep difference alive in women's human rights within a global arena was a difficult one, made even more difficult by the asymmetries of power of states and various women's groups.

The global feminism that emerged from women's international alliances was problematic can be best described as "the hegemony of first world women's groups to affect women's lives and women's groups worldwide by creating a "common agenda" that produced women as their subjects and as a target population." (Grewal & Kaplan, 1994; Mohanty, 1991). Global feminism constructed western feminists as saviors and rescuers of oppressed women elsewhere around the world. Discourses of rescue erased histories of colonialism, as well as economic and political repressions sanctioned by the powerful states of



the North. Hence, many have argued that global feminism became another means of “colonizing” the non-Western female subject by using discourses of “global sisterhood.” Cultural othering was prevalent among global feminists. The cultural narrative that represented the “African woman” constructed her as the victim of “traditional cultures.” Indeed, the “African woman,” and other minorities across the world, were to be rescued by Western feminists and all she needed to do was to explain her well founded fear of her culture to a panel of “Western saviors” in refugee camps through the involvement of the UNHCR to be granted an asylum opportunity to break free from her culture in the safety of the west.

Contemporary discourses of global or transnational feminism remain critical of the earlier notion of “global sisterhood” and its cultural and gender essentialization, and note also the uncritical attachment to commonalities to women’s oppressions around the globe. However, in this literature review I utilize a combination of feminist postcolonial and intersectionality theories, and human rights theory and empirical studies, partly because this mix allows me to articulate the issues of difference and inequality experienced by African refugees living in the U.S. versus those heroic constructs reminiscent of global feminism. The integration of postcolonial and intersectionality feminist theories in refugee scholarship allow us to explore how the non-Western other has been constructed

through contrasting images of the West (Anderson, 2000). In addition, intersectionality encourages us to explore the interconnectedness of forces that affect the everyday lives of refugee women in the post-migration. Further, a postcolonial lens helps us to understand how the views of refugee women are shaped by their experiences pre-migration and post-migration. This review of literature is divided into two sections: theoretical and empirical literatures. I now turn to the theoretical literature.

### **Theoretical Literature**

Theoretical frameworks elucidate social structures and social actions (Payne, 2005). The theories discussed in this study help us to critique various ideologies linked to refugee displacement and to understand the complex nature of the refugee system. Examining and linking various theories within the refugee context provides a well rounded perspective on refugee issues. For this dissertation, the frameworks of postcolonial, intersectionality and human rights theories are used as a foundation for emphasizing the refugee experience as a consequence of multiple social and political constraints which are embedded in the personal experiences of refugees. Examining and linking these theories within the refugee context provides diverse perspectives on refugee experience. It also provides an understanding of the complexity of issues facing refugees and allows

for the development of an effective and appropriate intervention by health care providers.

### **Postcolonial Theory**

Postcolonial theory is best conceptualized as a family of theories sharing a political, social and moral concern about the history and legacy of colonialism (Young, 2001). For over five decades, the term 'postcolonial' has proven an ambiguous intellectual site. Anderson (2002) points out that postcolonial has been taken:

To signify a time period (after colonial); a location (where the colonial was); a critique of the legacy of colonialism; an ideological backing for newly created states; a demonstration of the complicity of Western knowledge with colonial projects; or an argument that colonial engagements can reveal ambivalence, anxiety and instability deep within Western thought and practice.

As a political movement and academic interest, postcolonial theory critiques Western science as being the unique source of knowledge production to uncover health inequities resulting from colonization and neocolonization (Racine, 2009). The word postcolonial does not mean the end of the colonizing process; it provides a link that connects the past to the present. Therefore, postcolonial

theory is directed at uncovering the exclusionary effects of dominant ideologies in marginalizing other forms of knowledge. It interrogates traditional Western ideologies and thoughts about non-Western people, and tries to contextualize history (Philip, 2004). It challenges ideas of there being a universal standpoint on knowledge production (Quayson, 2000).

While many point to Edward Said's orientalism as signaling the beginning of postcolonial theory, others have asserted its origin in the earlier work of Frantz Fanon (1963), whose work applies psychoanalysis to postcolonialism, thus politicizing the personality of the oppressed. Fanon elaborated how unstable dichotomies produced through colonial practices shaped the identities and relationships of colonizer and the oppressed. More recently, Said, using Michel Foucault's notion of discourse, has examined the impact of the cultural construction of orientalism on colonial consciousness. But Homi Bhabha argues that Said asserts too readily the hegemony of colonial discourse. Bhabha has deconstructed colonial literary texts to reveal a destabilizing ambivalence within these Western discourses. Gayatri Spivak also uses the postcolonial site to emphasize the unrecognized persistence of alternative local knowledges, which sometimes might be retrieved by giving voice to those who are made mute in

colonial discourses. Spivak has focused on “epistemic violence”, the exclusions produced by colonial discourse and academic practice.

Postcolonial theory has thus often worked to destabilize, or at least challenge, the assumption that Western knowledge is objective, authoritative and universally applicable. Influenced by various disciplines, postcolonial theorizing precludes a single unified conceptualization. There are many concepts associated with postcolonial theory, including representation, culture, othering, subjectivity, subalternity, epistemic privilege, and identity. The concepts that seem most relevant to refugee health focus on issues of othering, identity and culture (Anderson, 2004). Hence, postcolonial theory provides the framework to look at the role of colonization in the development of the refugee problem. These issues often shape the overall experience of refugees.

For example, othering refers to the projection of assumed cultural characteristics, differences, or identities onto members of particular groups. Such projection is founded on stereotyped identities and has no basis in actual identities. Spivak (1998) cogently points out that othering created subalternity and subjugation among citizens. Most African women are constructed as passive victims of barbaric cultures who are prone to diseases due to sexism and lack of cultural awareness. These stereotypes tend to endure today and have an impact on

the way host communities relate to African refugee women. In health-care settings, this helps explain, for example, how assumptions about African women as culturally submissive and unaware can unwittingly shape health care providers' views of patients (Browne, 2003). Hence, a postcolonial perspective pays attention to the voices of the historically 'Othered'. This is not to suggest that postcolonial theory has supplanted dominant western discourses, however.

Postcolonialism, a discourse from the perspective of the colonized provides another perspective that was once ignored, as regards the knowledge production process, and it redefines who has the right to produce knowledge and who has the power to speak for whom. Bhabha (1994) further explains the notion of postcolonialism:

Postcoloniality, for its part, is a salutary reminder of the persistent 'neo-colonial' relations within the new world order and the multinational division of labor. Such a perspective enables the authentication of histories of exploitation and the evolution of strategies of resistance (p.6).

Bhabha highlights how resistance and change occur when examining the historical, political, economic, and cultural factors that intersect with racism, sexism, and classism to influence the health of non-Western populations. As Bhabha (1994) points out it is from those who have suffered the sentence of

history-subjugation, domination, diaspora, displacement- that we learn our most enduring lessons for living and thinking. Coyte and Holmes (2006) argue that postcolonialism is a means of addressing health disparities stemming from social inequalities in a globalized world marked by structural factors that perpetuate injustice through neoliberal policies that govern healthcare delivery.

There are many ways one might engage with postcolonial theory. I interpret the postcolonial as providing the framework for interrupting ahistorical, generalizing, racializing, culturalist, and essentialist discourses which have categorized people according to racial categories and hierarchies. These hierarchies carry implications of superiority and inferiority. Cashmore (1988) points out that racialization is a political and ideological process by which particular populations are identified by direct or indirect reference to their real or imagined phenotypical characteristics. Racial categories are usually aligned with particular cultural attributes seen to determine social behavior. These constructions of race and culture are by no means benign. As Allman (1992) and Barbee and Little (1993) have argued, racialization has profound consequences on health care delivery in the United States.

Postcolonialism provides a framework for challenging the fixity of race and culture. It directs attention to race and racialization as socially produced

through historical, socio-economic and political processes of colonization and imperialism. It challenges the unitary notion of culture and contests images and representations of the essentialized cultural 'other'. Importing such conceptualizations of race and culture into feminist health research would transform racialized and culturalist notions into a view of race as socially constructed, and culture as fluid and dynamic. Such a perspective would illuminate the political and historical processes that have shaped what we take as the culture of the racialized other. From a postcolonial vantage point, we might come to understand that the difficulties African refugees face in accessing and utilizing reproductive health care may not be due to their 'culture', but instead, to historical processes that have produced systemic inequities and oppression (Anderson, 2000; Stubbs, 1993). Given population movements in the postcolonial era, Bhabha's insights into race, culture and hybridity seem especially important to health research and practice in the United States.

As postcolonial subjects, African refugees engage in a different kind of border-crossing characterized by oppression, displacement, trauma, and domination. Recognizing African refugees as postcolonial subjects compels us to question and scrutinize the historical, political, and social contexts from which refugees are produced. This challenges how we think about the countries that



produce refugees and those countries that provide resettlement in regards to the dominant discourses about refugees. The argument I make here is that the dominant discourse on African refugees needs to focus attention on postcolonial displacements, and the contemporary constructions of ethnicity, national origin, and culture as they continue to create patterns of inclusion and exclusion in health care settings. The existing health disparities between refugees and their host community sheds light on the unequal power relations that are the legacy of the colonial past and postcolonial present (Anderson, 2000; Reimer-Kirkham & Anderson, 2002).

Gagne (1998) proposed a theory to explain colonial domination and dependency on indigenous people. She provides a postcolonial perspective which establishes the connection between colonialism and social and psychological consequences. This framework may be revisited within the context of refugee experience. Colonial policies and manipulations of geographical borders promoted socio-political dependency, questionable borders, and anarchy. For example, at the end of colonial era in Africa, inter-ethnic rivalries came to the surface during the fight for control of the emerging nations. In some cases, such as Sudan, a protracted civil war has developed from secessionist movements. Consequently, inter-ethnic conflict remains one of the major causes for refugee

migration in Africa. In addition to the ethnic and geographical tensions that became the legacy of postcolonial Africa, the postcolonial nation states in Africa were typically modeled after the value system of the colonizer. The civil war in Rwanda exemplifies how the relationship between the powerful colonizer and the powerless colonized was extended along ethnic lines in postcolonial Africa. Consistent with the colonization theories of Memmi (1969) and Fanon (1963), lengthy periods of colonization promoted the superiority of the European colonizer which the Hutus assumed, thereby relegating the Tutsis to inferior status. Hence, during the civil war in Rwanda, oppression and discrimination were subsequently extended in a similar manner, as in the relationship between the colonized and colonizer, that is, between the powerful Hutus and the powerless Tutsis.

Postcolonial theorists argue that colonization influenced the implementation of neo-liberal economic policies, such as structural adjustment programs during the postcolonial era. This resulted in further impoverishment of poor nations whose governments coercively signed onto impossible loan conditions and thus were unable to meet the basic needs of their citizens (Hyndman, 2000; Stein, 1998). At the same time, wealthy nations which gave out these predatory loans continued to intervene in the internal issues of these poor

countries in the guise of humanitarian aid (Hyndman, 1999; 1996). The demand for scarce resources and ethnocentrism often associated with rationing of public assistance has dire consequences and in some cases can lead to conflict situations that displace people, thereby adding to the refugee problem in Africa.

Postcolonial theorists examine the refugee problem by detailing the difficulties of displaced persons resettled in developed countries. Stein (1998) argues that the process of selecting who is admitted as a refugee gives host countries enormous power to restrict certain individuals. Hyndman (2000) points out that governments of wealthy nations use migration policies as a form of population control. As the process of admitting refugees to wealthy nations often requires extensive screening and assessment, refugee migration policies are designed to exclude certain individuals who do not meet the criteria.

Quayson (2000) argues that postcolonial theory challenges the status quo by examining structural factors that interact with race, gender, culture and class to shape people's lived experience. However, postcolonial theory on its own typically does not address the issue of gender. In combining postcolonial theory and feminist theories, postcolonial feminist theory focuses on epistemological and methodological assumptions to assess how subordination is intertwined with patriarchy, traditionalism, and modernity in affecting the everyday lives of

racialized women and men (Racine, 2009). More precisely, postcolonial feminism is aimed at disrupting the relations of ruling that silence the culturally different other and exploring the power relations that pervade patient/provider encounters in order to develop transformative knowledge aimed at correcting health inequities arising from social discrepancies affecting non-Western people (Racine, 2003).

Meleis and Im (1999) assert that cultural theories in nursing have made non-Western populations and refugees “stereotyped, rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized, and ordered around” (p.95). They suggest postcolonial theory as an alternative to cultural theories to explore issues of racialization and marginalization in health care from a broader epistemological platform. Postcolonial feminist theory strengthens research endeavors because the focus is not only on examining gender discrimination but on unveiling and critiquing the interlocking system of oppression composed by race, gender, ethnicity, and social class. Anderson (2000) points out that postcolonial feminism must critically examine how migration and racism are ideologically and socially constructed within the discourses of racialization and marginalization. She further explains that if not critically examined within the specific and multiple contexts of oppression,

people's experiences of racism and marginalization can be translated into fixed identities of 'oppressed' and 'oppressor' similar to that of the 'colonizer' and the 'colonized'.

Most importantly, postcolonial feminist theory recognizes the need for knowledge construction from the perspective of the marginalized female subject whose voice has been silenced in the knowledge production process. This is important in examining the patient/provider relationship of refugee women, especially as the conceptualization of health care in American society has been developed from the perspective of Western science and biomedicine (Lock and Gordon, 1998). This underscores the need to explore feminist scholarship from the vantage point of the postcolonial female subject and emphasizes that knowledge production must be linked to specific social locations.

Hyndman (2000) utilizes postcolonial feminist theory to explain how gender plays a significant role in determining whether a refugee's application to seek asylum is successful or not, a decision which ultimately results in further trauma. Hyndman cites Refugee Board hearings as being insensitive when they intervene with female refugees. For example, female refugees are required to provide a medical certificate to prove they have been raped, and this requirement is applicable to all female refugees regardless of culture, age, class, marital status,

or ethnicity (Crepeau, Foxen, Houle & Rousseau, 2000). Women refugees have the same level of traumatic experience as men during their pre-migration/migration and settlement period, but they also have experiences unique to women.

### **Intersectionality**

This dissertation utilizes intersectionality as a theoretical framework to critically assess our understanding of the complexity of issues that constitute refugee women's reproductive health experiences. Contributions to the development of intersectionality theory can be traced to the early work on exclusionary theorizing about gender in women's studies in which "all the women are white, all the blacks are men, but some of us are brave", as the title of an important reader stated (Hull, Scott, & Smith, 1982). Statements expressing a distinctive "woman of color" standpoint (Combahee River Collective, 1986; hooks, 1981) joined with Patricia Hill Collins' (1990) influential articulation of standpoint theory as black feminist thought to emphasize the effects of multiple forms of oppression experienced in particular social locations.

As Deborah King (1988) puts it, thinking in terms of "multiple jeopardy" challenges the idea that "each discrimination has a single, direct and independent effect on status, wherein the relative contribution of each is readily apparent as

well as the non-productive assertions that one factor can and should supplant the other” (p.46). Feminist scholars increasingly present race, class, and gender as closely intertwined and argue that these forms of stratification need to be studied in relation to each other, conceptualizing them, for example as a “matrix of domination” (Collins, 1990), “complex inequality” ( McCall, 2001), “integrative” (Glenn, 1999), or as a race-class-gender complex (Pascale, 2007).

In an influential article published in the *Stanford Law Review*, critical race scholar Kimberle Crenshaw (1991) gave this concern the now internationally recognized label “intersectionality”. She emphasized locating distinctive standpoints that could reveal complicated and contested configurations of power. However, the woman of color perspective that was to be included was not necessarily formulated only by researchers who belonged to these marginalized groups, but it privileged a political and social standpoint that actively moved their experiences “from margin to center” of theorizing (Collins, 1990; hooks, 1984). Crenshaw explicates the intersectionality of race and gender:

The experiences Black women face are not subsumed within the traditional boundaries of race or gender discrimination as these boundaries are currently understood, and...the intersection of racism and sexism factors into Black women’s lives in ways that cannot be captured wholly

by looking at the race or gender dimensions of those experiences separately.

Crenshaw further argues that the focus on the intersections of race and gender illuminates the need to account for multiple grounds of identity when considering how the social world is constructed (1991, p.1245). Hence, intersectionality theory argues for a broader definition of what it means to be a black woman: one that does not compartmentalize gender or race but centers multiple identities. Black women's lives, for example, are better understood when race and gender are perceived as intertwined and inseparable (Crenshaw, 1989; 1991).

By emphasizing the differences among women, these scholars not only countered the unwarranted universalizing of white middle-class American women's experiences as "women's" but began a productive line of theorizing about how lived experiences of oppression cannot be separated into those due to gender, on the one hand, and those due to race, on the other, but rather are simultaneous and linked (Brewer, 1993; Glenn, 2002). Moreover, this analysis highlighted the implications of such intersections for practical politics since "women of color are situated within at least two subordinated groups that frequently pursue conflicting political agendas" (Crenshaw, 1991, p.1246).



At the core of intersectionality theory is the understanding that individuals occupy complex and dynamic social locations, where specific identities can be more or less salient depending on the historical or situational context. Social categories such as gender, race, ethnicity, religious affiliation, and sexual orientation are central concepts of interest in intersectionality-grounded research. From an intersectionality perspective, social categories are historically grounded and socially constructed, and work at both micro and macro structural levels (Burgess-Proctor, 2006; Weber & Parra-Medina, 2003). Accordingly, this concept provides the framework to militate against essentializing or assuming that all African refugee women share the same experiences, perspectives, and reproductive health needs. Hence, this research moves beyond single categories of analysis by considering simultaneous interactions among different aspects of African refugee women's social identity such as ethnicity, nationality, age, class, employment status, pre-migration and post-migration experience, and religion, and their various views in relations to health care providers. As argued by feminist scholars, intersectionality shows how thinking beyond a single category helps contextualize the experience of women in the interstices of social relations (Weldon, 2005; Collins, 1995; Crenshaw, 1989).

Reflecting its origins, the theoretical concept of intersectionality makes visible the complexities that constitute everyday life and the power relations that are central to it (Phoenix and Pattynama, 2006, p.187). It refers to multiple oppressions that are simultaneous (that is, gender and ethnicity and class, etc.), inseparable (for example, the impact of ethnicity cannot be isolated from the impact of gender), and intertwined (for example, ethnicity and gender are mutually significant in everyday life). Consequently, groups and communities do not occupy a subordinate position by virtue of some inherent identity (for example, their culture or religion), but rather acquire this position as the outcome of socio-historical and political processes. Moreover, they may be positioned in contradictory ways, being advantaged in some aspects (perhaps by virtue of being middle class) and disadvantaged in others (perhaps by virtue of being Black). Consequently, the intersectionality framework is very suitable for highlighting hybrid positions and identities associated with diversity.

Feminist scholarship, within women and gender studies and other disciplines, has embraced the call for intersectional analysis, leading McCall (2005), to call intersectionality theory the most important theoretical contribution to emerge from women's studies so far. The significance of intersectionality is not so much that it maps out multiple identities, but that it shows the fluidity of power

in regards to time and space. By placing primary attention on the construction of multiple social inequalities as they are simultaneously produced, this research is particularly well-suited to explicate African refugee women's reproductive health issues and the power dynamics between refugee women and health care providers. As feminist women's health scholars (Clarke and Olsen, 1999; Krieger et al, 1993; Ruzek et al, 1997; Zambrana, 2001; Schultz and Mullings, 2007) have aptly demonstrated, intersectionality problematizes and seeks ways to revision women's health in a more complex and inclusive way taking seriously the intersectional processes that co-construct inequality and women's health.

Intersectionality theory provides a comprehensive foundation for interrogating the multiple ways that pre-migration and post-migration experiences shape refugee women's reproductive health across their lifespans. Refugee reproductive health highlights the intersections of gender, race, ethnicity, class, migration, and cultural identity. Krieger (2003), Weber (2006), and McGibbon and Etowa (2007) explored the health impacts that result when social factors intersect with identities such as race, class, and gender, and furthered the thinking about intersectionality to include the ways in which geographical locations are antecedents of compromised health outcomes. This is true for refugees who were survivors of geographically-based violence, and having been displaced, had to

travel across various countries and be subjected to all kinds of inhabitable conditions before a final resettlement.

By focusing on the social construction of inequality and centering research on the perspectives of multiply oppressed individuals and groups, intersectionality theory provides situated knowledge that raises new questions and presents new opportunities for understanding African refugee women's reproductive health experiences. An intersectional approach emphasizes that when we make social distinctions we construct differences and opt for indifference to similarities. Importantly, such social distinctions can be conceptualized in terms of a number of dimensions, including cultural and social. As such, intersectionality shifts attention to the individual's social positioning at the intersection of a complex set of social relations. Intersectionality refers to social groups, individual identities, and the connection between the two, but within this social constructionist framework the macro and micro levels are not reducible to one other (Phoenix and Pattynama, 2006). By encompassing several social differences, an intersectionality framework highlights the simultaneity of similarity and difference; that is, an individual can be both similar (same race) and different (female rather than male) from others depending on the context of comparison.

Moreover when and where particular differences matter is subject to variations of time and place.

Within the feminist health research literature, some attention has been paid to the practical worth of using intersectionality to conceptualize difference in the women's health context. Robinson (1993), an early advocate of intersectionality, argued that disadvantaged gender, race, class and cultural positions may provoke feelings of powerlessness and, by breaking the silence about the enormity of those intersections while also focusing on patients' strengths, health care providers might encourage their patients' empowerment. She argued further that this would enable them to accept their realities, reframe the situation, and resist the internalization of negative behaviors and attitudes. More recently, Chantler (2005) suggested that incorporating intersectionality in person-centered health care may address the structural dimensions of inequality in patients' experiences of racial and sexual abuse, and limited access to health care services due to lack of transportation, preferred language or preferred gender of provider.

In addition, Salazar and Abrams (2005) created a tool to conceptualize the patient's self-perceptions in relation to a number of cultural groups as interwoven and at times inseparable by utilizing intersectionality to connect racial/cultural identity with marginalization within oppressive systems such as sexism. Their

stated aim is to support development towards increasing levels of awareness and empowerment. Such explorations reflect a burgeoning interest in finding new ways to incorporate social and political differences into the health context, articulating power relations in patients' lives and acknowledging patients' perspectives.

In their book *Gender, Race, Class and Health: Intersectional Approaches* (2006) Schultz and Mullings challenge disciplinary boundaries and provide an overview of what an intersectional approach may mean for health care specifically meeting the needs of diverse groups. On the one hand, intersectionality points toward new perspectives on understanding the health problems of diverse social groups. On the other hand, it raises questions as to how to address the plethora of issues that affect the health of diverse social groups, bearing in mind that these issues are related and simultaneously impact individuals' lives.

Burman (2004) provides the most detailed example of an intersectionality-inspired health research analysis. She argues in favor of including multiple social differences to avoid reproduction of existing power hierarchies by health care providers and policy makers. For example, when culture is privileged over gender, problems like domestic violence and female circumcision (the two issues

she focused on) are defined as a private matter; that is, as “culturally specific” practices that are the concern of a particular cultural community and therefore are not matters to be addressed by the regular health care system. Also, discourses of ethnic specificity and specialization may lead health care providers to simply assume that consulting room encounters will include cultural and language barriers. Such discourses contribute to race anxiety, whereby health care providers may not offer available health care expertise and treatments because they feel ill prepared and worry about being inappropriate and possibly be accused of racism. Instead, patients may be referred to resources available in their cultural communities. Poor health may result when there are simply no comparable services and patients may avoid services within their cultural communities, especially smaller ones, because confidentiality is an issue. That is, seeking those services may publicly expose the nature of the individual’s health problem. Burman argues further that policies and laws, for example, regarding immigration and residency status, may result in certain women being excluded from the health care system. In her view an intersectionality framework that draws attention to similarities as well as differences can serve to disrupt the processes that obscure or exacerbate certain health-related problems, impede inadequate care, and exclude some people from the reproductive health care system.

McCall (2005) and Gressgard (2008) have discussed intersectionality theory within the context of complexity, thus underscoring methodological and practical challenges when the subjects of analysis expand to include multiple dimensions of social life and categories of analysis. McCall described three categories to explore the complexity of intersectionality in social life: anticategorical, intercategorical, and intracategorical complexity. McCall problematizes the assignment of categories of identity (for example, race, ethnicity, class) and discusses the ethical and theoretical implications of categorizations in intersectionality theory. These distinctions in feminist intersectionality theory are consistent with my use of the word complexity in this research. Intersectionality theory creates a view into the complex landscape of inequality and social exclusion. These everyday experiences illustrate how intersectionality operates in the life of refugee women and their families. Although the individual struggles in the stories may not be overwhelming, it is the synergy of classism, displacement, religious intolerance, ethnic discrimination, sexism, and racism that must be unpacked to appreciate the hardship experienced by refugee families.

Hancock (2007) provides useful historical reviews of the different theoretical needs that led to the emergence of the concept of intersectionality in



the first place and the variation that remains in how it is understood and applied today. This research builds on Hancock's comprehensive reviews to highlight two dimensions of theorizing that have become part of what intersectionality signifies: the importance of including the perspectives of multiply-marginalized individuals/groups, particularly women of color, and an analytic shift towards explicating multiple institutions as overlapping in their co-determination of inequalities to produce complex configurations from the start, rather than as extra interactive processes that are added onto main effects (Choo & Ferree, 2010). Furthering the use of intersectionality theory in women's health research, the analytical chapters in this dissertation emphasize the inclusion of refugee women and health care providers' perspectives, thereby not focusing only on those on the margins of society.

Part of the utility of intersectionality theory is to give voice to the particularity of the perspectives and needs of women of color who often remained invisible as women even when they were organizing on "separate roads" to express feminist demands (Roth, 2004), and invisible as Blacks despite their significant contributions to the American civil rights movement (Robnett, 1997). Because women of color argued that their oppression was experienced in a qualitatively different way, their experience required distinctive attention in order

to see “how race, gender, and class, as categories of difference, do not parallel but instead intersect and confirm each other” (Espiritu, 2000, p.1). These qualitative differences made achieving “voice” a significant intellectual and political demand, since only by inclusion of the perspectives of these groups could the political issues emerging from their experiences be addressed by policy-relevant scholarship. Inclusion is therefore hardly a trivial concern, and a long line of path-breaking studies by women of color developed this race-gender analysis.

Utilizing intersectional approaches in the reproductive health context stands out for me because there has been persistent emphasis on the importance of provider cultural competence and the need to be sensitive to the patient’s cultural background and ethnic identities. Furthermore, I envision a synergy between biomedicine’s concern for refugee women’s reproductive health and the interdisciplinary field of women and gender studies, with biomedicine contributing to the interdisciplinary dialogue on intersectionality through direct interaction with patients and research related to reproductive health and women and gender studies contributing to biomedicine through the theoretical and methodological debates related to intersectionality. Such synergy between a traditional academic discipline and the interdisciplinary field of women and gender studies remains exceptional (McCall, 2005).

## **Human Rights**

This study argues that reproductive health rights in the United States, and elsewhere, should be seen as a basic human right which will contribute to refugees' antecedent integration in their host communities. The study has been conducted based on the principle that refugee women's reproductive health rights are women's rights and the promotion, protection and fulfillment of these rights should be endorsed by all. Refugee health is not only a women's rights issue, but should be recognized as an important factor for integration. It is argued that refugees in a state of well-being would be more inclined to contribute to their host communities.

The earliest delineation of health as a human right in the modern era is contained in the constitution of the World Health Organization (WHO). In that document, WHO defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmities" (WHO, 1993). This definition, dating back to 1946 and promulgated by the international body charged with setting policy and monitoring health concerns worldwide, reveals that health has long been viewed broadly as an issue that encompasses the totality of factors and conditions in life. It further demonstrates a concern with

protecting an affirmative state of being, rather than simply an absence of a negative condition of illness or infirmity.

The importance of human rights became widely recognized after the atrocities of World War II. The promotion of human rights became a core objective of the United Nations when it was founded in 1945. Then in 1948, the UN General Assembly adopted the Universal Declaration of Human Rights (UNDHR), a document setting out a list of basic rights as a common standard of achievement for all peoples and all nations. This declaration provides the foundational document for present-day conceptualization and articulation of human rights and provides the guiding principle for the establishment of the 1951 Convention relating to the Status of Refugees (also known as the Refugee Convention). The Refugee Convention recognized the social and humanitarian nature of the problem of refugees as well as the heavy burden that granting asylum may impose on certain countries. The Refugee Convention is dedicated to the protection of refugees and other populations displaced by conflict, famine, and natural disasters. Its mandate is to lead and coordinate international action for the protection of refugees and the resolution of refugee problems worldwide. Refugees are granted a special status under international law. Once a person is considered a refugee that individual automatically has certain rights, and states

that are parties to the Refugee Convention and its protocol are obligated to provide certain resources and protection.

Article 25 of UDHR states that, “everyone has the right to the standard of living adequate for health and well-being of himself and his family including food, clothing, housing and medical care”. Although the drafters’ use of the phrase “him and his family” can be perceived as gendered, I believe it is safe to assume that this language was intended to mean all people and not just males. However, Wright (1988) points out that “the language of human rights is purposely drafted and is a modern euphemism for the “rights of man” which has meant, for the most of their history, “men’s rights” in the literal gender-specific masculinist sense of the word” (p. 242).

In 1994, at the UN-sponsored International Conference on Population and Development (ICPD) held in Cairo, feminist scholars and activists from around the world articulated the meaning of reproductive health as a basic human right. The Program of Action that emerged from ICPD defines reproductive health,

As a state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes...Implicit in this is the right of men and women to be informed

and to have access to safe, effective, affordable, and acceptable health-care services that will enable their reproductive well-being (ICPD, 1994).

Chapter 10, section D of the ICPD program of action addressed the rights of refugees. It states that,

Governments should...strengthen their support for international activities to protect and assist refugees...Refugees should be provided with access to adequate accommodation, education, health services, including family planning, and other necessary social services (ICPD, 1994).

A major achievement of this conference was the recognition of the responsibility of governments to translate international commitments into national laws and policies that promote reproductive health.

The outcome of ICPD made reproductive health a human right, and like all other human rights, it is also applicable to refugees. To realize this right, refugees must have access to comprehensive reproductive health information and services so they are free to make informed choices about their health and well-being. Human rights increasingly form part of the language and approach of many international organizations, governments, nongovernmental organizations and civil society groups concerned with refugee women's reproductive health. This

application is now so widely accepted that human rights have been named as a guiding principle in the WHO's (2004) reproductive health strategy.

Meron (1998) and Wright (1998) point out that reproductive health as a human right should not be viewed as an additional right that women are trying to include with other rights. It is, rather, an independent free-standing right that is intertwined with other rights; one that should be recognized and treated on equal footing with other human rights. When health is viewed in that broad context, it becomes clear that there cannot be any meaningful protection of health as well being without protection of other basic human rights. The recognition of the right to health imposes an obligation upon states to respect, protect, and fulfill the aspirations implied in the WHO's definition of health.

Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) dictates, "that state parties shall take all the appropriate measures to eliminate the discrimination against women in the field of health care, in order to ensure, on the basis of equality between men and women, of access to health services, including those related to family planning" (CEDAW, 1979). This language specifically deems unequal access to health care as a discrimination that must be addressed and eliminated in order for signatories to CEDAW to be in compliance with their obligations under the convention.

Thus, CEDAW does not create a new right but rather, frames health as an issue of equality for women relative to the health care and medical treatment received by men.

Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health therefore implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (WHO, 2000). Implicit in this is the right of refugee women to be informed of and to have access to safe, effective, affordable and acceptable reproductive health care services during pre-migration, migration and post-migration phases of their experience.

A human rights framework identifies the civil, political, economic, social, and cultural dimensions of life that are linked to, and may even be determinant of, reproductive health status. Reproductive health care is one area where the link between assistance and protection are critically important. Health workers often become aware of the special health problems of refugee women when women who have been sexually abused seek medical care (Gilbert, 1995). In recent



years, UNHCR has recognized the gravity of the problem of sexual violence against refugee women and has taken measures to combat it (UNHCR, 1994). Gilbert (1995) points out that even though violence against women often has far-reaching implications for women's reproductive health, such as unwanted pregnancies and sexually transmitted diseases (including HIV/AIDS), human rights standards are not invoked in refugee contexts to further women's access to vital social services including reproductive health care.

The relationship between human rights and the refugee problem is evident as violations of human rights are not only among the major causes of mass exoduses but also rule out the option of voluntary repatriation for as long as they persist. Violations of rights of minorities and ethnic conflicts are increasingly at the source of displacement and refugee migration. Disregard for the minimum rights of refugees is another dimension of the relationship between the two issues. During the process of seeking asylum, a growing number of people are faced with restrictive measures which deny them access to safe territories. In some instances, refugees are detained or forcibly returned to areas where their lives, liberty and security are threatened. Refugees are also victims of racist aggression in their host communities. A rights-based approach can be used to protect refugee women from sexual violence and abuse. It can also be applied to promote the progressive

realization of refugee women's economic, social, cultural, and reproductive rights, including the right to decide freely and responsibly the number, spacing, and timing of their children, to have the information and means to do so, and to have the right to attain the highest standard of reproductive health.

### **Empirical Literature**

The empirical literature examines refugees' pre-migration and post-migration experiences and their impact on their reproductive health and well being. It details not only the micro issues but also the macro-level problems such as specificities of the host country's health care system. An understanding of refugees' pre-migration and post-migration experiences provides us with insight into refugees' unique struggles, and enables health care providers to understand the context in which most refugees view their health. Acknowledging the migratory journey which includes pre-migration and post-migration experiences, moderated by the host country situation, will assist health care providers in comprehending refugees' experiences which may affect their reproductive health. This section also details the concept of patient-provider relationship which is necessary in understanding how refugee women interact with their providers.

## **Refugee Categorization**

With large scale migration, the categorization of refugees has gained greater attention from theorists. Despite critiques from some scholars regarding the politics of categorization (Crosby, 2006; Hyndman, 2000), these theories are still widely used to understand refugee migration. E.F. Kunz's (1973) model of refugee theory provides insights on refugees' attitudes towards displacement. Kunz (1973) points out that most refugees conform to two categories- anticipatory refugee movement and acute refugee movement (Collins, 1996).

Anticipatory refugees are those who sense danger early, thus allowing an orderly departure before the crisis occurs. They are often accompanied by their entire family with their resources intact and prepared for a new life. This group of refugees migrates once they find a country willing to take them in. Acute refugees, on the other hand, are unprepared for the crisis. They respond to an overwhelming push where people are forced to leave their homeland on a moment's notice. Due to the unpreparedness with this group of refugees, they concentrate on simply surviving the disaster zone (Kunz, 1973). As little thought is given to the consequences of their flight, there is an increased risk of acute refugees experiencing or witnessing traumatic events, and they are therefore more likely to require help coping with their struggles. Once a place of asylum is

reached, often in a state of shock, acute refugees have a difficult choice to make: return home, seek to remain in the place of asylum, or accept another distant resettlement opportunity in a third country, mostly Western nations. Also, acute refugees are often lacking in education, job skills and finances (Zhou, 2001). Since the 1990s, most refugees fleeing from violence in Iraq, the Balkans, Afghanistan, and Sub-Saharan Africa have belonged to the acute refugee category. Most African refugees fall into the acute refugee category and have lived in a second country prior to resettling in the United States. Since most African refugee women are in the acute category, they are unlikely to have high levels of education or vocational skills.

Paludan (1974) proposed an expansion of refugee theory: new versus traditional refugees. New refugees are racially, ethnically, and culturally different from their hosts, they come from less developed countries at a greatly different stage of development than the host country, and they are likely to lack kin and/or potential support groups in their country of resettlement. Traditional refugees, on the contrary, are culturally and ethnically similar to the people in their host country, come from societies whose levels of development are similar, and are likely to be welcomed and assisted by family and friends who know their language and can cushion their adjustment.

For example, most African refugees seek asylum in neighboring African countries due to geographical proximity. These African refugees in Africa would be considered traditional refugees. Meanwhile, during the past three decades, a significant number of African refugees have been resettled in the United States. This group of refugees would be considered new refugees because they had to become accustomed to a new language and culture. Paludan asserts that differences between new and traditional refugees can influence certain patterns of settlement behavior (1981).

Kunz's later work (1981) classified refugees' flight and settlement patterns into three distinct categories. Those refugees whose opposition to political and social events at home shared is by their compatriots, both refugees and those who remain in the home areas, are called majority-identified refugees. Refugees who have left their home areas because of overt or covert discrimination against a group to which they belong frequently retain little interest in what occurs in their former homes once they have left. Kunz refers to these refugees, who feel irreconcilably alienated from their fellow citizens, as events-related refugees. A third type of refugee includes people who decided to leave their home country for a variety of individual reasons. These self-alienated refugees feel alienated from their society not by any active policy of that society, but rather by

some personal philosophy. Host countries often treat refugees based on the categories they belong to. The United Nations High Commissioner for Refugees (UNHCR) gives priority to refugees leaving countries due to socio-political reasons (that is, majority- identified refugees), typically those who are from pro-Western countries (Stein, 1998). Most of the time, self-alienated refugees and events- related refugees do not receive enough attention from host countries.

### **Pre-migration**

Before coming to the United States, refugee women are typically exposed, directly or indirectly, to a range of pre-migration issues. Like other areas of refugee research, studies on refugee pre-migration experiences are based primarily on Southeast Asian and European refugees, and less on refugees from Africa. An example of this is found in Hollified et.al's (2002) review of over 300 studies measuring trauma among refugees; all but one of these studies were based on Southeast Asian refugees, with the only one exception being a Latin American sample. None of these studies mentioned or acknowledged the existence of African refugees.

Refugees can face a long period of displacement, flight and settling, often carrying with them the pain that caused them to flee their homes/countries of origin. For many refugees the process of settling and adapting to a new

community and culture can be equally traumatic (White, 2004). Given the unprepared nature of refugee migration, they tend to be at great risk of discrimination and violence compared to other migrant groups (Kunz, 1981). Schriver (2001) points to the importance of understanding the social environment that affects human behavior. In the case of refugees, health care providers need to understand the individual's as well as the host community's social, cultural and political environment and how it relates to refugees' perception of health.

Many refugees spend months and even years in refugee camps set up by the UNHCR in neighboring countries. Although women in these camps are safe from the bombing and gunfire, they often experience sexual or physical abuse, lack of food, inadequate health care, isolation, and severe emotional trauma (Cardozo, Talley, & Crawford, 2006). Commenting on refugee camps, Crisp (2001) notes the lack of funding from the UNHCR and the failure to promote sustainability and development in these communities, thus promoting a cycle of dependency for aid recipients. Shanks and Schull (2000) point out the occurrence of gender-based violence in refugee camps, asserting that the perpetrators of violence are often the peacekeepers, who have coerced women to engage in sexual activity in return for food (Black, 1998; Hynes, 2004).

Researchers assessing pre-migration experiences have collected data from refugees who were living in temporary settlement locations (usually refugee camps close to the border of their home country) and also those who have been permanently resettled (usually in Western countries). Occurrences have been measured in simple terms such as adding up the number of refugees in a sample who respond “yes” when asked whether or not they had been displaced within their home country before resettlement (Simich, Hamilton, & Baya, 2006), and in more sophisticated ways, such as using the Harvard Trauma Questionnaire, a standardized instrument designed to assess for particular traumatic experiences common to Southeast Asian refugees (Mollica et al, 1992). Some of the common experiences that have been assessed are displacements (fleeing), violence against themselves or their family members, witnessing violent events, separation from family members, and forms of torture or persecution. A principal components analysis of pre-migration events reported by Bosnian refugees yielded four trauma dimensions: human rights violations, dispossession and eviction, life threat, and traumatic loss (Momartin, Silove, Manicavasagar, & Steel, 2004).

Adams, Gardiner, and Assefi (2004) point out that the circumstances of war and famine, which have created refugee crises, generally affect basic amenities, services and infrastructure in sub-Saharan Africa. This disruption, in



turn, contributes to limited availability of health services, reproductive services, antenatal care and immunization against disease. All are key factors for reproductive well-being. This limited access to services adds to the conundrum of poorer pre- migration health for African refugee women (Krause et al., 2002) who are typically exposed to malaria, malnutrition, and poor reproductive health care prior to migrating (Springer, et al 2010). Some studies note that many African refugees are malnourished (Hampshire et al, 2004; Ukoko, 2005) which contributes to iron-deficiency anemia and poorer immunity (Adam, Khamis, & Elbashir, 2005). Similarly, psychological trauma associated with political conflict and displacement contributes to poorer reproductive health (Harris, Humphries, & Nabb, 2006; Schweitzer, Melville, Steel et al, 2006).

Many African refugee women have been circumcised prior to migration. The WHO (2000) defines female circumcision as a procedure that involves the partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious, or other non-therapeutic reasons. Banks et al (2006) define female circumcision according to the degree of cutting as follows: Type 1: removal of the prepuce or clitoris, or both; type 2: removal of the clitoris and labia minora; and type 3 (infibulations): removal of part or all of the external genitalia with stitching or narrowing of the vaginal

opening. Female circumcision is practiced extensively in sub-Saharan Africa (Banks et al., 2006; Kim, Torbay & Lawry, 2007), and estimates suggest a prevalence in excess of 80% in some African countries, particularly among Muslim women (WHO, 2000; Kim, et al, 2007). The UN and the African Union Protocol on the Rights of Women in Africa identify female circumcision as a form of gender-based violence against women.

Johnson et al (2009) note that recent refugee resettlement from countries where type 3 female circumcision predominates (such as Somalia) has resulted in a rapid surge of girls and women with this type throughout North America. It therefore presents among high numbers of African refugee women and is associated with a range of poorer maternal outcomes such as: caesarean section, postpartum hemorrhage, prolonged labor, and extended maternal hospital stay (Lax, 2000; Ukoko, 2005; Banks et al., 2006). Women with the most extensive forms of female circumcision seem to fare least well (Banks et al., 2006).

Although it is generally accepted that poorer maternal outcomes are associated with female circumcision, Essen et al. (2002a,b) found no clear association between female circumcision and maternal mortality, and suggested that other factors such as socio-economic disadvantage may contribute to poorer outcomes among circumcised refugee women. Similarly, Johnson et al (2009)

explain that female circumcision may not be such an important cause of obstetric morbidity as once perceived. They suggest that other factors such as verbal miscommunication, distrust, refusal of care, fear of pain, and anxiety may contribute to sub-optimal health outcomes. This view is counter intuitive and incongruent with recent WHO publications (Banks et al., 2006; WHO, 2008), and may relate to specific study contexts. Other difficulties identified by researchers include the lack of reliability of self-reporting of female circumcision. In addition to pregnancy outcomes, some studies discuss female circumcision-related concerns experienced by health care providers in host countries (Kangoum et al., 2004; Thierfelder et al., 2005). These studies suggest a need for greater health care provider awareness and knowledge of female circumcision.

Rape and other forms of sexual violence are common occurrences during war (and even peace times). This adds to the various forms of gender-based violence experienced by refugee women. Nikolic-Ristanovic (2000, p.48) notes that the brutality and acceptability of rape are escalated by the fact that “in the eyes of the rapist, the woman is the enemy.” In a study conducted in Sierra Leone, women in 94% of the households surveyed had experienced wartime rape, torture, and/or sexual slavery (Hynes, 2004). The use of rape as a weapon of war has been

clearly documented in studies with refugees from the Balkans (Nikolic-Ristanovic) and Mozambique (Sideris, 2003).

The manner in which women experience wartime rape is exacerbated by the patriarchal values ingrained in society and amplified by what Hynes (2004) calls the “culture of war.” Nikolic-Ristanovic, (2000, p.63) argues that during wartime “women’s bodies become battlefields where men communicate their rage to other men, because women’s bodies have been the implicit political battlefields all along.” Sideris (2003) observes that gender discourses tend to lay the main responsibility for sexual integrity on women as the bearers of culture. For example, after the mass rape of women in Rwanda, the combined pressure of Roman Catholic values against abortion and preservation of the sanctity of life and social norms dictating that children of militiamen be rejected and considered “lixo” (rubbish) resulted in women giving birth in secret and abandoning their babies (Sideris, 2003). Clearly, the socio-cultural expectation of women as nation builders places a heavy burden on them, especially on their reproductive capacities.

### **Post-migration**

Many researchers have described the multiple losses refugees face following migration to a new country. Prominent among these are the loss of

homeland, loss of family members, loss of language and loss of culture and its values (Martin, 1992). Refugee women in particular are continually faced with socio-cultural adjustments and cross-cultural clashes (Parvanta, 1992). Resettlement is considered an extremely stressful experience for women who are separated from their families as their identity is often attached to their role in the family. In Fox, Cowell, and Montgomery (1994), Asian refugee women were studied to understand the impact of disruption of family ties on resettlement. Other researchers noted that it is the conditions in the host countries of resettlement that greatly impact its success (Beiser, 1999). However, in the case of African refugee women, very little research has been done to document their post-migration experience in the United States (Kamya, 1997).

Refugees, in contrast to economic immigrants, often arrive in resettlement destinations with significant problems developed either pre-migration or during their migration journey. They can face a potentially long process of settling, often carrying with them the pain that caused them to leave their countries of origin. For many refugees the experience of settling and integrating into the host community can be equally traumatic (White, 2004). Most immigrants have basic settlement needs when they come to a new country. However, refugees facing difficult pre-migration and migration experiences have greater needs. Studies

have shown that there are three factors to note about the nature of African refugees. First, they often arrive having no previous experience with urban living, such as using amenities of electricity, telephones, and computers. Often these displaced populations come from pastoral or nomadic lifestyles in their homeland. Second, these populations are primarily from regions that have strong tribal affiliations and histories, therefore enhancing the importance of their ancestral traditions (Ortiz-Thompson, 1998). Third, these refugees are placed in communities that have little experience with integrating a foreign population (Akokopari, 1998; McSpadden, 1987).

During the post-migration period, refugees begin to grapple with system-based issues such as racism, cultural discrimination, gender bias, religious discrimination, language barriers, and isolation. Hence, refugee post-migration settlement and integration are complex processes (Stein, 1998). After a difficult pre-migration and migration experience, a refugee approaches the new land with mixed feelings. The refugee left home to escape danger with no destination in mind, no positive original motivation to settle elsewhere (Collins, 1996). Often the country of resettlement is chosen against or despite their wishes by UNHCR officials (Hyndman, 2000), and the refugee is forced to take their chances based on the United Nations' quota to fill for each host country. In the initial period,

refugees are confronted by the loss of their culture, their identity, their habits and their place. Every action that used to be routine will require careful examination and consideration (White, 2004). There will be interpersonal struggles at home because they are not sure how to adapt to the new culture (George & Tsang, 2000). Nostalgia, loneliness, depression, anxiety, guilt, anger, and frustration are so severe that many refugees may want to go back to their country of origin even though they fear violent consequences (Mollica, 2000). Many refugees receive considerable support from their ethnic communities, but in some instances these communities are themselves divided or under pressure. They may not be in a position to provide the level of help that new refugees need. There can also be tensions between individual refugees and their communities as well as between individuals, ethnic communities and the host community (Gray and Elliot, 2001). Refugees also need support from the wider community. Discrimination, prejudice, ignorance and lack of understanding can inhibit the resettlement process.

A 1997 UNHCR study on resettled refugees noted that the constraints to resettlement included, in order of priority: lack of employment, racism and discrimination, delays in family reunification, inability to speak the host community's language, lack of recognition of qualifications and experience, and inadequately resourced integration programs. Among these factors, family

reunification is of prime concern to refugees while governments tend to put more focus on employment. However, employment remains an important determinant of integration.

Refugees who are unemployed from the outset of resettlement or for long periods are at risk of becoming socially excluded from the mainstream, since the main source of regular social contact with other groups is through the workplace. Refugees typically respond to difficulties finding employment opportunities by creating their own ethnic capitalism, referred to as “ethnic entrepreneurship” (Gray & Elliot, 2001). Refugees have special needs, tastes, and preferences that cannot be met by the non-ethnic sector so business develops to fill an ethnic niche. In a program for refugee microenterprise development based in the US, funding goes to agencies, which then make grants to individuals. A study of this program found that the greatest need for many was not capital but training and technical assistance, with refugees needing more training and technical assistance than anticipated (Gray & Elliot, 2001). However, many refugees involved in the program obtained their capital through families and local communities rather than relying on the scheme.

Race and ethnicity influence the levels of discrimination in relations between host communities and refugee populations (Briant & Kennedy, 2004).



Krieger (2000), and Borrell et al (2006) point out that the experience of discrimination is patterned along many biosocial lines, although in the U.S. race/ethnicity are perhaps the most dominant or visible characteristics. Refugees resettled in the U.S are at particularly high risk of discrimination because they show many outward signs of their minority status, including dress, skin color, and language (Hadley & Patil, 2009). For example, Noh et al (1999) used a single item measure of discrimination in a study of 647 Asian refugees and reported that 26% of the respondents experienced discrimination on the basis of “race.” Similarly, in another study of Cuban refugees, several individuals mentioned experiencing discrimination while living in the U.S (Barnes & Aguilar, 2007). Stephan and Stephan (2000) explain that racism and discrimination can arise from perceiving members of an out-group as a real or symbolic threat. Also, political and social processes affect people’s attitudes toward newcomers.

Reflecting the interaction between U.S. history and skin color, African refugees may experience heightened levels of discrimination. Although studies are fewer, this pattern appears to hold true for African refugees resettled in Europe, Australia, and North America (Fangen, 2006; Phan, 2003). In a study of 263 Sudanese refugees living in Nebraska, 53% reported that they had experienced racism and 20% reported that racism was a barrier to adequate health

care (Willis & Nkwocha, 2006). These statistics underscore the pervasiveness of racism and the importance of racism for health and health seeking. Implicitly, refugees who are resettled in the U.S may experience different levels of health and wellbeing following post-migration because of the interaction between skin color and existing cultural norms.

Furthermore, in a qualitative study of post-settlement barriers to health for refugees in San Diego, Morris et al (2009) found that the majority of refugees do not regularly access health services due to language and communication issues. They also noted that acculturation presented increased stress, isolation, and new responsibilities for refugees. Additionally, cultural beliefs about health care directly affected refugees' expectation of care. These barriers contribute to delayed care and may directly influence refugee short and long-term health. Similarly, Bulman and McCourt (2002) contend that language and communication difficulties are responsible for limited access to services and late attendance for prenatal care for sub-Saharan African refugees. Other barriers to accessing health service post-migration include limited health literacy and poor knowledge of services (Sheikh-Mohammed et al, 2006; Carroll et al, 2007); limited financial resources (Sheikh-Mohammed et al, 2006); stigma associated with refugee status (Sheikh-Mohammed et al, 2006); unsympathetic services

(Bulman and McCourt, 2002; McLeish, 2002). Women who feel uncomfortable with services may choose not to attend appointments (Bulman and McCourt, 2002).

The issue of acculturation remains a huge part of post-migration experience for refugees. As refugees enter a new culture, transformations gradually take place in their lives. The process of acculturation often has been equated with deethnicizing and the incorporation of immigrants or minorities into the mainstream (Messias & Rubio, 2004). The process of assimilation requires individuals to acquire a second culture, usually that of the host society, while letting go of their original culture (Wang & Freeland, 2004). In integration, individuals can develop healthy identities and mutually positive intergroup attitudes in a multicultural, sociopolitical context. Studies on refugees indicate that migration per se does not necessarily compromise the health or mental health of the newcomer, but assimilation can be a highly stressful process (Aronowitz, 1992; Munroe-Blum, Boyle, Offord, & Kate, 1989).

Relying on extensive research on the migrant experiences of Kurdish women, Ahlberg (2000) reported that mental problems and the stress among refugees stem mostly from their imposed acculturation, especially in the cases of those refugees whose values are totally different from those of the host country,

and from their interactions with the host communities. Consequently, women develop post-traumatic stress disorder (PTSD) which, if prolonged, untreated and combined with sexual and domestic violence can degenerate into disorder of extreme stress not otherwise specified (“DESNOS”) (Ahlberg, 2000).

PTSD seems to be the most common diagnosis given to refugee women (and men) who experience trauma. As presented above, other studies are dedicated to various refugee groups who showed symptoms of PTSD. However, Friedman and Jaranson (1994) question “the validity and usefulness of the PTSD construct” (p. 216) with respect to refugees from non-Western countries. This assertion is based on Friedman’s and Jaranson’s clinical experience and research that suggests that PTSD represents a diagnostic established on Western individuals who experience trauma and was adapted to refugees coming from non-Western countries. While they admit that all individuals display some similar symptoms, they also emphasize that “ethno cultural differences in the expression of traumatic stress may not conform to DSM-111-R diagnostic criteria for PTSD” (p.215). Therefore, ethnocentricity and narrowness of the PTSD model might deepen the gaps existing in the phenomenology of PTSD which will hinder health care providers from accurately understanding, assessing and treating refugees’ mental health problems.

## **Refugee Women's Experiences**

As mentioned in chapter one, both international laws and international refugee assistance programs have traditionally been gender-blind, with the introduction of gender as an analytical category only in the past fifteen years. In the academic literature on refugees, consideration of refugee women or gender has only been recently explored, and then only minimally (DeVoe, 1993; Rogge, 1994). Yet bringing women into the picture, it is possible not only to illustrate the unique experiences of refugee women (Ager, Ager, & Long, 1995), but also to understand more fully the dynamic of refugees in pre-migration and post-migration situations. This section concentrates on the experience of refugee women.

The proportion of refugee women globally increased over the past two decades from ten percent in 1980 to over eighty percent in 2007 (Nunez, 2010; UNHCR, 2003). The presence of refugee women in developing countries was estimated at ten percent compared to seventy percent in middle income countries and twenty percent in high income countries (Nunez, 2010). Sixty-five percent of refugees resettled in the U.S are women (Gozdziak & Long, 2005). The refugee experience of men and women can be very different. Common challenges refugee

women face in host societies around the world include difficulty accessing health care services, social services and legal protection (Nunez, 2010).

In a study of refugee families living in refugee camps in the 1980s, it was estimated that eighty percent of Cambodian families, seventy-five percent of Somali families, and sixty percent of Sudanese families were headed by women (DeVoe, 1993). The early 1980s saw an increasing awareness of the gendered nature of the refugee experience (Barnett, 2002; Callamard, 1999). In the 1990s, the UNHCR identified women as a policy priority. This accomplishment can be attributed in large part to the persistent lobbying of the UN by transnational advocates for refugee women over the UN Decade for Women (1975-85). Refugee women constitute the majority of the displaced persons of the contemporary world (UNHCR, 2000).

Refugee women have special needs and raise particular interest because of the gender-specific problems they face and the mechanisms they devise for survival amidst the daunting challenges of refugee situations and their own position in society. Refugees generally do not have an automatic claim to basic needs and income generation. But among these vulnerable groups can be found others that are even more deprived, namely unaccompanied women and minors. Women residing in refugee camps experience multiple physical health issues.

Tuberculosis and other respiratory diseases, parasitic diseases, sexually transmitted infections such as HIV/AIDS, anemia and malnutrition, hepatitis B, malaria, and other infectious diseases are frequent and serious consequences of living in crowded, makeshift conditions (Toole, Waldman, & Zwi, 2001). Refugee women also experience myriad mental health issues. The experience of forced migration requires a continuous response to change and the skill to cope with traumatic new circumstances (Pavlish, 2005). In addition, many refugee women have experienced the trauma of war and might have been victims of violence, especially the rape and torture associated with ethnic conflicts (UNCHR, 2003). All of these conditions contribute to an increase in stress that impacts women's health (Rehn & Sirleaf, 2002; Walker & Jaranson, 1999).

Refugee women who care for their household members (such as children) are often exposed in a multifaceted fashion. First, they have to find their place among the various power relations which exist in all societies but are more poignant in refugee situations. Secondly, they also have to deal with the gender roles directly related to the power structures in their communities and in the new refugee situation that are related to their reproductive, productive, and community roles in society. In the face of these challenges of refugee life, the choices women

make concerning their health can highlight how they rank their own livelihood and health concerns and exercise their options.

Refugee women can be at risk as a group, by their association as a discriminated and persecuted ethnic and religious minority, and at the individual level due to gender and their responsibility to care for dependent family members. Refugee women are vulnerable during pre-migration and post-migration. Each of these phases renders women vulnerable for various reasons. For example, patriarchal structures- to which women are subjected in their own societies- are deeply embedded in notions of “pure ethnicity” and national identity that lie at the heart of armed conflict and civil war (Nunez, 2010). The gender scope of war and armed conflict demonstrates how in these contexts, the private and public sphere are very closely linked. In addition, during the pre-migration, women are vulnerable due to war, rape and exposure to sexual and gender-based violence as they flee sometimes on foot, with few, if any, resources for sustenance (Halcon et al, 2004; Hynes & Cardozo, 2000; Jaranson et al, 2004; UNHCR, 2006a). Refugee women are considered to be doubly vulnerable due to age and gender characteristics associated with vulnerability (Moore & Miller, 1999; Rogers, 1997). Despite their traumatic pre-migration experiences and vulnerability,



refugee women demonstrate extraordinary human capacity for survival, adaptation and resilience.

Often less educated than men, or lacking command of the host society language, women see their employment options in the host society as limited to the informal and domestic services sectors. In a study of refugees, Colson (1999) points out that traditional gender roles can be affected by disruption of status and power hierarchies, geographical dispersal of kin and friendship networks, new residence patterns, loss of economic resources, differential access to new resources, shifts in work patterns, exposure to strangers, and different expectations. Women without partners tend to be a particularly vulnerable group. They tend to be disadvantaged in terms of access to information, social support and socio-economic status, and may experience poorer health than those who have partners.

McSpadden and Moussa (1993) found that male refugees from Ethiopia and Eritrea living in North America were unused to terms with a lower status and limited opportunities on resettlement, leading to a high level of depression and even suicide among this group, and a high incidence of violence by men towards their wives. In contrast, women from these cultures had already experienced conflict in their home environment between their traditional roles and individual

aspirations. This, along with the traumatic experiences of flight and asylum (including rape, and the possibility of prostitution as the only survival strategy) made the women realize that for them, a much lower status than menial employment was possible. Consequently, they tended to see the new environment as offering more possibilities in the long term, and to have less difficulty in accepting a low position in the short term. Matsuoka and Sorenson (1999) recorded a similar phenomenon in relation to the same population. They also point out that women from cultures where women are traditionally disadvantaged in terms of access to education (for example Eritrea) are also disadvantaged in relation to the men in “developing language facility and securing employment” in their host countries.

Each of the phases of refugee migration renders women vulnerable for different reasons. Refugee women are vulnerable pre-migration and post-migration due to such things as violence, rape, and lack of access to social services (UNHCR, 2006). Refugee women’s vulnerability can lead to instances where they are afflicted with long lasting consequences such as unwanted pregnancy and HIV/AIDS (Hynes & Cardozo, 2000). The risks refugee women face have been addressed by a special committee for the UNHCR. This report resulted in the publication of Guidelines on the Protection of Refugee Women

which recommended heightened awareness of the risks facing female refugees, and a need to increase medical, especially reproductive health and psychosocial services in the refugee camps (Executive Committee of the High Commissioner's Program, 2006). Many women are forced to live in refugee camps for decades raising families and waiting for return to their country of origin or resettlement to another country, usually a developed country.

Even during the post-migration phase, refugee women continue to be vulnerable to marginalization, discrimination, and social isolation due to their minority status, and lack of language and educational skills necessary for employment (Lipson et al, 1997). Meleis (1991) addresses the stress inherent in living between "two cultures." Refugee women must negotiate language and cultural differences for themselves and their families as they attempt to integrate into institutions within the host country such as the health care system. In spite of the profound trauma and adversity that refugee women experience during flight and time in refugee camps, they identify problems with resettlement as the cause of their depression (Tillbury & Rapley, 2004).

Social connectedness and integration are a social resource that can decrease refugee women's vulnerability (Flaskerud & Winslow, 1998). Connection with a similar cultural and ethnic community in the country of

resettlement is reported by refugees to facilitate their well-being in the resettlement transition. In a study of 19 Afghan refugees who resettled in California, involvement and participation in the community helped them to make the transition to the new environment (Lindgren, 2004).

### **Patient-Provider Relationship**

Patient- provider relationship theory highlights the unequal power distribution between providers and their patients. Effective patient-provider relationships can increase a patient's awareness of health problems and solutions, influence perceptions and beliefs, prompt action, demonstrate healthy behaviors, and reinforce existing knowledge or behaviors (Freimuth & Quinn, 2004). Customization of health programs and health services to better meet the needs of minority and vulnerable populations is done by recognizing and practicing culturally relevant modes of appropriating knowledge (Kreuter & McClure, 2004). Culture is best understood as an adaptive system of meaning, in which behavior, values, and ethnicity contribute to, but do not encompass the mass of, its depth and density (Corby, 2010). Factors such as familial roles, religiosity, the importance of individualism versus collectivism, and specific behavioral engagement can help define culture for a group if the aforementioned factors have a special meaning to group members (Kreuter et al, 2002). These integrated

patterns of human behavior are the underlying determinants of individual decision-making, especially those related to the use and trust of health care (Paez et al, 2008). Refugee populations are especially vulnerable to significant discrepancies in health care access and are in great need of culturally relevant, accurate, and timely health information (Kreps & Sparks, 2008). Hence, the patient-provider framework provides the context to explore how refugee patient and health care provider relate to one another in the management of reproductive health.

The significance of cultural awareness in the patient-provider relationship cannot be over emphasized. No doubt culture influences expectations and thus cultural orientation is one determinant of satisfaction. However, feminist scholars have warned against cultural essentialism and the need for a more nuanced view of patients' health needs without over generalizing every health perception as culturally motivated (Anderson, 2002; Racine, 2003). Further, minority groups have been found to be less satisfied with the patient-provider relationship than whites (Lin & Guan, 2002). Some studies indicate that African Americans who are concordant with their physicians are more satisfied with their care independent of the patient-centeredness of the physician (Chen, et al, 2005; Cooper & Roter, 2003). In contrast, African Americans in managed care plans

were as likely as whites to rate their satisfaction as high and were more likely to recommend their physician to others (Murray-Garcia et al, 2000). The inconsistency in these research findings indicates that the satisfaction of minority patients is complex. Hence, developing culturally appropriate programs and services is highly important and requires the identification of authentic community structures, beliefs, and roles instead of relying on superficial and vague identifiers like ethnicity and race (Kreuter et al, 2002). Examining cultural issues that impact and influence the way in which members of vulnerable populations respond to health communication and care is crucial in health management (Kreps & Sparks, 2008). In addition, patient beliefs can impede the provision of care, delay, or complicate clinical care and result in a lack of treatment or inappropriate remedies (Flore, 2000).

The patient-provider relationship often exists in a context in which negotiations about illness take place, and management of these negotiations plays a key role in how patients experience the illness (Mechanic, 1992). Health care providers' willingness to acknowledge the existence of a patient's unique health culture and belief systems and their potentially conflicting etiologies is critical to an effective patient-provider relationship. By accepting the idea of a different sociocultural context through which patients are communicating their concerns as

well as hearing medical professionals' instructions, health care providers can begin taking steps to modify their own messages for greater treatment success.

In order to insure that patient-provider interactions are successful, clinicians must learn about their patient's health literacy and health culture and use that information to improve communication with diverse patients (Andrulis & Brach, 2007). The health culture in which a patient is immersed affects several levels of care. This includes interpretations of origins of disease and decisions concerning compliance and overall efficacy of care (Ito, 1999). The elicitation of symptoms and evaluation of signs and descriptions of illness are highly related to a patient's health culture and the selection of mediations or treatment plans must be done with regard to patient culture (Horner et al, 2004).

Differences in language and explanatory frameworks of health and illness between refugees and healthcare providers create barriers to access in the healthcare system that can lead to miscommunication, misdiagnosis, and lack of follow-up. The more different the dominant culture is from that of the refugee, the more potential for disparate explanatory models. In a study of African women's belief about health and illness, it was found that they attributed poor health to supernatural causes such as punishment from God, or a curse from an evil spirit or witch (Nelms & Gorski, 2006). In another study, a group of Somali refugees

reported valuing professional services (such as healthcare providers), yet they identified religious and cultural conflicts in accessing these services. These conflicts included differences in beliefs about spirit possession, gender, family responsibility, and female circumcision. They reported fear of disclosing beliefs about spirit possession to Western healthcare providers due to fear of being misunderstood and being over-medicated (Whittaker et al, 2005).

Trust is central to the patient-provider relationship and serves as a reflection on the quality of the relationship (Thom, Hall, & Pawlson, 2004). It is a key outcome in the patient-provider relationship (Hall, Dugan, Zheng, & Mishra, 2000). Multiple definitions of trust exist, but most agree that trust is the optimistic acceptance of a vulnerable situation in which the truster believes the trustee will care for the truster (Hall et al, 2001). Patients with healthcare needs are placed in a vulnerable position where they expect their healthcare providers will act in their best interest. Trust (or mistrust) emerges as the patient evaluates the congruence between his/her expectations and their providers' actions (Hupcey, Penrod, Morse, & Mitcham, 2001).

Burgess (2004) contends that in the absence of linguistically and culturally accessible care, refugees may have difficulty developing trust and respect for physicians and western medicine. Without the means of communicating medical



history, current needs, and personal health practices and beliefs, this population is prone to medical mistakes. Possible errors include patient-provider miscommunication; the patient may leave the visit confused, possibly misdiagnosed and with little confidence in the care provided and the medical system in general (Burgess, 2004). Hence, the patient-provider framework is utilized in this study to examine how refugee women and health care providers negotiate access and provision of reproductive health care.

## **Chapter 4**

### **HISTORICAL CONTEXTS OF AFRICAN REFUGEES**

African refugees are those people of African descent who have been displaced due to civil war, ethnic conflict, and political unrest. Africa's colonial past has greatly affected its current refugee problem. The colonial rule brought about its own restricting of African societies and new forms of forced migrations. In Western Africa, for example, movement of people was directed to coastal cities and entry ports for the extraction of resources in the immediate interior and onward transfer of such resources to European economies (Kalipeni & Opong, 1998).

However, the most insidious aspect of the colonial rule was the imposition of boundaries drawn at the Berlin Conference of 1884 with total disregard for the prevailing cultural entities. Traditional enemies were lumped together in one territory, while nationalities or ethnic groups with a shared identity and history were separated by national borders and forced to serve different colonial masters (Kalipeni & Opong, 1998). This total disregard for the local context and cultural identities has contributed to numerous inter-ethnic conflicts and outright warfare throughout Africa (Liebenow, 1986; Wilson, 1994). The implication of the imposed boundaries is evident in the Great Lakes region where ethnic frictions in

the Democratic Republic of Congo, Rwanda, and Burundi have created millions of refugees in the past two decades. The situation is similar in the horn of Africa where civil wars and armed conflicts have displaced millions of Africans simply because of the struggle for territorial control. Political struggle has been responsible for over two decades of war in Sudan which created an unprecedented refugee movement in that region. The western region of Africa is not an exception to the havoc created by European partition of Africa. For example, the political struggles in Sierra Leone and Liberia have created millions of refugees in the past years.

The refugee problem in Africa grew slowly in the 1960s as many African nations gained independence in the 1960s and faced the reality of how to govern along borders created by European colonialists; the problems dramatically increased in the 1970s leading to politically-induced ethnic and religious conflicts. Africa is currently one of the leading producers and hosts of refugees in the world today (Zlotnik, 1999). African refugees comprise roughly 20 percent of the global refugee population. As mentioned in chapter 1, there are currently some 3.6 million African refugees across the world and additional 2.2 million refugees across Africa (UNHCR, 2010a). Political violence and state terrorism have taken many hideous forms across Africa. Although the motives for oppression varied

from country to country, they all shared the same common goal associated with the colonial mentality: to disempower and silence the population or specific segments of the population, to maintain and perpetuate hegemonic and societal structures, and to eliminate any form of resistance on the part of the people. Traces of colonial mentality of intimidation and domination can be seen in the ongoing violence in the Democratic Republic of Congo, and the political chaos in Somalia, Sudan, and other parts of Africa, which have continued to displace many Africans leading to the current refugee crisis. Most displaced Africans seek asylum in neighboring countries before resettling elsewhere. Traditionally, refugees in Africa have been allowed to remain- and in many cases to effectively integrate locally- until repatriation is possible.

African refugees represent a unique population in the United States and throughout the world. In the case of African refugees in the United States, the capacity of the healthcare services to meet new challenges arising from the arrival of new users in diverse situations and with a heterogeneous history and culture is an element of great importance in strategic healthcare planning. Many African refugees represent a preliterate population; they have no native written language (Springer et al, 2010). The refugees speak several different African languages/dialects, with few African refugees who speak English. Many of these

refugees lived in refugee camps in countries such as Kenya, Uganda, Ivory Coast, and Tanzania before achieving permanent placement in the U.S.

A significant number of African refugees are Muslims. Most Muslim African refugees, particularly those from Somalia, dress fairly modestly, especially the women who often wear loose, long dresses and head wraps. In contrast, most of the African refugees from Sudan come from the south of the country and are Christians. Hence, health care providers must pay attention to how religion and spirituality influence their patient's adherence to care. For the Muslim refugees, eye and physical contact between men and women is usually avoided in public out of respect, and should not be misread by providers as avoidance.

The heterogeneity and diversity of African refugee populations cannot be overemphasized. They represent a variety of cultures and languages. For example, among the Somali refugees, there is a clear ethnic distinction between the Somalis and Somali Bantus. Many of the Somali Bantus trace their roots to tribes in southeast Africa who were resettled in Somalia as slaves. The Somali Bantus are physically distinct from other Somalis with easily distinguishable curly hair; they are subject to discrimination in Somalia. Derogatory terms are used by the Somalis to describe Somali Bantus, such as *adoon* and *habash* (slave) *ooji* (which

refers to the perception that the Somali Bantu thinks only in the here and now and is not able to think beyond the moment) (Mburu, 2004; Van Lehman & Eno, 2002). American healthcare providers must be knowledgeable about the diversity and distinctions among African refugee groups in order to provide culturally appropriate care.

Sexual violence and exploitation are shockingly frequent experiences for African refugee women before or during flight and even in refugee camps (Kalipeni & Oppong, 1998). For example, Stepakoff et al (2006) posit that refugee women from Liberia and Sierra Leone were subject to systematic rape and enslavement. Pre-migration, sexual violence is routinely an element of persecution of women. During migration, sexual exploitation or violence may be part of their experience with border officials, other refugees or people in the host community. In the past decade, the world listened to women in Rwanda recount their horrifying rape stories resulting in unwanted pregnancies and high rates of unsafe abortions. In some raids in Rwanda, during the 1994 genocide, virtually every female who survived the attack was subsequently raped (UNICEF, 1996). In 1993, the incidence of rape was reported to be high in Somali refugee camps in Kenya (Kalipeni & Oppong, 1998). Unfortunately, a high risk of sexually transmitted infections accompanies all sexual violence against refugee women.

Yet these women lack even the most basic elements of reproductive health care while facing unwanted pregnancies. Most of the women studied in this research have lived in refugee camps in Africa and have various experiences that need to be acknowledged by health care providers to insure that the reproductive health needs of these women are properly addressed.

The twenty refugee women who participated in this study comprise a cross-section of African refugees resettled in Phoenix, Arizona. They are refugees from six different African countries: Burundi, Democratic Republic of the Congo (DRC), Liberia, Somalia, Sudan, and Togo. While the bio-sketches of these refugee women will be the focus of the next chapter, the next section of this chapter provides a brief historical context of the countries of origin of refugee women interviewed in this study.

## Burundi



*Figure 1.* Map of Burundi.

Burundi is situated in the Great Lakes region of East-Central Africa, sharing borders with Rwanda, Tanzania, and Democratic Republic of the Congo. Burundi was once part of German East Africa. Belgium won a League of Nations mandate in 1923, and subsequently Burundi and Rwanda were transferred to the status of United Nations trust territories. The population of Burundi is divided between the Hutu (85%), Tutsi (14%), and Twa (1%). The Hutus are a majority



while the Tutsi are the minority elite with significant power. Although the Hutus and Tutsis have a history of conflict, they speak the same language and have a lot of common features. The 1933 requirements by the Belgians that everyone carry an identity card indicating ethnicity as Tutsi or Hutu increased the distinction between these ethnic groups.

By 2003 Burundi was the single source of the largest refugee population in the world, most of them residing in the neighboring country of Tanzania (UNHCR, 2003). Burundi gained its independence from Belgian colonial administration in 1962, at a time when ethnic violence was rampant in neighboring Rwanda and a large number of Tutsi refugees had fled into Burundi to escape the Hutu/Tutsi conflict in their own country. This exacerbated tensions in Burundi, where the Hutu majority and the Tutsi elite were vying for political dominance. In 1965, the Tutsi King refused to inaugurate the Hutu Prime Minister, leading to a minor Hutu uprising which was suppressed by combined military and civilian (Tutsi) reprisals. A further uprising by the Hutus in 1972 resulted in the deaths of hundreds of civilian Tutsi, followed by the deaths of over a hundred thousand Hutu civilians in a reprisal mounted by the Tutsi-controlled military (Lemarchand, 1998; Ndikumana, 1998).

The events of 1972 led to mutual distrust between the two ethnic groups. Two military coups in the next few years reinforced Tutsi military rule in Burundi. The first coup was in 1976 and led to the creation of a one-party state. A second coup followed in 1987 leading to mass killings and reprisals followed by a large number of Hutus fleeing Burundi to neighboring countries (Lemarchand, 1994). Democratic reforms were gradually introduced leading to a referendum in 1992, the introduction of new constitution, and elections in 1993.

Following the 1993 elections, Melchior Ndadaye, a Hutu civilian, was elected president but was assassinated three months later. The second Hutu president, Cyprien Ntaryamira, was killed in 1994, when a plane carrying him and the Rwandan president was shot down. As a result, Hutu youth gangs attacked and killed their Tutsi neighbors (Lemarchand, 1998). About twenty thousand Tutsi civilians were murdered in two months; the Tutsi-controlled military responded by a mass killing of mostly Hutus. This led to many Hutus seeking sanctuary in the neighboring countries of DRC, Tanzania, and Rwanda (Des Forges, 1994). In 1996, after three years of unstable government, Tutsi ex-President Major Pierre Buyoya seized power again and suspended the constitution. In 2001, an internationally brokered peace agreement put a three year Hutu/Tutsi power sharing government in place. Elections in 2003 and 2005

voted Hutus into the Presidency under an ongoing power-sharing constitution. Although the country-wide curfew implemented since 1972 came to an end in 2006, the political future of Burundi remains uncertain.

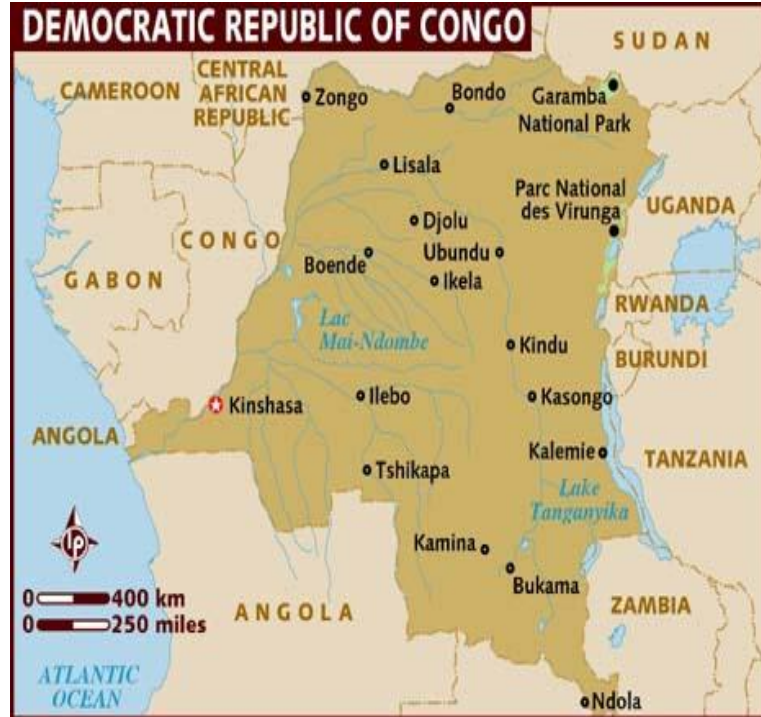
Years of civil war have left Burundi ravaged by poverty and violence. The circulation of firearms and weapons, due to the years of civil war, has led to increased criminality with a lot of female victims. Women are always more vulnerable to the burdens of war. Many Burundian women lost their husbands during the war and are now left homeless, landless, and shunned by society as widows. Some women, even those as old as seventy, were victims of mass rape and some have been repeatedly gang-raped, and face HIV infection, stigma, blame and humiliation as a result.

Since the civil war ended in 2006, Burundi has been struggling to cope with high maternal and infant mortality. Many Burundians live in extreme poverty and have little or no access to health care. Without access to reproductive health care, the majority of women in Burundi give birth at home. In fact, only twenty-five percent of births in Burundi are attended by a skilled health care provider. As a result, a Burundian woman has a one-in-nine lifetime risk of dying in childbirth. Although the reproductive health situation in Burundi has witnessed

tremendous change since the introduction of free health services in 2008, women who are not pregnant still have to pay for health services (UNICEF, 2009).

Six of the refugee participants (Nadege, Juliette, Nshimirimana, Nsegiyumva, Gloria, and Marthe) in this study are from Burundi. They represent one of the largest groups of participants from the same country. These women did not know each other back in Africa, but have become friends post-migration. In fact, Nshimirimana, Nsegiyumva, and Gloria currently live in the same apartment complex and are quite friendly. As the Burundian refugee women in this study shared their stories with me, it became clear that the political instability and government - sanctioned violence is far from being over. Hence, war and conflict combined with political instability provide the context for the flight and resettlement of Burundian refugee women in this study.

## Democratic Republic of Congo (DRC)



*Figure 2.* Map of Democratic Republic of Congo.

Democratic Republic of Congo (DRC) is situated in the middle of Africa in the Central African region, sharing borders with Angola, Burundi, Central African Republic, Congo, Rwanda, Sudan, Tanzania, Uganda, and Zambia. DRC first had its border drawn during the Berlin Conference in 1884-1885. This new borders separated families, while other people without previous contact suddenly became part of one nation. Consequently, many of DRC's leaders have favored

certain ethnic groups and areas over others, exacerbating differences between ethnic groups.

DRC gained its independence from Belgium in 1960. A year later, the first democratically elected Prime Minister was assassinated (French, 2004; Kanza, 1972), leading to enormous political unrest and violence throughout the country. Joseph-Desire Mobutu took power following a coup in 1965. He asked that everyone drop their missionary- given Christian names in an effort to re-Africanize the country. He changed his own name to Mobutu Sese Seko. He also renamed the country Zaire, dismantled all vestiges of parliamentary democracy and ruled by military dictatorship for the next thirty-two years. Although Mobutu's years in office were rife with flagrant abuses of human rights and rampant corruption, he enjoyed widespread international support for most of this time, particularly from the United States, France, and Belgium- all keen to secure the country's natural resources (French, 2004; Ewans, 2002).

By 1996, the international support for Mobutu had waned. Mobutu's government lacked support from some neighboring countries such as Rwanda and Uganda. These two countries supported DRC's anti-government forces. The Alliance of Democratic Forces for the Liberation of Congo/Zaire (ADFL) mounted an aggressive military campaign to overthrow the government supported

by governments of Rwanda and Uganda (Nzongola-Ntalaja, 2006) starting what is known as the First Congo War. This was continued until mid-1997 when Laurent-Desire Kabila and the ADFL took over the government (Reed, 1998). The newly renamed Democratic Republic of Congo remained unstable as numerous militant factions had emerged.

The Second Congo War erupted in 1998, carrying on into 2004 (Nzongola-Ntalaja, 2006). This is widely considered to have been one of the most violent wars in African history- nine African countries and no less than twenty armed groups played a role in the conflict that impacted the lives of approximately fifty million Congolese (Jackson, 2006). An estimated four million people died as a result of violence, starvation and disease, and millions of people were displaced- many seeking asylum in neighboring countries (Coghlan et al, 2006).

By 1999, five neighboring countries had troops in DRC. The government controlled approximately one third of the country, while forces from Rwanda, Uganda, Angola, Zimbabwe and Namibia secured the rest of the country (Global Security, 2007). Kabila was assassinated in 2001. Joseph Kabila immediately took his place and committed the government to peace negotiations with all factions. In 2002, a peace accord that provided for transition to constitutional government was

signed by all political and military factions, and by representatives of civil society (McCullum, 2006; Nzongola-Ntalaja, 2006). Elections held in 2006 saw Joseph Kabila returned to office. Factional differences remain in DRC and there is little to show that the war is over.

The effects of war are mostly visible in Eastern Congo, where mortality rates have been particularly high. Thousands of Congolese women have been physically and emotionally traumatized, targeted for rape as a means of terrorizing and subjugating the population by numerous armed factions (McCullum, 2006). The last year of the war (2006) saw twenty-seven thousand sexual assaults reported in just one province (Gettleman, 2007). The refugee camps set up by the UNHCR have been overwhelmed with demands and are unable to deal with the sheer weight of humanitarian need in the country and the large number of displaced persons (Coghlan et al, 2006). Some two million Congolese are internally displaced, while another 355,000 have fled to other countries as refugees or asylum seekers.

The humanitarian crisis in DRC is among the worst in the world. The years of wars have decimated the country's health care system. Hence, the reproductive health needs of women were not being addressed. Much of the population does not have access to good quality reproductive health services. For



example, prenatal care and childbirth in a health facility are too expensive for many women leading them to deliver at home with a traditional birth attendant. There are high rates of unsafe abortions, and family planning is rarely available in health facilities throughout the country. Few women use contraceptives even where they are available due to their husband's objections to their use. Women need their husband's signature to receive contraceptives, and are refused contraceptives without one. By law, single adult women have the right to contraceptives without a signature, but they too are often refused service without one (Casey, 2002). In addition, women suffer from stigma surrounding rape, which prevents many women from seeking care. Few health facilities have protocols to manage the consequences of rape (Casey, 2002).

Margaret was the only participant from DRC. Her story comes alive when situated within the historical context of war in DRC. Margaret spoke with such confidence and calmness that it is hard to imagine what she endured as a refugee before resettling to the U.S.

## Liberia



*Figure 3.* Map of Liberia.

Liberia is located in West Africa, and shares borders with Guinea, Sierra Leone, and Ivory Coast. Liberia has had a relatively short but turbulent history. In 1820 former slaves (dubbed Americo-Liberians) were sent to Liberia to make a new home for themselves, free from slavery and oppression in the U.S. The population of Liberia is comprised of 97% indigenous and 3% Americo-Liberians. In 1847, Liberia declared its independence from the U.S. In 1869, the Liberian True Whig Political Party was formed and leadership was controlled by

the Americo-Liberians. For 133 years Liberia was ruled by Americo-Liberians, while the indigenous population was largely excluded from the political process during this time (Adebajo, 2002). Notwithstanding reforms which began to emerge in the 1940s (Harris, 1999), significant social inequity and discrimination on ethnic grounds remained rife (Adebajo, 2002).

By 1979, the indigenous population was largely unemployed and there were calls for social and economic change. A coup in 1980 led by Samuel Doe was initially welcomed by the indigenous population (Adebajo, 2002), but he soon placed members of his own ethnic group (Krahn) in strategic positions in the army and government and formed alliances with the wealthy Americo-Liberian minority and the two most powerful ethnic groups (Gio and Manic) to bolster his position. From 1980 to 1989, Liberia witnessed disorder and human rights abuses under Samuel Doe, who became increasingly controlling and paranoid. Doe's military would regularly imprison and beat students and intellectuals whom he viewed as challenging his ideology (Adebajo, 2002). His military also murdered dissenters, most of them civilians, women, and children (Huband, 2001). Many educated Liberians left the country around this time to escape the violence.

A coup attempt in 1985 led by members of the Mano and Gio ethnic groups resulted in military reprisals in central and north- eastern Liberia, which is

home to those ethnic groups. Approximately three thousand civilians were killed and their villages destroyed entrenching ethnic tensions and differences in Liberia (Adebajo, 2002). Due to Doe's oppression of the Mano and Gio ethnic groups, a former senior member of his regime, Charles Taylor, began to organize a rebel group called the National Patriotic Front of Liberia (NPFL). The government retaliated by giving the military free reign to quash the insurgency resulting in yet another mass murder of civilians and villages being destroyed (Adebajo, 2002). In spite of all, Taylor forged ahead and within six months was able to secure control of 95% of the country (Adebajo, 2002). But, before he could enter the capital more than half of Taylor's army joined a splinter group, the Independent National Patriotic Front of Liberia (INPFL), formed by one of his commanders, Prince Yeduo Johnson, which intensified the civil war.

In 1990, Monrovia, the capital of Liberia, came under attack from the NPFL and INPFL as they fought Doe's Armed Forces of Liberia (AFL). Civilians who were unable to escape from the city were caught in the conflict. There was disaster and mayhem in the streets of Monrovia as control by the government was nonexistent. Due to the conflict and political instability, the Economic Community of West African States (ECOWAS) with military delegates from Nigeria, Guinea, Mali, Sierra Leone, Ghana, Gambia, and Togo decided to send a

newly formed Economic Community Monitoring Group (ECOMOG) to Liberia. ECOMOG was charged with reducing conflict in the nation and encouraging Doe to leave the country. In spite of the presence of the ECOMOG troops, Doe, Taylor, and Johnson continued to pitch battles in the streets of Liberia. Taylor declared ECOMOG illegal and himself President of Greater Liberia. Johnson's forces captured, tortured and executed Doe, after which Johnson declared himself President (Adebajo, 2002; Kieh, 2004).

ECOMOG continued to negotiate with the three warring factions until a disarmament agreement was signed in 1991. However, Taylor continued the war making the country highly unstable; new rebel groups emerged and the violence continued unabated. In 1996, ECOMOG was able to secure another cease fire from the warring factions with a promise of disarmament. This was followed by elections in 1997- with Taylor securing 75% of the votes (Adebajo, 2002). Although Liberians attributed much of the violence and hardship at that time to Taylor, they supported him by resigning themselves to the understanding "that a vote for Taylor was the best hope for peace, since they knew that if Taylor did not win the election, he was likely to restart the war" (Ellis, 1999, p.109). Both before and during his presidency, Taylor committed atrocities against his people and in particular children as he secured them as soldiers in his rebel forces. Looting and

violence were rife and rebel forces were in control. Another peace agreement was put in place in 2003; owing to international pressure, Charles Taylor fled Liberia to Nigeria (UN, 2005). Following another disarmament program, elections were held in 2005 and Ellen Johnson Sirleaf became the president of Liberia. By 2007, Liberia was moving towards economic and political stability although rape remained one of the most frequently reported crimes in the country (UN, 2007).

As a result of the fourteen-year civil war out of Liberia's prewar population of 2.8 million an estimated 200,000 – 300,000 were killed, about 800,000 fled the country, and 1.1 million became internally displaced (Williams, 2002). The war caused the destruction of the country's health infrastructure, eliminating reproductive health services for Liberian women. During the war, torture, rape, and sexual violence were commonplace. Also, as is true in most war-ravaged countries, women and children comprise the largest part of the most vulnerable populations in Liberia. For example, women were an estimated 50%-80% of the displaced Liberian population during the civil war years, and an estimated 40% of all women in the country were raped during the civil war (International Conference on Women and Infectious Diseases, 2004). The four participants- Donyen, Agnes, Bendu, and Esther- from Liberia were among the hundreds of thousands of Liberians who fled the country. These women lived

through the chaos in Liberia and carry with them the burdens of war, which have forever impacted their lives.

## Somalia



*Figure 4.* Map of Somalia

Somalia is situated in the Horn of Africa in the eastern part of Africa. It shares land borders with Djibouti, Kenya, and Ethiopia. By 1920, British and Italian protectorates occupied what is now Somalia. The British ruled the entire area after 1941, with Italy returning in 1950 to serve as United Nations trustee for its former territory. In 1960, Britain and Italy granted independence to their

respective sectors. Despite local resistance, the two protectorates of Somaliland merged (Ahmed, 2006). Following the creation of the Republic of Somalia, the electoral law and constitution of the new state was put together by “foreign experts” and showed little understanding of a pastoral society based on power sharing and clan allegiances, which inflamed local rivalries (Adam, 1994). Somalia broke diplomatic relations with Britain when the British granted the Somali-populated Northern Frontier District of Kenya to the Republic of Kenya.

A coup by the Somalia Revolutionary Socialist Party (SRSP) placed Muhammad Siyaad Barre in power in 1969, where he remained for the next twenty-two years. His regime leaned towards intimidation and suppression. In this time, Barre depended heavily on ties of lineage and clan to shore up his flagging popularity and actively excluded members of clans considered a threat (Lewis, 1989). Consequently, two major resistance groups emerged- the Somali National Movement (SNM) and the United Somali Congress (USC), and Siyaad’s regime came under attack in 1988. Attempts to quell the rebellion resulted in over 100,000 deaths and the displacement of at least 500,000 more people in northern Somalia (Ahmed, 2006).

By 1991, the capital, Mogadishu, was overrun by rebels, and virtually all vestiges of the Somali state had disappeared. President Barre fled the country in



early 1991. His departure left the country in the hands of clan-based militias. Many government officials also fled the country and the army was making little effort to protect the regime. The rebels destroyed what remained of public offices and set about hunting down members of Siyaad's clan, the Darod. Hundreds of people were killed despite the lack of any evidence of their involvement with the Siyaad regime (Compagnon, 1998).

The quest for power continued, with various factions refusing to disarm their militias in case they were needed to enforce power sharing negotiations. Members of the various militias, most of whom were previously unemployed, showed no desire to return to their pastoral life and leave behind the freedom and relative power they had enjoyed- including the "license to kill, loot, and rape" (Compagnon, 1998). The civilian population found it increasingly difficult to differentiate between members of the USC and bandits. SNM forces soon withdrew to the north, where a peace conference of all of the northern clans was held and the former British Protectorate of Somaliland declared itself the Independent State of Somaliland; this region has remained relatively stable ever since, especially compared to the situation in the south of the country (Ahmed, 2006). Several other warlords have also set up their own mini-states in Puntland

and Jubaland. Although internationally unrecognized, these states have been peaceful and stable.

In 2000, Somalia's first government in nearly a decade was elected. After its first year in office, the government still controlled only 10% of the country, and in 2003 its mandate expired. A new government began in 2004, and spent its first year operating out of Kenya. In 2006, Somalia's worst outbreak of violence in ten years began, with Islamist militias called the Somali Islamic Courts Council (SICC). The Islamic militias seized control of the capital and established control in much of the south. The Islamic militias continue to attack the African Union peacekeepers and have vowed to destroy the country's Western-backed and broken government. Successive peace agreements have been brokered and hundreds of thousands of Somalis have been displaced. Many people fled Somalia, mostly seeking refuge in neighboring Kenya. Dadaap refugee camp in Kenya remains the world's largest refugee settlement, and is home to over 400,000 Somali refugees (UNICEF, 2011).

Before and during the war, reproductive health has been a major problem in Somalia. The maternal mortality of 1,044 per 100,000 live births is one of the highest in the world (UNICEF, 2001). Few women in Somalia have access to prenatal care, leading to pregnancy complications. Somali refugees also

experience poor reproductive health services at refugee camps due to overcrowding and lack of adequate facilities and personnel. Six women in this study- Zahra, Lamia, Zeynab, Awrala, Safiya, and Halima- are from Somalia. They lived through the war and violence in Somalia before resettling to the U.S. Some of them were relatively young when the war broke out and spent virtually all their lives in refugee camps.

## Sudan



*Figure 5.* Map of Sudan

Sudan is located in the northern part of Africa. It shares borders with Egypt, Ethiopia, Eritrea, Chad, Central African Republic, Libya, Kenya, Uganda, and Democratic Republic of Congo. Khartoum is the capital and political center of North Sudan. The capital of South Sudan is Juba, where the newly formed country of South Sudan is building a state. The tensions between North and South Sudan have been shaped by historical and contemporary inequalities between the two regions, resulting from prejudices based on race, ethnicity,

religion, culture and identity (Deng, 1995). Bernstein (2005) argues that reducing the war to race, religion, and riches, the same things people always kill each other over, fails to recognize the complexities of those elements and the history that has shaped them. Iyob and Khadiagala (2006) contend that there is no clearly unified south or north Sudan; each is beset by factional infighting and driven by the politics of the past- along with ideological and ethnic rifts, cleverly manipulated by the ruling elites since independence was attained in 1956.

Conspiracy in the ranks of the southern army and police units on the eve of independence resulted in the deaths of large numbers of northerners living in southern regions and could be considered to be the start of the civil war in Sudan (Iyob and Khadiagala, 2006). Soon afterward, the head of the military took over power, harshly quelling strikes and demonstrations, closing mission schools and actively promoting Islamization of non-Muslims in the south. This resulted in increased resistance from the South Sudanese, and a push for self-determination (Anderson, 1999). Six years of sustained guerilla warfare and a general strike within the military resulted in a change of government in 1964, followed by a coup in 1969. By this time, disparate armed factions in the south had formed a loose alliance and the governments of Uganda and Ethiopia provided them with military support which exacerbated the situation (Iyob and Khadiagala, 2006).

Civil war continued to rage across Sudan with the population in the south of the country bearing the brunt of much of the action. In 1972, after sixteen years of escalating violence and war, the population was starting to scatter, seeking refuge further north or in neighboring countries. A truce was signed between the government and the rebel forces in that year, but civil unrest continued unabated and fully fledged war erupted in 1983 (Johnson, 1998). The government introduced Sharia laws across the country in an attempt to contain the situation, but was overthrown in a popular revolt in 1985. A new government was elected in 1986, but was unable to contain the hostilities or prevent militias from raiding villages and terrorizing civilians.

In 1999, in the face of famine and continued atrocities, countrywide peace talks commenced between the government and the southern forces. A peace accord was signed in 2002, signaling an end to the civil war and the establishment of self determination in Southern Sudan. However, in 2003, the army was deployed to quell an uprising in Darfur and pro-government militias wreaked havoc in the region, killing indiscriminately. After prolonged heavy fighting across the country, peace agreements were once again signed in 2005- between the southern rebel groups and the government, and between the government and the main rebel groups in Darfur. In July 2011, south Sudan became an

independent state officially known as the Republic of South Sudan. However, tribal conflicts still persist in this newly formed state.

Two million people are estimated to have died between 1986 and 2006, over four million people have been internally displaced, others trekked vast distances to seek asylum in Ethiopia, Kenya, Uganda, and Egypt. The two Sudanese women who participated in the study (Florence and Charuni) were among those who fled the country. Florence sought refuge in Egypt, while Charuni lived in Kakuma refugee camp in Kenya for twelve years.

## Togo

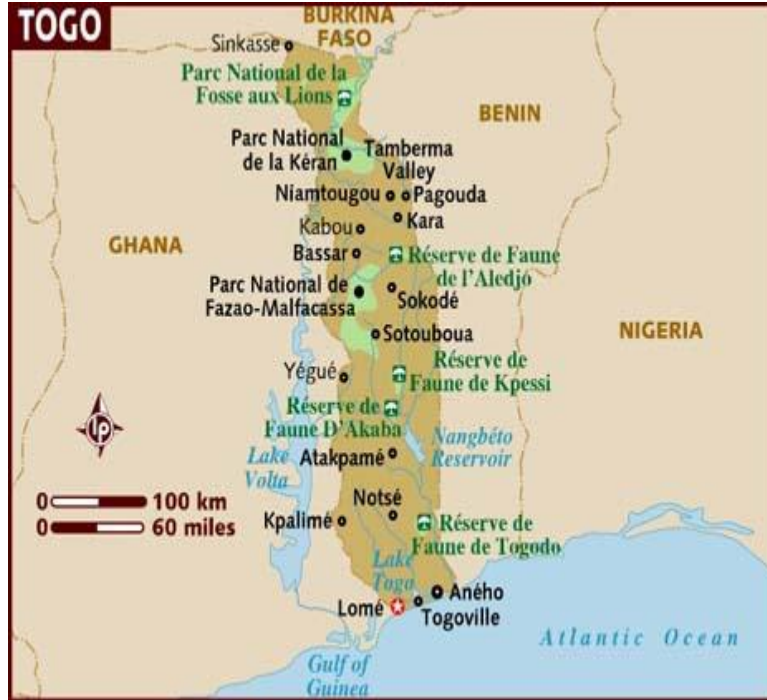


Figure 6. Map of Togo.

Togo is a very tiny country in West Africa. It shares borders with Ghana, Benin, Burkina Faso, and Nigeria. As was the case in many parts of Africa, the borders of Togo were formed by European colonizers with little regard to pre-existing cultural, ethnic, or linguistic boundaries. After gaining independence from France in 1960, Togo endured seven years of political turmoil in a military coup which brought Gnassingbe Eyadema to power. Eyadema set up and dominated what was effectively a one party state backed by the army. Limited



democratic reforms were introduced in the 1990s but Eyadema clung to power in the midst of accusations of political violence. He ruled until his death in 2005 after which his son, Faure Gnassingbe, was installed as leader in defiance of constitutional procedures. After protests and pressure both at home and abroad, Gnassingbe held elections in April 2005. The poll was marred by accusations of electoral irregularities and violence followed Gnassingbe's win.

Clashes in 1992 and 1993 between security forces and opponents of Eyadema's rule caused the displacement of approximately 300,000 Togolese. Many of them escaped to Ghana or Benin. Also, the election held in 2005 sparked fresh violence which sent approximately 40,000 more people fleeing across Togo's borders. Although the majority returned to Togo over the next few years, others have remained in neighboring countries, many of them living in refugee camps ever since. Collette was the participant from Togo. She was among the 300,000 Togolese displaced during Eyadema's rule. Collette lived in a refugee camp in Benin before coming to the U.S.

Unlike refugees from other Africa countries such as Somalia and Sudan, Togolese refugees have a hard time convincing people of their refugee status. In fact, when Collette told me she was a refugee from Togo I was surprised and asked her, how come? She then went on to explain that a lot of people ask similar

questions. Perhaps Eyadema's long years of dictatorship did not attract as much attention as they should have done internationally.

## **Conclusion**

This chapter illustrates the war situations in the countries of origin of the refugee women who participated in this study. These women fall under the category of acute refugees (Kunz, 1973). As mentioned earlier in chapter 1, the U.S. is one of the countries in the West where African refugees are permanently resettled. As a signatory to the 1951 United Nations Convention and 1967 Protocol Relating to the Status of Refugees, the U.S. has certain international obligations to refugees. These include offering protection to anyone who meets the U.N. definition of a refugee and providing financial assistance to UNHCR to supply support and relief materials to refugees, and it accepts a certain percentage of refugees to be resettled in the U.S.

In order to be resettled in a third country, most of these Africa refugees who fled their countries to refugee camps in neighboring countries have to prove their claims for human rights abuses even though the whole world knows they are fleeing wars in their countries. After they successfully prove to the UN officials that they are victims of gross human rights abuses in their country of origin, they may be sponsored for resettlement. Several of the refugee women in this study

had to undergo the interviews which include medical screenings before they were shortlisted for resettlement in the U.S. Nshimirimana and Nsegiyumva described how they were asked to go completely nude during the medical screenings. They said the process was very long and tedious.

For the refugees, the price of freedom is not always free. Their plane ticket from refugee camps was paid for by sponsoring agencies who receive funding from the U.S. government. These plane tickets are loans that need to be paid back as soon as refugees start work. Finding decent employment has remained a huge problem for most of these women. The next chapter provides a bio-sketch of the refugee women and healthcare providers who participated in this study.

## **Chapter 5**

### **DESCRIPTION OF PARTICIPANTS**

This chapter serves to introduce the reader to the twenty African refugee women and ten healthcare providers whose personal and professional experiences constitute the core of this study, and provides a compressed narrative for each participant. The bio-sketches reveal the issues refugee women faced pre-migration, thus providing the foundation for understanding their experiences of forced migration. For each refugee participant, information about life in refugee camps is discussed. Additionally, an overview of family situation is provided.

Despite their earlier harsh life realities, the majority of refugee women have been able to use the latest hurdle, their refugee status, as a catalyst in their ability to still maintain their sanity. Their displacement and forced migration made them reconsider and appreciate other aspects of their lives that had not been the central focus earlier. It would be impossible to present all the information that makes every one of these women unique. I do hope, however, to illustrate and allude to the general worldview of each woman as characterized by their insights about reproductive health. The reader will meet these women and their themes again throughout the next chapters.

The focus in many of the bio-sketches is on defining and explicating their reproductive health experiences within the context of forced migration and provision of care. The participants are grouped into two categories: African refugee women and health care providers. Each group provides their unique experience in regards to dealing with reproductive health needs of refugee women. The experiences described in the bio-sketches provide relevant information on refugee participants' pre-migration experiences.

The names of the participants have been changed to protect their privacy and some details about their experiences have intentionally been omitted to avoid any association with their personal identifying information. For the purpose of this dissertation, each participant has been assigned a fictitious name based on their ethnicity/nationality, race, and/or religion (that is, the Muslim participants will be assigned a Muslim name, while the Christian participants will get Christian names. Some names are ethnically derived, but the religions of such participants can be derived from their stories).

## Refugee Participants

Table 1

*Characteristics of Refugee Participants (n = 20)*

---

<b>Category</b>	<b>(N = 20)</b>
Gender	
Female	20
Country of Origin	
Burundi	6
Democratic Republic of the Congo	1
Liberia	4
Somalia	6
Country of Origin (continued)	
Sudan	2
Togo	1
Religion	
Christianity	14
Islam	6
Pre-migration Education	
No formal education	3
Elementary	4
Middle School	2
High School	10
Some College	1
Post-migration Education	
ESL	4
Certification	1
Some College	1
Associate Degree	2
None	12

*Characteristics of Refugee Participants continued*

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<b>Category</b>	<b>(N = 20)</b>
Employment Status	
Employed	7
Unemployed	13
Currently Pregnant	3
Have Children	16
Interview	
Used Interpreter	7
Did not use interpreter	13

---

The table above provides a quick glance at important demographic characteristics of the refugee participants that are discussed throughout the rest of the chapter and dissertation. Donyen, Florence, Halima, Nadege, Bendu, Zeynab, Juliette, Agnes, Zahra, Safiya, Margaret, Nshimirimana, Nsegiyumva, Gloria, Lamia, Collette, Awrala, Marthe, Esther, and Charuni- each of these women have endured difficulties due to displacement and resettlement. Their bio-sketches provide insight into who they are. Although these women have different personalities and have different personal experiences of reproductive health, they have the collective experience of surviving war and conflict.

## **Donyen**

Donyen is a forty-two year old Liberian refugee woman. In 1995, Donyen and her family fled Liberia due to civil war and lived as refugees in Ivory Coast for eight years. Donyen and her five children were resettled to the U.S in 2004 by the UNHCR. She completed high school pre-migration in Liberia. Donyen describes herself as a bible-believing Christian. My first meeting with Donyen was at RWHC; she had accompanied her sixteen-year old pregnant daughter for a prenatal visit. I also conducted a follow-up interview with Donyen at her local church. When I visited her church, Donyen introduced me to the women's fellowship and encouraged them to participate in the study. I was able to recruit other participants from the church.

Donyen recalled the atmosphere in Ivory Coast when she lived there as a refugee. Over there, she survived on fishing but was constantly harassed by the Ivorian police, who would forcefully take their fish and other belongings leaving them with nothing. In spite of the hardship she experienced in Ivory Coast, Donyen still believes that the living condition there was much better than life in Liberia. During our interview, Donyen revealed that her major reproductive health concern was the issue of menopause. She was surprised when her monthly period became less frequent and she was later diagnosed to be premenopausal.



## **Florence**

Florence is a soft-spoken, thirty-seven year old refugee from Sudan. Florence fled Sudan in 2002 and sought asylum in Egypt where she lived for three years before her resettlement in the U.S in 2005. Florence is a Christian and is originally from southern Sudan. She was clerical staff in both Sudan (pre-migration) and Egypt (migration). She and her family (two children and husband) were initially resettled in Nebraska, but in 2009 she moved to Phoenix to get away from her husband who had become abusive and even threatened to kill her.

My interview with Florence was held at the RWHC. She was eight and a half weeks pregnant and had come for a routine prenatal check. Florence had sad memories from Sudan. With so much difficulty and sadness, she recalled how her nine-year old daughter passed away in Sudan while she herself was in a refugee camp in Egypt. She feels her current pregnancy is God's way of consoling her over her deceased daughter.

Florence spoke fluent Arabic and little English. Her education pre-migration stopped in Junior High School. She described herself as independent-minded, a characteristic that did not match the dominant narrative about the "needy and dependent" nature of African refugees. Florence, like most participants, only utilizes health care facilities when she is pregnant or very sick.

**Halima**

Halima is a twenty-four year old Somali-Bantu. She was eleven years old when her family fled to Dadaap refugee camp in Kenya due to civil war and violence in Somalia. The rest of her family still reside in Kenya. Halima got married in Dadaap refugee camp before she resettled in the U.S. Her husband was the first person to arrive in the U.S. and she joined him after two years in 2005. She completed fourth grade pre-migration and has not had any formal schooling since then. Halima and her husband are currently unemployed and depend on government disability due to a mental health issue she was diagnosed with. She did not want to discuss the nature of the mental health issue but was happy to tell me that she just had a second baby and was visiting the clinic for her two-week postpartum visit.

Halima was one of the few Muslim participants in this study. She was dressed in ethnic/religious clothing. She was a patient who depended on the clinic to make transportation arrangements for her.

**Nadege**

Nadege is a thirty-four year old Burundian and identified as a Christian. She was born to refugee parents in Congo. Nadege, her husband and six children were refugees in Tanzania for twelve years before the Catholic Charities resettled

them in the U.S. in 2004. She completed sixth grade in Congo before she fled to Tanzania. Nadege has completed English as a Second Language (ESL) classes which she describes as an “important way to gain the confidence she needs to communicate in American English.”

Nadege recalled that as a refugee in Tanzania, she could only eat one meal a day due to rationing. She talked about people dying from hunger and diseases. She takes pride in being in the U.S: “I am happy to be in America because my children can go to school, eat, and play.” Nadege complained of premenopausal symptoms and told me she believed her constant headaches are related to that.

### **Bendu**

Bendu is a forty-seven year old refugee from Liberia. She describes herself as a Christian and was one of the participants that I interviewed at the Church. Bendu and her husband and six children were resettled in the U.S. in 2004 by the Catholic Church. They were initially resettled in Michigan, but her family moved to Phoenix, Arizona in 2007. Prior to their resettlement, Bendu’s family were refugees in Ivory Coast, where they lived for twelve years. They spent about eight months in Guinea before they reached Ivory Coast.

Bendu has had no formal education but speaks good English due to her Liberian origin. She is one of the few participants who were employed at the time

of the interviews. She is proud of her janitorial job at the Phoenix Sky Harbor International Airport, but laments her husband's unemployment: "in Liberia, my husband was working and I had to stay home to raise our children, but now things have changed," she says regretfully. Bendu also complained of workplace disrespect and how she has been struggling with her health due to exposure to cleaning chemicals at work.

### **Zeynab**

Zeynab is a twenty-five year old Muslim refugee from Somalia. Zeynab and her family were refugees in Kenya for twelve years until the UNHCR resettled them in the U.S in 2004. She got married to a fellow Somali refugee in 2005 and they have three children. She completed high school pre-migration and is currently studying to become a registered nurse. Although Zeynab's English language skill is above average, she lacks confidence and would occasionally say: "my English is bad." Zeynab is considered a "refugee camp baby" since she started living at the camp from the young age of nine. She recalls that the camp had many families with children of similar age as she and even younger. According to Zeynab, growing up in a refugee camp makes you very appreciative of the basic things in life: "you are very thankful for the food even though it is not enough for the family... my mother used to hide some food for later."

### ***Juliette***

Juliette is an eighteen year old Burundian refugee. She is a practicing Christian. Juliette was my youngest participant and can be described as a “refugee baby” as well. Born in Burundi, she became a refugee at the age of four and grew up in a refugee camp in Tanzania. Her family lived at the camp for 11 years before their resettlement in the U.S in 2007. Life as a refugee had its many downs but it also gave Juliette the opportunity of basic education. She was in tenth grade before being resettled in the U.S, and is currently a senior in high school. I met Juliette and her husband during her prenatal visit at RWHC. She was very excited and happy about her pregnancy and looked forward to having her baby. Asking her questions about her reproductive health experiences revealed her dependence on her husband. She would not answer any question without looking at him for approval. When the husband offered to leave the interview room she declined.

### ***Agnes***

Agnes is a thirty-one year old Liberian refugee. She was born a Christian and still calls herself one but does not attend church regularly. She arrived in the U.S. from Ivory Coast with her three children. She was one of the participants who relocated from another state. Agnes was initially resettled in Albuquerque, New Mexico. She moved to Phoenix in 2009 and was unemployed at the time of

the interview. Agnes was my only participant who talked openly about considering an abortion since she could not afford to keep her pregnancy. Agnes describes herself as a resilient young lady who is trying so hard to raise her three children in an unfamiliar sociocultural environment. She complained about the difficulty with living between two cultures, especially as American child care laws contradict with her cultural views. Agnes talked about not being able to discipline children here in America because of the laws that favor children. She completed fourth grade in Ivory Coast and speaks fair English.

### **Zahra**

Zahra is a big woman with a soft voice that holds her listener's attention. She is a Muslim and was dressed in traditional clothing. Zahra is of Somali origin, and is forty-three years old. She and her family were refugees in Yemen before her resettlement in the U.S. She arrived in the U.S. in 2000 and is the only participant who had lived in the U.S for 10 years at the time of the interview. She moved to the U.S alone but has since married a fellow Somali refugee and together they have four children. Zahra told immigration officials that she was twenty-three at the time of her application for refugee status, which means that her official government-issued ID shows she is thirty-three instead of forty-three. She told me that younger women were given more preference and that she lied

about her age out of desperation in search of a better life elsewhere. Zahra had to disclose her real age to her healthcare provider when she was pregnant: “she (referring to the doctor) didn’t judge me when I told her my story. She was nice to me and told me she understands.” Zahra completed high school in Yemen, but has not had any formal schooling in the U.S. One of the first things that Zahra tells me during the interview is: “I am currently on birth control pill; I do not want to have more children. All my children were born through caesarean section”. I later learned during the interview that she had complications from fibroids during her previous pregnancies. What makes her unique is her willingness to disclose such personal information at the beginning of the interview.

### **Safiya**

Safiya recalls being in the midst of violent conflicts and fighting. At the very young age of six, her family fled Somalia to Nairobi refugee camp. Safiya lived in the refugee camp until 2004 when her family was resettled in Atlanta, Georgia. She later moved to Phoenix to join her husband in 2008. Safiya is twenty-six years old and is pregnant with her second child, the first with her husband. She has a seven-year old daughter who lives with her paternal aunt in Somalia. Safiya did not want to discuss the circumstances surrounding the birth of her seven-year old daughter, but her body language and facial expressions

revealed so much pain. When I probed further, Safiya tearfully told me she was supposed to marry her seven-year old daughter's father but he was killed in a motorcycle accident shortly before her resettlement in the U.S.

Safiya was a high school junior in Nairobi, Kenya before her resettlement in the U.S. She has since attended classes to "improve my American English" (her exact words). Safiya is a Muslim.

### **Margaret**

At the age of eleven, Margaret's family fled their home town in Democratic Republic of the Congo (DRC) to a refugee camp in Zambia. They lived in Zambia for eleven years before their resettlement in the U.S in 2007. Margaret is twenty-two years old and is married to a fellow refugee from DRC. Margaret was seven and half months pregnant during the interview and also disclosed to me that she had lost her first pregnancy. She describes her earlier miscarriage "as the most difficult thing that has ever happened to me". Margaret's husband lives in New York City; she told me they were having marital problems so she decided to come to Phoenix to stay with her family until the baby is born.

Margaret recalls that life in Zambia was very tough and they barely had enough food to eat: "everything was rationed and we had to sleep with empty



stomach sometimes.” Margaret completed ninth grade before resettling in the U.S. She wanted to complete her high school education in the U.S but was told that she is too old for high school. She is currently planning to take ESL classes after the baby is born. She identifies as a Christian.

### **Nshimirimana**

Thirty-six year old Nshimirimana’s refugee experiences reflect true resilience. Originally from Burundi, she was a refugee in Congo for ten years, before resettling in Tanzania refugee camp where she lived another ten years before moving to Kenya from where she was resettled in the United States in 2007. Nshimirimana recalls being stripped naked by Kenyan government officials at the border between Kenya and Tanzania. She slept on cold concrete floors in a makeshift detention center with her one year old baby who has Down Syndrome. She was interrogated because she did not have immigration documents, which is common with refugees who have to flee hurriedly most of the time. Nshimirimana is a Christian.

Nshimirimana completed eleventh grade in Congo before her resettling in Tanzania and the US. She laments about her current unemployment and wishes to be employed: “we Africans want to work but there is no job”. Nshimirimana speaks fluent Kirundi, Swahili, French, and some English. Although her English

language skill is above average, Nshimirimana lacks the confidence to communicate in English and prefers to use an interpreter.

### **Nsegiyumva**

At fifty-two years old, Nsegiyumva is the oldest participant. She is a Christian and originally from Burundi, but lived in Rwanda and Tanzania as a refugee before she and her two adult children were resettled in the U.S in 2007. Nsegiyumva lost her husband during an ethnic conflict in Burundi in 1997. She has had no formal education but is able to communicate in not-so-perfect English. Nsegiyumva is very proud of her cleaner job at a café in Phoenix and she feels empowered by the income she makes.

Nsegiyumva has mixed feelings about her refugee experience. She recalls the sleepless nights, rationed food, and young girls being violated, yet she believes it was that experience that qualified her to be in America, which she is very proud of.

### **Gloria**

Gloria is a twenty- eight year old Burundian like Nsegiyumva, she also lived in Rwanda and Tanzania before resettling in the United States in 2007. Gloria identified herself as a Christian and she was one of the women I interviewed in their homes. Gloria did not speak much English and I had to use an

interpreter to conduct the interview. She complained bitterly about her husband's unemployment but remains thankful to God that she is in America: "I can go to sleep with my doors open." She recalls the uncountable sleepless nights she had during her refugee sojourn in Rwanda and Tanzania: "the camps were not safe so we have to sleep with one eye open."

Gloria completed sixth grade in Tanzania and has had no formal education since then. She is very proud of her housekeeping job at a local hotel. She is able to support her family of six (four children and husband) with her income.

### **Lamia**

Lamia is a twenty-year old Muslim woman and has spent most of her life as a refugee. She is a Somali-Bantu from Somalia but lived in Kenyan refugee camp with her family for twelve years before resettling in the U.S in 2004. Lamia's family was resettled in Chicago, but she moved to Phoenix in 2005 after she got married. She completed seventh grade in Kenya and has received an associate degree post-migration. She is currently unemployed but spends most of her time volunteering at various places.

My first impression of Lamia was that she appeared sad. As we became familiar during the various interview sessions, she told me that she desperately wants a second child but is unable to conceive. I tried to reassure her that her baby

is only 2 years old and that she is still very young, but she complained that her husband might resent her if she is unable to conceive her second pregnancy very soon. Lamia remains hopeful that the refugee women's clinic will help her fix her reproductive problems.

### **Collette**

Collette fled her village in Togo in 1997 and lived as a refugee in Benin. Despite living in Togo and Benin, Collette speaks little French and is only comfortable communicating in her ethnic language (Mina). Her brother-in-law, who is a medical interpreter at International Rescue Committee, served as the interpreter during the interview. The decision to use Collette's brother-in-law as an interpreter was made on the spur of the moment. She had expressed keen interest in participating in the study but complained about her lack of excellent English language skills. She asked if it was okay for her to use the brother in-law and I said yes. Collette identified herself as a Christian.

Collette's husband was resettled in the U.S in 2004 and he filed for her to join him also as a refugee. She was finally granted refugee status and the necessary visa to join her husband in the U.S in 2008. At the time of the interview, Collette had a six weeks old baby and still had to continue her housekeeping job at a local hotel. She could not afford being unemployed since

her husband was unemployed. She complained about the stress of being a new mom and having to juggle a full time job. Collette did not have any formal education before resettling in the U.S and her inability to master American English discourages her from going to school.

### **Awrala**

Awrala is a shy, quiet, and religious Muslim woman. She was the only participant whose husband participated actively in the interview. Awrala is thirty-four years old and identifies as an ethnic Somali. She lived in Syria for eight years as a refugee before resettling in the U.S. in 2009. She and her husband and daughter were initially resettled in San Diego. They decided to move to Phoenix in 2010. They had only been in Phoenix for six months at the time of the interview in November 2010. Awrala completed high school in Somalia before her flight to Syria. Although currently unemployed, Awrala has also completed ESL classes to enable her find a decent job.

Awrala and her husband talked about their fertility problem. Their daughter was six years old and they have not been able to have any more children. While discussing her reproductive health experiences, Awrala talked about her experience with fibroids. She continually talked about her various attempts to conceive another child. Her husband would sometimes remind her of certain

things throughout much of the interview. Awrala's husband dominated much of the interview.

Although her English is good, she deferred to him during our interview, allowing him to answer most of the questions. This was very different from all other interviews I conducted. While I conducted interviews in the home of some participants, with their husbands at home during the interviews, all their husbands excused themselves after exchanging pleasantries with me before the interviews commenced.

### **Marthe**

Marthe is a forty-eight year old Burundian refugee who lived as a refugee in Ethiopia and Uganda before resettling in the U.S in 2008. Although she had seven children, Marthe was only able to arrive in the U.S. with her youngest baby. She then filed immigration papers for the rest of her family. She did not have much problem bringing her family to the U.S because she had given their personal details during her interview in Ethiopia. Her husband and six remaining children joined her in 2010.

Marthe completed high school and even got a teaching diploma to teach elementary school in Burundi before she fled for her personal safety. She felt that her life and that of her family was at stake after she was jailed and her husband

taken to an unknown place for months due to their participation in politics. Following her release from jail, Marthe took off and has never gone back to Burundi since then. Once the husband managed to escape from his captors he also fled Burundi. For over a year Marthe and her husband did not have contact with each other or their children. She recalls that it was very tough on her, but she had to do it in order for them to survive. Marthe has completed ESL classes and is currently working at the Phoenix Sky Harbor Airport. She is very happy that her family is finally united and all in one place. Marthe identified herself as a Christian.

### **Esther**

Esther is a thirty-year old Liberian refugee who had lived in Ivory Coast for ten years before resettling in the U.S in 2004. She came to the U.S with her mother, father, and five siblings. Esther talked about the difficulty of living in a refugee camp. Additionally, she recounted her experience of almost being raped by a man who happens to be a refugee too and having people stigmatize her for speaking up traumatized her. While discussing how upset she was with the refugee camp security for their lack of efficiency, she simultaneously discussed how some guards take advantage of young girls' hunger to sexually exploit them.

Esther completed high school in Liberia and has obtained an associate degree in nursing. She works as a registered nurse in a local hospital. She described herself as ambitious and having to “rush” to school as soon as they arrived in the U.S. Esther’s family depends on her for financial support. She pays most of their bills and other necessary needs. Esther is a Christian and she attends a local African church.

### **Charuni**

Charuni is a thirty-three year old Sudanese refugee. She and her family lived in a Kenya refugee camp for twelve years before she resettled in the U.S. in 2007. Charuni self identifies as a Christian. She has three children. She conveyed that she always believed that one day she will be in America. “I wanted to come to America to help my family.” Coming to America meant a better and safe life for her and the opportunity to improve her financial situation. Charuni completed high school in Kenya and works as a certified nurse assistant (CNA) in a group home. She describes herself as ambitious and still hopes to go back to school to study nursing.

Although Charuni did not come out and say specifically in the interview that her dissatisfaction with her job was because of the double hours and stress, it can be inferred from her narrative that she was concerned with the number of



hours she puts in at work and how it is affecting her well being. Her reason for being at her present job is that it will prepare her for nursing school. She continually talked about her future plans to go to nursing school.

All the refugee women in this study were forced out of their homeland because of religious, ethnic, and political crises. They left due to fears for their safety and the safety of their family members. Many witnessed the destruction of their entire community. Most of these women migrated with family members such as children, spouses, parents, nieces, and other relatives across regional and international borders. Each of these women started a new life in one or two different countries of asylum before applying for refugee status to enable them to resettle to the U.S. The average amount of time the women lived in the diaspora was 10 years. The range was from six months to 10 years from the time they left Africa until they arrived in the U.S. The refugee women who participated in this study have adapted to extreme situational transitions during and after their flight. Their lives are a testimony to the strength and adaptability of refugee women.

### **Healthcare Providers**

Healthcare providers were included in this study to have a holistic view of reproductive health experiences and needs of African refugee women. I spent several months negotiating access and participating in community coalition

meetings with RWHC and was able to gain access and recruit key personnel via email. Interviewers were selected on the basis of professional experience caring for refugees and African refugee women in particular, and all had strong interest in the unique reproductive health needs of African refugee women. The providers were emailed letters of recruitment through the director of the Refugee Women’s Health Clinic. Most of the providers that I contacted through email accepted my invitation to participate in the study. Table 2 below provides a summary of the characteristics of providers who participated in this study.

**Table 2**

*Characteristics of Health Care Providers (N=10)*

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<b>Category</b>	<b>(N =10)</b>
<hr/>	
<b>Gender</b>	
Male	0
Female	10
<b>Race</b>	
White	8
Chinese Immigrant	1
Indian Immigrant	1
<b>Qualification</b>	
Registered Nurse (RN)	6
Certified Nurse Midwife (CNM)	1
Ph.D in Nursing/CNM	1

*Characteristics of Health Care Providers Continued*

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<b>Category</b>	<b>(N =10)</b>
Obstetrics/Gynecology (OB/GYN)	1
Social Workers	2
<b>Populations often served</b>	
Both Refugee and non-refugee groups	10
<b>Services Provided</b>	
Labor and Delivery	3
Postpartum Care	3
Education and Counseling	2
Gynecological	2
<b>Years of Providing Service to Refugees</b>	
1-5 yrs	9
6- 10yrs	1
<b>Able to speak a second language</b>	
Hindi	1
Spanish	2
Mandarin	1

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A brief bio-sketch of health care providers follows below. Like the refugee participants, each provider is assigned a fictitious name.

**Brenda**

Brenda is a white female. She is a registered nurse (RN) with over twenty years of professional experience. She has been providing care to African refugee

women for over a year at the time of interview. Brenda was my first provider participant. She was very nice and helped to recruit other participants from her unit in the clinic. Brenda's primary role with refugee patients is that she oversees their labor process. She works with the doctor to deliver a baby then she does routine postpartum care.

**Jessie**

She is a registered nurse. She is a white female. Jessie has had over twenty years of professional experience and has worked with refugee patients for three years. Jessie described her role with refugee patients, "I advocate for them, watch the baby, take care of moms in pain, get the doctor when it's necessary." Jessie was excited about the study.

**Tiffany**

Tiffany is a white female. She is a registered nurse with twelve years of professional experience and two years experience with refugees. Tiffany also works in labor and delivery. Her primary role is in triage, she helps patients with the admission process. She assists them with labor until the baby comes and then they are transferred to postpartum care.

**Saba**

Saba is an Indian immigrant and has lived in the U.S. for over fifteen years. Saba is a registered nurse.. Saba has ten years professional experience and three years experience providing care to refugees. Saba provides postpartum care and education for refugee women. She was loquacious and was a little bit blunt in her descriptions of refugees.

**Sandy**

Sandy is a Chinese immigrant. She has lived in the U.S since the age of six. Sandy is a registered nurse and has had seven years of professional experience and two years experience with providing care to refugee populations. She provides postpartum education, follow-up appointments for baby and mom. Sandy also teaches moms breast feeding and dispenses birth control pills.

**Daniela**

Daniela is a certified nurse midwife (CNM). She works in labor and delivery. She has had sixteen years professional experience and has worked almost all her career with refugee patients, particularly those from Bosnia, Burma, and Somalia. Daniela assists refugees with postpartum care and supports patients who have complications like excessive bleeding or needing birth control. She also provides breastfeeding assistance.

**Karen**

Karen is a social worker at the hospital. She is white and has had thirteen years professional experience and two years experience with refugees. She supports refugee patients in the area of counseling, especially if they have had a real tragedy, loss and horrific time in the refugee camps. She follows up with patients after they are discharged from hospital.

**Maggie**

Maggie is a social worker and has had fifteen years professional experience and two years experience with refugees. She is a white female. She describes her role in the hospital as multiple and centered on behavioral help. She also consults the psychiatrist, if needed. She follows up with the families – mother and child.

**Judy**

Judy is a white female. She has a lot of professional titles. She has a Ph.D as a nurse practitioner. Judy is also a certified nurse midwife and a certified women's health nurse practitioner (WHNP). She has had over twenty-five years of professional experience and has been working with refugee patients for about three years. She assists refugee patients in birthing and consults with them in the

clinic for the prenatal visit and postpartum care. Judy consults with refugee women only and does not interact with men, except relatives of her patients.

### **Betty**

Betty is a white female. She is an obstetrician/gynecologist. Betty has eight years of professional experience and has been providing care to refugee patients for about three years. She explains that she does not have a specific job designation but covers for the director of the clinic. She also takes care of labor and delivery.

### **Conclusion**

This descriptive chapter has laid the groundwork for understanding the context of refugee women's lives prior to coming to the U.S and since resettling to the U.S. It also provided a description of healthcare providers interviewed during the research. Subsequent chapters will fill in the very important middle of the story. Before moving on to those dramatic moments, it is critical to highlight the degree of similarity across refugee participant and health care provider experiences and what it might suggest to us regarding patterns for refugee-provider relationship.

## Chapter 6

### **LIVING BETWEEN TWO CULTURES: REFUGEE WOMEN'S PRE-MIGRATION AND POST-MIGRATION EXPERIENCES**

*It's hard because refugees now they are in the middle, them not in American culture and them not in African culture. They are just in the middle of nowhere.*

*-Florence, thirty-seven year old.*

One cannot help but hear the experiences of the refugee women who participated in this study echoed in the quote above. Each of these women brings with them their unique stories of pre-migration and post-migration in the Phoenix area. In the previous chapter, I have described the characteristics of the study participants. Delineating pre-migration and post-migration experiences of refugee women is the focus of this chapter. Also, this chapter explores the phenomenon of African women speaking of their experience in their own voices. These women owned their experience by expressing their views in their own words. Although they came from different countries of origin and countries of first asylum, and are of different ages, their stories contained many similarities. For all, the sudden nature of their flight and their uprooting and displacement, both geographically and emotionally, were central to the shaping of how they conceive reproductive health.



Although the refugee women in this study were now geographically far removed from the war and violence in their countries, many of the women continue to fear for their safety and that of their loved ones, some of whom remained in their homelands or refugee camps in neighboring countries. The fear was intensified by American social and health institutions. As refugees, they feared that they will not be able to navigate the health systems as they could barely speak English or could not read and write. The women expressed fear of being misunderstood combined with the distrust of people. The women, particularly those from Liberia and Burundi, spoke of being betrayed by neighbors and “friends” during the war, explaining that they now found it difficult to establish trusting relationships, which contributed to their increased sense of self-consciousness.

The women’s narratives, accounts, and stories in this chapter address one of the research questions posed earlier in the study: How do African refugee women describe their pre-migration and post-migration experiences? Five themes emerged from the pre-migration and post-migration category: lives forever changed; redefining normality; living between two cultures; learning American ways; and racial and religious discrimination. The themes that emerged under this category are explored in the following sections.

### **Theme One: Lives Forever Changed**

The theme of “lives forever changed” was derived from the conceptual category of pre-migration experiences. Due to civil war and ethnic conflicts, these women were forced to flee their homeland changing their lives forever. More than half of my participants are described as “double flight” (a term coined by the United States Refugee Program -USRP) which means that after escaping their homeland and fleeing to a neighboring country, they were once again forced to flee their second country of asylum as war broke out again. The women described how their lives changed emotionally, socially, and physically, and noted how these changes in turn affected their health and well being. Some of the women attributed hair loss and weight loss to their war experience, and they shared a deep sense of helplessness knowing that their loved ones were being tortured or killed by rebels/militias. They described the profound impact that this had on them, stating that witnessing violence was as devastating as having violence inflicted upon them.

Nsegiyumva, Donyen, and Marthe’s narratives are organized around the first theme. As narrated by several of the participants, wars and ethnic conflict were perceived to have begun rapidly and the women’s lives changed suddenly. Donyen, from Liberia, recalled that “all of a sudden” Liberia was at war and she

was trapped until she was able to get out and fled to Ivory Coast. Nsegiyumva from Burundi had not believed that the war in Burundi was imminent when she was forced to flee with her two children to Rwanda before proceeding to Tanzania.

After she lost her husband to war, Nsegiyumva was left to care for her two children and did not hear from the rest of her family for many years. She describes the horrendous event that changed her life forever:

Me and my two children are sitting at home one day. My husband go work. I hear loud noise, people shouting and running. I run outside and saw people beating people. People beating people, killing people. I ran inside the house and took my two children and started running. As I was running, I see people running and I followed them ...I did not know where we were going. We ran to a church and were hiding there until morning. I went home and saw my husband's dead body in front of our house. My children saw the dead body with their two eyes. They (referring to the militia) killed him (shakes her head). They killed him, maybe he came to carry me and our children and they killed him... (deep sigh). My life was turned upside down...I became a different woman. I became a refugee and was living in a camp in Rwanda before we went to Tanzania. Life in camp

was bad...we didn't have enough food. I didn't have anybody to help me (sigh)...thank God am in America. It is now that I can sleep well without thinking someone will come and kill us in the night.

Donyen begins her story by telling me she had never told anyone her story: "No one asked me, Donyen, tell me what happened to you in Liberia. I carry it all inside me." It was during my second interview with her that she opened up about her devastating war experience, particularly when her husband was killed and of her own narrow escape from death at the hands of the rebels:

It was very hard. The rebels were very wicked and they were killing everybody. They first cut my husband's hand and he was in pains and somebody said let's finish him and they used machete to kill him. I was hiding in the latrine with my children. We were afraid that they will come and get us. So I start thinking "what am I going to do," if I go out they will kill all of us. I was praying in my mind. And at night we came out. When I came out, I saw dead bodies lying everywhere. Me and my children were jumping over the bodies on our way to the bush. We walked for fifteen days to go to refugee camp in Ivory Coast. (long pause )...since I leave Liberia I have not go back there. My life is not the same again.

Marthe, also from Burundi, recalled an incident involving her husband, a teacher. On that particular day, he had gone to work as usual when he was arrested by the government, beaten and jailed. Two weeks after his arrest, their home was invaded and Marthe was arrested and jailed for one month. She recounts her experience:

It is a complicated process. I can't comprehend how it happened. It is God who had a hand in it for me to survive it. They beat me and wound me bad (points to a scar on her left leg) and say "your husband thinks he can make trouble with the government?" They kept questioning me and then I realized we were no longer safe in Burundi. I was crying and begging them to allow me to go back home but they refused. I did not eat anything for the first two days I was in jail, after they will bring small food and throw it to me and mockingly say "woman eat". When they released me, I went home carried my last child who has Down syndrome, I wrapped him on my back and ran away. I did not know where I was going to. I told my other children to run to their paternal grandfather's house that I will come and get them later. I went to Rwanda first and started my journey to Ethiopia. But when I reach the border town between Kenya and Ethiopia, the government officials take all my belonging and I was jailed again with

my sick child. They searched me and took even my wrist watch. I can't hide anything because they search even my underwear.

Interviewer: Why were you jailed at the border?

Marthe: I didn't have immigration paper. I tell them that I run for my life.

No time for immigration paper, but they say "go there."

Interviewer: Was it the Kenya or Ethiopia side of the border?

Marthe: I don't know. They are calling it "neutral zone". Many people have died in this area. The government officials showed us different pictures and ask us "where do you think these people are"? And they will tell us the people are all dead. Then they will ask us "do you want to be them?" I was very afraid for my life there. When I left there, I entered mini-van but the road was very bad so sometimes we will turn around. It took me two months to finally reach Ethiopia. When I reach there, they accepted me as a refugee. My life was miserable because I did not see my children and husband for four years until this year. They joined me in America in August, 2010. When I was in Ethiopia, I was begging for food, I was using dry leaves to cover my son from mosquitoes and flies when he sleeps. My life changed so much that I cannot cry for serious matter again.

Marthe's account illuminates the horrid experience refugee women go through in order to get to a comfortable and safe environment. Marthe told her story with so much passion. One could see the metaphorical scars of political violence on her face. She was one of the most eloquent participants. She also complained that even though she and her husband were teachers in Burundi, finding employment in the U.S. with her teaching certificate is impossible. She explains, "I am not happy that they will not employ me here. I am working at the airport now."

What is striking about Donyen, Nsegiyumva, and Marthe, is that at the beginning they seemed to have difficulty telling their stories, either laughing nervously, pausing for long and constant deep sighs as they reflect on the horrid past that has become their present identity. The profound way in which war and political violence had altered their lives was particularly evident in the words of Donyen: "war not good at all. It changed my life". Another striking aspect of the women's stories is the consistency with which they describe their experience, and the fact that they later characterized these events as changing their lives forever.

### **Theme Two: Redefining Normality**

The second major theme of the women's narratives is that of making the best out of a chaotic and uncertain situation. Although most of the women were able to recall life in the "good old times," they stated that once war and/or violent

conflict began it became a defining feature of everyday life. Experiencing and witnessing violence became commonplace and normal and they grew thick skins about it as a means of redefining what normal is. It became routine for people's houses to be attacked by ethnic militias, anti-government rebels, government forces, and armed soldiers. In Liberia, for example, war machines patrolled the streets and the sound of gunfire became normal. According to Agnes, one of the Liberian participants, the most disturbing aspect of this situation is that it came to represent the usual state of affairs leading to prolonged war periods and constant displacement of people. Agnes told of the time when she would hear gunshots and grenades going off sporadically and because she was used to the sound, she knew it came in twos. After the two grenades went off, she and her neighbors would clean up the debris on their street. They had normalized a very violent situation and grew accustomed to the only life they could conceive of at the time.

The refugee women described their migratory experience as one ridden with lack of electricity, water, basic health care, and little or no food. In spite of all these hardships in the refugee camps, the women take pride in their ability to have survived it without having serious health complications and constantly expressed gratitude to God that they are alive and living in America. As Agnes stressed repeatedly during the interview "we adapt to every bad condition so we



can be happy...there's no time to worry." She discussed how she was able to normalize abnormal living situations:

When me and my family were living in Ivory Coast refugee camp, the food was not enough so we started sneaking outside the camp to trade goods, we were never caught (she laughs). My mother was digging gold for mine owners and they used to pay her small money but we were happy to have money to buy food and soap. My family did not sit down to worry our head, we decided to look for how to support ourselves.

Agnes also disclosed that has she was seeking to terminate her pregnancy because as she states, "I have suffered too much in her life and don't want my child to be born to poverty." Similarly, Florence, from Sudan, describes her experience in Egypt:

The Arabs in Egypt don't like us from Sudan because we black. They will say "go go go" (waves hands in front of face). I didn't let it bother me. I have to accept my condition in Egypt so I can survive. They treat me very bad. Rather than complain about it, I stand on my two feet and did not mind them. I have to send money home so I have to work.

Florence's and Agnes' narratives capture their experience as refugees in neighboring countries. Their stories recapitulate the stories of most refugees who

have lived in refugee camps. Several participants recounted that while they cannot normalize war or political violence, they devised ways to live their lives without dwelling so much on the violence going on around them. As Agnes puts it “I cannot stop the fighting...I have to live like that.” As the above narratives indicate, the women maneuvered their situation in order to make a living. The focus of redefining what normal means contributed to making the women feel hopeful of a “better tomorrow.” Donyen succinctly sums up her migration experience, “I cannot wish war for my enemy. It is very tough.”

### **Theme Three: Living Between Two Cultures**

The theme of “living between two cultures” was derived from the conceptual categories of maintaining African traditions and adapting to new American cultures. This theme reflects how refugee women experienced living these two different cultures, their challenges trying to balance these two different cultures and the impact on their reproductive health and well being. The women described an experience of not feeling part of either culture. They talked about the tension of being pulled back by traditional ways and at the same time, pushed forward into a new American life. It is this tension that characterized the refugee women’s experience of living between two cultures. Florence captures the experience of living between cultures by saying, “It’s hard because refugees now

they are in the middle, them not in American culture, and them not in African culture. They are just in the middle of nowhere.”

As African refugee women began new lives in the U.S “in the middle of nowhere” between two cultures, they shared the ways they negotiated new space for themselves and their families in the U.S. They have chosen to maintain African traditions and have adopted new American ways as they struggle to adapt to their new environment and the challenges of learning to live in the U.S.

There is a lot of pressure on the women, “You are carrying the culture of Africa,” as Florence puts it. The women have the social responsibility to maintain African cultural traditions in the U.S; however, many of these traditions conflict with American values and social practices. Africans have a strong sense of communality that provides an important buffer for refugee women in the U.S. This communality was evident during my visits to the African Expression Church which serves as a religious and social center for the African refugees who have been resettled to Phoenix area. During the weekly service, traditional practices included chanting Christian hymns in the various African languages. Social events held at the church included birthday celebrations, baby showers, and memorial services for those family members who had died in Africa. It is through the church that most refugee women are able to maintain ties with family and

friends back home as well as in the U.S. The women are able to continue the African traditions of language, dress, food, and music in the U.S through their association with the church. The events at the church allowed the women to stay connected with each other and gave them a sense of belonging and familiarity. The women's association with the church provided them with a religious and social network that had a huge influence in their lives.

The African tradition of communality had a restrictive as well as protective influence on the women. For example, in promoting the traditional African ways of patriarchy and family unity, the church discouraged divorce for any reason. If an African woman filed for divorce she was immediately shunned by the community and church. Several of the women in this study were victims of domestic violence perpetrated by their husbands. Florence could not condone the beatings and injuries the husband inflicted on her, and she was tired of her community telling her things will be alright, so she fled Nebraska for Phoenix to begin a new life without her husband. Although Florence is still legally married to her husband, she has no plans of either filing for a divorce or returning to him:

My husband will go to the store buy drink and he will finish the drink, his eyes will be red. When I come back from work, he will say, "woman you go to your boyfriend," and start beating me. I will not shout because I am

afraid police will come. One day he beat me too much and said he will kill me and I pack my bag and carry my children and run to Phoenix.

Interviewer: How did you decide to come to Phoenix?

Florence: My friend told me to come here. You know, in our culture if I divorce my husband it is not good so I run for my life.

Interviewer: Has he contacted you since you left Nebraska?

Florence: He phoned me before I change my number. He has not phone this new number.

Interviewer: Are you still afraid that he will come and harm you?

Florence: Yes.

Interviewer: Why don't you report to the police, they can help you?

Florence: Ha! (Exclaims with her eyes wide open, I then realized that she is still very afraid of her husband) He will kill me if I do that. American woman do that is ok...it is not in our culture to call police for my husband. If I divorce him, people will be judging me. They will say I am bad woman.

Florence's story illuminates the dilemma some of the participants have with living between two cultures. Another of the participants, Margaret, explained that she had been cut off from her Congolese community in New York because she was

separated from her husband after he beat her while she was four months pregnant. She could not deal with the misjudgment that followed her so she came to Phoenix to stay with her mother who is also a refugee.

Esther, a Liberian, exclaimed “it’s a misjudgment because we always judge the woman as a bad person when she divorce. Nobody wants to step up and do anything for her.” Separated and divorced African women were avoided by married women outside the church as well, presumably because they feared conflict within their own marriages if they associated with the outcasts. Refugee women going through domestic violence have to endure it and stay in their marriages or risk being avoided by their community if they press charges against the abusive partner.

Florence also explained that if she pursued divorce in the U.S. because of domestic violence her family in Sudan will be expected to return the dowry that was paid to her family by the husband’s family as part of the marital contract. This loss of dowry may cause serious financial problems for the woman’s family. Hence, part of the reason she is not filing for divorce is because she does not have the money to return to the husband’s family. She said, “If I’m going to divorce, my husband’s people are going to ask their money back. And they will ask it from my family, so I don’t want my family to go through that.”

Despite going through violent conflicts and wars, African refugee women are pressured to pass on the valued cultures of their various ethnicities and are blamed by family members and their community if their children do not follow the African ways. Several of the women shared their struggles raising children in America while trying to preserve African traditions. Bendu, a Liberian, explained how the Liberian community blames women if their children do not follow traditional cultural ways. She states, “They (children) can keep a little culture from Liberia; they cannot drop it yet because they (Liberian community) will blame us (women) for it.”

Several other participants expressed fear that their children would not learn the traditional values and they will fail in their expected role to teach them African values and tradition. Charuni, a Sudanese, was disappointed that when she tried to teach her children Sudanese culture they would say “they are not from Sudan. We are from Phoenix.” She has tried to emphasize to her children the importance of continuing the Sudanese culture once they were resettled in the U.S. But the children are resistant to their culture and want to be Americans. Esther laments that, “My children don’t understand that I am teaching them our culture. Because they go to school every day, they are now thinking they are American. So, it’s hard to teach them how to be Sudanese.”

Florence, Margaret, and Esther's accounts illustrate what other women experienced: the difficulty of living between two cultures. After resettlement to the U.S. the women continue to maintain their traditions such as communality as they realize that it provides protection and buffers the stress of being refugees in a new country with an unfamiliar culture and language. They also realize that things that are culturally unacceptable such as divorce are deterrents to their well-being and hinder their efforts to adjust to a new culture. They were anxious to balance their valued traditions at the same time they are learning American values.

The anxiety of living between two cultures- African culture and American culture- presents problems for African refugee women as mentioned above. As a consequence, they hold two modes of living and thinking in an oppositional culture. This experience compels us to turn to W.E.B. DuBois' (1903) double consciousness. African refugee women's double consciousness was having to live in the internal conflict of upholding their African values and embracing American values simultaneously and the potential problem of conforming to an identity ordered by hegemony. DuBois' double consciousness relates to Bhabha's (1994) "hybridity" whereby a different kind of identity emerges from the interaction of these two cultures. Narayan's (1997) points on "third world" women living in the west being caught between two cultures is particularly useful for analyzing the



experiences of African refugee women. Narayan argues, and I concur, that third world women are burdened with the socially-sanctioned pressure of choosing between two cultural views. Most importantly, the processing of having to negotiate between two opposing cultural views can lead to alienation on both sides.

#### **Theme Four: Learning American Ways**

This theme highlights the women's efforts at learning American ways in order to get by with their daily lives. As mentioned by all the participants, resettlement to the U.S. was a dream come true and provides them with opportunities that they never had in refugee camps. As Agnes succinctly puts it "America restored my hope in God." The women embraced the American values of equality and independence. However, they soon discovered that these American values are often in opposition with their traditional African values and soon realized that the racism of Americans interferes with equality too. Most of the participants experienced the American value of equality and protection of rights for the first time when they arrived in the U.S. Upon arrival, they were required to learn new skills necessary to parent children in America, and learn the social ways of life. Most of these women struggled with these new responsibilities considering that they did not have much education and could barely communicate

or write in English. Zahra, a Somali who had lived in the U.S. longer than most participants, stated: “It’s difficult to adjust in America. I am still learning how to be American. It’s hard for me to be a Somali woman in America (shakes her head).”

Employment created many new challenges for the African refugee women and their families. Taking a job meant the women had to learn to speak English to their co-workers and supervisors, they had to find transportation to work, and had to learn how to earn and manage money in a culture that was very unfamiliar. For the single parents, arranging childcare while they worked was one of the biggest deterrents to employment. Some women lamented their husband’s unemployment and felt the weight of running their household on their body. Bendu, a Liberian, laments that:

Before the war in Liberia, my husband was working and I had to stay home but now things have changed. I was trading in Ivory Coast before we came to America. Now, I am the only one working, my husband has eye problem. The work is too much for me. But, I have learned how differently Americans talk, communicate and relate with one another. It has given me great experience.

Adjusting to life in America puts an added financial pressure on the women when their household depends on their income. Dislocation from extended family members also puts added emotional and financial stress on refugee families when both parents work outside the home. They sometimes had to place their children with strangers for childcare and this made them very uncomfortable.

Bendu states that, “In Africa, you can leave your children in the house and tell your neighbor to look after them. But here, if you leave your children at home, someone (referring to Child Protection Services) will come and take them away from you.” Concern for their children was the most frequently discussed topic in the interviews with African refugee women. They lamented that while in refugee camps raising their children was very difficult because they did not have enough food to eat nor could their children go to school. But in America they are faced with new challenges on how to raise their children and they believe that they live in a different culture from their children. Bendu explained, “My kids are going to College now. But sometimes, you know, they have a different culture. They take American culture and what can I do.”

Some of the participants complained that they lacked the skills to help their children with their home work. Nadege, a Burundian, shared how ashamed she felt when she could not help her children with their homework. She stated,

“When my children come home with the homework, I don’t know what to do with it. I don’t even know how to read it. It’s embarrassing to me.”

Gloria, from Burundi, regretted that she had only completed 6<sup>th</sup> grade in Tanzania refugee camps and when she tried to help her daughter with her homework, she said to her, “mom, you don’t know how to speak English. How can you help me with my assignment?” Her daughter’s words stung her like bees, but deep in her heart she knew her daughter was telling the truth. She was still mastering American English and could barely communicate in English.

The women wanted to learn how to cook American meals, but did not know to prepare them. In fact, one of the participants, Awrala, pleaded with me to teach her how to cook American food. She could not use the internet and was unable to search for recipes online. Awrala explained that, “My son likes to eat apple pie.” But she does not know how to make it. She explains, “In the camp (referring to refugee camp), we did not eat apple pie.” The women experienced pressure from their children who wanted to fit in and be Americans.

Agnes, Zahra, Bendu, Nadege, and Gloria recounted the difficulty of becoming American when you have different cultural values. They also describe the immense pressure from their families to “fit in”. Despite the pressures that African refugee women experience when they resettle to the U.S. to maintain their

tradition and learn American ways, they demonstrated an ability to discern which traditional values contributed to their well-being and which detracted from or inhibited their well-being in the U.S. For example, Florence's decision to leave Nebraska to get away from her abusive husband illustrates how refugee women are making decisions based on their well-being. The women also had to negotiate these differences for other family members as well as for themselves. This push-pull experience created a great deal of ambivalence and stress for the refugee women as they experienced the opposing forces of living between two cultures.

#### **Theme Five: Racial and Religious Discrimination**

Echoing previous research findings on African refugees in the United States, participants in this study said they lived in a wider context of racism and discrimination. Many felt marginalized and excluded from the mainstream culture. They felt the public discourse on African refugees in the U.S. makes them look like lazy people who only want hand-outs. Marthe explains "African women are not lazy, we can work. Tell them we need work, not pity." Marthe's statement invokes the concept of "us" and "them," which is prevalent in most racialized discourses. However, her views express her perceived sense of powerlessness and dependency on a "them" who wield enormous power to influence the fate of most refugee women.

Participants' feelings of exclusion were related to direct experiences of racial and religious discrimination. The women talked about being dismissed at work or denied employment on the basis of their skin color and religion because they were perceived as different from the mainstream Americans. One of the most poignant responses that reflected racial discrimination came in Bendu's response: "I survived war, people dying everywhere, but I cannot survive how the white people are treating me." This was really powerful to hear and I could hear and feel the anger and helplessness in her tone. In order to make sure that I was reporting accurately, I asked Bendu, "What makes you think you cannot survive how white people treat you?" She replied "I cannot survive because it is making me sick." I became really confused and probed further, "Why does it make you sick?" Bendu elaborates her experience at work:

In my job, my supervisor treats me different because I am refugee from Africa. There's no respect. He is very rude and talks to me in a commanding tone. He gives other people gloves and mask to do their job, I asked for my own and he said, "you don't need it." Now, I am getting chest pain and my hand is peeling because I have to spray the bathroom walls with chemical. I have to bear it before I get into trouble.

Several other women also talked about their work experiences of race/ethnicity- based discrimination. These women claim that they were treated badly at work due to their race/ethnicity. Agnes recounts her experience with her supervisor, who is a white male,

I was fired because I worked extra hours. My supervisor was the one who approved it for me. Later, he started accusing me of stealing the extra hours and when I tried to explain to him that the hours were approved, he became very angry and said I was talking back at him. I was fired immediately. I didn't believe I could lose my job like that. So, that's why I am having this abortion. I cannot take care of a baby without job. I know government is helping, but it is not enough...you know these people don't like us.

Interviewer: Which people are you referring to?

Agnes: I mean these white people. They don't like us refugees from Africa. They talk to you anyhow, no respect.

Agnes' work experience and her subsequent decision to terminate a pregnancy clearly show how social factors, such as racial discrimination, influence women's reproductive health decision.

Similarly, some women in this study talked about experiencing discrimination from fellow Africans. The rift between African refugees and African immigrants is mostly class and ethnicity based. Unlike refugees, most African immigrants are highly educated and possess the social capital to be independent in the U.S. Further, Africans of similar ethnic groups tend to have misconceptions about other ethnicities. As mentioned earlier in chapter four, ethnic conflicts are a leading cause of war in Africa. Indeed, some of these ethnic stereotypes make it difficult for African refugees to be fully embraced by Africans (or other African refugees as well) who are not of the same ethnic background. The rifts among Africans (both refugees and voluntary immigrants) illustrate the complexities involved in the new African diaspora where there is a lack of social bonding between the educated and uneducated.

In addition to race, Muslim refugee women in this study explained that religion affected their social life as people treated them differently. Safiya, a Somali, explains that her veil was always an issue and that she has been told on several occasions at work to use smaller veils so her long veil does not interfere with her job security. Similarly, Zahra explains:



It was difficult for me to assimilate. People look at me funny. They are always asking me about my religious dressing. They look at me in a bad way before telling me, “your dress is beautiful,” I know they just hate it.

Muslim refugee women’s experience of religious discrimination makes it difficult for them to be fully integrated in their host community. The religious polarization that emerged post 9/11 makes it even more complicated for Muslim refugees to be fully integrated in their community. Similar to Zahra’s experience, several Muslims in this study expressed their social isolation and being constantly judged because of their religious affiliation.

As I noted in my fieldnotes, Christian refugees were more comfortable about their religion and they did not disclose any religion-based discrimination. Unlike their Muslim counterparts, Christian refugees did not have to worry about being perceived wrongly because of their religious dress. Muslim refugees do not experience the same religious freedom as Christians. The Muslim women in this study complained of employment discrimination due to their Muslim visibility.

## **Conclusion**

This chapter has outlined the pre-migration and post-migration experiences of the refugee women participants in this study. These women’s accounts illustrate how they fled from their home countries and the experiences

they have had living as refugees. As mentioned previously women and girls account for more than half of the refugee population in the world. The circumstances these women lived through during flight and in refugee camps are almost unimaginable to those who have not lived through them. At various times during the interviews I was moved to tears. I could barely contain my emotions listening to these women tell their stories on how they were catapulted into situations that require extraordinary ability to adapt and change rapidly in order to survive. The circumstances these women found themselves in redefined what normal was and they had to learn how to live between two cultures that have little or nothing in common. The women's accounts have drawn attention to their strength and resilience. Martins (2004) elaborates on this, saying female refugees, in particular, have shown extraordinary desire to survive and clear ability to adapt to extreme circumstances. They are resourceful and upon resettlement learn ways to adapt to their new environment.

## Chapter 7

### EXPLORING REFUGEE WOMEN'S REPRODUCTIVE HEALTH

#### EXPERIENCES

*American doctors don't believe in herbal medicine and demons as the cause of health issues. Back home in Africa, we believe in these things.*

- Lamia, Twenty

*I now have routine mammogram and pap smear. I have never used birth control pills because I don't trust its effectiveness. But right now, I have no need for it because my period has stopped.*

- Marthe, Forty-Eight

This chapter focuses on the women's reproductive health experiences. It addresses the research question, how do pre-migration and post-migration experiences affect African refugee women's reproductive perceptions and experiences in the U.S? During the interviews, I realized that there is no direct translation of the English term "reproductive health" to any of the refugee women's languages. However, when asked what reproductive health meant to them, several of the women described it as "having a healthy reproductive system that is capable of bearing healthy children." Terms such as "pregnancy,

motherhood, prenatal care, and infertility” were frequently used by the women to allude to reproductive health care. Even though there was no direct translation of reproductive health to participants’ languages, their responses showed a strong understanding of reproductive health issues. From their personal accounts, six of the women were pregnant and receiving prenatal care, two had symptomatic fibroids with only one considering surgical treatment for the fibroid, two women had fertility issues, one woman wanted an abortion, four women were experiencing menopausal symptoms, one reported she was suffering from Pelvic Inflammatory Disease (PID), one woman also reported having bleeding from her birth control injection, and three women were receiving postpartum care.

Several of the women raised issues they are dealing with in regards to accessing reproductive health care. The women’s ability to describe their reproductive health experiences illustrates that a direct “word-for-word” translation of the term did not affect the data collection. While incorporating familiar terms to aid participants’ understanding, the meaning and significance of the term “pregnant” in the Somali language was discussed with Lamia, a Somali-Bantu. I learned from her that in Somali language, the phrase “making babies” is often used to denote good reproductive health and well-being. She explained, “When we want to say a woman is healthy we say she can make babies”. This

often translates to the women having healthy and fertile reproductive organs with the ability to make as many babies as her husband desires.

Experience with healthcare providers and perception of reproductive health care among refugee women were varied. While many women told of helpful and compassionate responses by providers, a few described the attitudes they encountered as condescending, patronizing, demeaning, and racist. Six themes emerged under the reproductive health category: women's autonomy in decision making; social isolation; cultural perceptions; religion and spirituality; language issues, and perceived discrimination. These women's stories resonate clearly in this chapter and set the stage for further discussion toward the end of the chapter about the relationship between their experiences and intersectionality.

### **Theme One: Women's Autonomy in Decision-Making**

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy in decision-making are associated with improved reproductive health outcomes. Considering that many women have little or no autonomy in many cultures, this theme illustrates the role of gender in determining women's reproductive health decisions. Most African refugee women are culturally socialized to allow men to make important household decisions, which also include decisions affecting women's

reproductive well being. Women's autonomy (or lack thereof) in reproductive health decision-making has the ability to affect how they obtain and utilize information from healthcare providers. Gender inequality in the home can impede women's access to reproductive health services. Some women in this study were unlikely to make decisions without consulting or depending on what their husbands want.

When the participants were asked who in their household makes decision regarding reproductive health care such as family planning, c-section, and annual exam, the women were split in their response. Some, particularly the single or widowed women, said they were in total control, while others still depended on their husbands to make such decisions. Agnes describes her reproductive decisions:

I have three children. All of them were born in the camp in Ivory Coast. I born them at home. I didn't want to go to the hospital. I didn't get any problem. I am 10 weeks pregnant now and I have decided to get an abortion. That is my decision that is why I came to the clinic today. People are telling me to keep the baby and give government for adoption and I said no "I cannot give my child to someone else." Why my child? (she asks me?)

Interviewer: What about your child's father? Does he want you to keep the baby?

Agnes: I did not tell him. He is just my boyfriend.

Interviewer: Why don't you want to tell him? He might be able to help.

Agnes: No. I have made up my mind. If I tell him, he be telling our Liberian people and they will be gossiping about me.

Interviewer: So, how are you paying for the abortion?

Agnes: I contacted an organization. You see that white woman that came with me, she is from that organization. They are helping me. I told them that I don't have money, no job.

Agnes' decision communicates an example of how some refugee women make their decisions. By not telling her child's father about the pregnancy, Agnes was hoping to keep it a secret and not be stigmatized by her Liberian community. Hence, even women who are able to make their own decisions still have to worry about their community's perceptions.

While Agnes is free to make her own choices, Awrala has to deal with the fact that her husband makes all the important decisions in their household. Awrala has been experiencing secondary infertility for about five years due to fibroids. Her doctor had informed them that the location of the fibroid is blocking her

fallopian tubes and suggested surgery as an option. During my interview, I noticed that Awrala was not enthusiastic about having the surgery, but her husband (who dominated much of the interview and spoke perfect English) insisted that it was necessary:

Awrala's husband: In our culture, we are supposed to have more than one child. We have to do the surgery and pray that God will help us have more children.

Interviewer: (to Awrala) "how do you feel about having the surgery?"

Awrala: (sighs) My husband needs more children, my job is to give him more children. I will do what my husband wants. If I do not have other children, people will laugh at my husband. The husband then continues "You see, I want to have sons. I like my daughter very well, but she will grow and get married and nobody will be in my house.

Interviewer: Have you considered other options?

Awrala: No, my husband said we should do the surgery first. Husband continues "we don't want to waste time, you know my wife is not a small girl anymore (referring to his wife's age).



My interview with Awrala (and her husband) illustrates how unequal gender dynamics can be reaffirmed post-migration in a manner that makes women's opportunities to exercise choice in matters related to fertility almost non-existent.

In another interview, Lamia disclosed that although she does not believe in birth control pills her husband does not like them as well. She explains that her husband believes that if she is on birth control pills it might encourage her to have extra marital affairs. During the interview, Lamia seemed desperate to have a second baby since her daughter is now eighteen months old. In line with previous studies (McKeary & Newbold, 2010), refugee women's decision making can be linked to ethnic origin, with women from more conservative Islamic cultures more likely to depend on their husband. When women are separated from other forms of social and kin relationships due to displacement, it heightens the gender inequality in decision making.

### **Theme Two: Social Isolation**

Social and cultural isolation emerged as a significant theme in how refugee women experience their reproductive health needs. Cultural difference and displacement contribute to women's isolation. Although there are many programs that encourage social interaction through religious groups, resettlement agencies, and community centers, refugees tend to feel isolated because they do

not understand how to familiarize themselves with the social and health care systems. Being new in the U.S, refugees lack the ability to get around, particularly when they are living in a big metropolitan area like Phoenix, where the distances are large, and public transit connections are complicated. They need to have a good knowledge of the local transportation system and be able to ask questions in English. Most of these women are usually stuck in their apartments and depend on their husbands or friends to get around.

Social isolation inhibits refugees' access to reproductive health care and is complicated by their inability to navigate public transportation. Most of the women in this study depended on RWHC to make transportation arrangements for them to and from their doctor's appointment. Without the help of the clinic, some of these women would be stuck in their houses. A few women in this study depended on their husbands, in-laws, or friends to bring them to the doctor's appointment. Marthe describes how she walked for about ten miles because she did not know how to use the bus system in Phoenix. While she walked along the 101 freeway in Phoenix, the police stopped her and told her it was illegal to walk on the freeway and she told the officer that she did not know how to use the bus. He told her to learn or else next time she will be cited. Marthe explains:

It is difficult to use the bus. I trekked, it's not hard. In Africa, we are trekking. But, police say they will arrest me so I have to wait for people to help me to go to the hospital. I think I am having menopause because I see my period three months ago. I have decreased sex drive and night sweats. I went to the hospital they took urine sample. I don't have transport to go back for the result. I am waiting for my friend to take me to the hospital.

Marthe's response shows how social isolation can lead to refugee women's inability to access medical care as needed. A striking aspect of Marthe's account is that she defies the assumption that African women in general are less willing to talk about their experiences. Perhaps the adjustment process and "living between two cultures" has made it possible for her and other refugee women in this study to open up about their personal struggles.

### **Theme Three: Cultural Perceptions**

Many refugee women spoke about their perceptions of reproductive health care and their conflicting views with providers. The refugee women's perceptions and expectations are rooted in their past experiences in Africa, and/or cultural interpretations. Their conceptualizations of what the concept of reproductive health entails are embedded in their cultural and spiritual interpretations which are often different from the medical practices of American health care providers.

Consequently, the refugee women sometimes found the doctors' practices to be deficient. One of the sources of concern that the participants discussed was that American doctors do not believe in non-medical causes of illness. Lamia states, "American doctors don't believe in herbal medicine and demons as the cause of health issues. Back home in Africa, we believe in these things."

This perception is concomitant with the cultural belief that one of the causes of disease is a curse, evil eye, or ill wish of a person with magical powers (Berhane et. al. 2001). The seeming lack of regard for unscientific claims of illness among American health care providers was disorienting to those refugee women who equated good health and well-being with demons and herbal medicine. The refugee women tended to imagine how things would have been done differently if they were in Africa. Further, in line with receiving prenatal care, Lamia explains that

We Somali women are not used to Pap test. In Africa, we are not doing it. I am scared the doctor will tell me "Lamia, you have this disease or that disease." They (doctor) say pap will prevent cancer. I know what cancer is, but we are not talking about cancer in Africa. I don't want to know because God will take care of it. There is a big difference between here and Africa. Even though we have more opportunity for healthcare here,

but the doctors don't know that some herbs can help you with your problem. When I was in Africa, I had my baby at home, but now they are telling me I have to go to the hospital every time.

Several of the women in the study interpreted preventive care, such as Pap smears, as strange to their cultural understanding of health. They could not understand the relevance of Pap smears or other concepts for cancer screening such as mammogram.

However, the six Burundian women in the study were very receptive to the concept of preventive care and Pap smears. Nshimirimana, who spoke through an interpreter, explains:

I feel ok with the reproductive health check. I am not afraid of those services. I have done pap smear and mammogram. I don't have any cultural reservation. For me, there's no problem. Even if they ask me to go naked (she laughs) from the clinic reception, I'll do so without problem because I know they want to help me. I think those women from Somalia refuse these things because of their culture, but I cannot hide anything from my doctor.

Nshimirimana's and Lamia's comments reflect a diversity of cultural perceptions of health care among African refugee women. This reminds us of the

heterogeneity of African refugees. The differences between Nshimirimana's and Lamia's views illustrate the different belief systems among Africans in general.

#### **Theme Four: Religion and Spirituality**

In many African societies, medical and religious/spiritual elements are never completely separated. It is therefore not surprising that religion and spirituality are common themes among the women. It was evident that most of the participants in this study believed in a higher being that has the power to influence their reproductive health outcomes. Religion is a protective factor for many African refugee women who are experiencing the difficulties of displacement and social isolation. Beginning during the colonial period, Islam and Christianity were the two dominant religions that spread across Africa. All the women in this study identified themselves as either Muslim or Christian.

As African refugee women were disconnected from their family and community support due to war and political violence, they began to migrate to refugee camps in neighboring countries and their religion was the only piece of identity that remained with them through all their challenges. Religion began to fill the void in the emotional and health support networks once met by traditional figures. Religious institutions offered refugee women a sense of shared identity and gave them social meaning.

Mirroring the support offered by religious groups, many participants believe that their reproductive well-being is greatly influenced by their religious beliefs. They found meaning in religious and spiritual principles which gave them hope that they could get over a sickness. Donyen explains, “Spirits can occupy your body and make you very sick. It is only God that can save you when the spirit is in your body.” Evident in Donyen’s account is the idea of the power of the spiritual world. She goes on to describe how some people have supernatural powers that can prevent their enemies from getting pregnant. She elaborates, “I know they are calling it different name in America, but in Africa we know that if a woman didn’t become pregnant that it is devil’s work. She has to make peace with God. I thank God that I have my own children.”

Echoing similar religious sentiments, Safiya, a Muslim, describes how religion plays into her reproductive health. She states:

I refuse birth control. Our religion, our culture says it is wrong. It is God that gives children. Even if I have 10 children then I know God has a reason for them...When I am sick, I tell God to help me.

In order to ensure that during these interviews each participant’s story was interpreted accurately, I would ask them to rephrase their statement or ask my participant to restate what she had said so that I did not misinterpret. Therefore, in

this interview with Safiya, I asked, “So when you are sick you don’t go to the doctor?” She responded, “I only go when it is very bad.”

### **Theme Five: Language Issues**

Language- related issues are the last (by no means the least important) and final theme under the reproductive health category to be considered. All the women in this study spoke multiple languages by virtue of their ethnicity and nationality. Because of their little or no English language skills, African refugee women perceived language to be a major barrier to refugee reproductive health care access. Some of them are wary of accessing public facilities like hospitals, due to prior negative experience. For most of the women, having to deal with unfriendly faces and lacking the ability to express themselves verbally was a new experience. However, the extent to which language was a barrier varied across various participants, with those who are more established in the U.S having less difficulty.

Florence was one of the several women in the study who do not use interpreters, although she lacked the confidence to engage in long discussions in English. Instead, she pretends that she understands what is being said to her. Florence says, “I was afraid to go the hospital because of no English, but I am coming now for my baby (points to her baby bump).” Language issues make it



impossible for these women to articulate their concerns or even ask their providers questions about their treatment plan.

Marthe describes her not-too-pleasant experience with her previous primary care physician (PCP):

When I come to Phoenix, my case manager briefly showed me a doctor and she said “this is your PCP.” I did not know how to tell the doctor my problem in English. So, the doctor was only writing prescription for me every time. Even before I finish describing my problem, the doctor would have written the prescription. I decide to find another doctor to treat me because I am not seeing my period (menstruation) anymore, but the PCP say I have depression.

Hospital appointments with refugee patients who speak little or no English may take additional time due to accommodation of interpretation, as well as making sure information is accessible and understandable. As indicated above, Florence and Marthe experienced difficulty communicating their concern to the providers. This had a way of adversely affecting their reproductive health choices. Marthe’s understanding of her experience with her previous PCP is indicative that she felt the doctor did not understand her medical concerns, but she lacked the language skill to make her concerns known to the doctor.

Language issues also impact on refugee women's ability to schedule follow-up appointments and obtain instruction with prescriptions, all of which are typically conducted in English. The women depended on the volunteers and social workers to help them navigate the complex health care system. The severity of the language issue is best summarized in Marthe's words, "if you don't know the language, how can you tell the doctor what is wrong with you?"

Although language is a major barrier to care for several women in this study, yet many of them reported having confidence in the care being provided to them. Collette, who spoke through her brother-in-law as her interpreter, describes her experience:

I believe the healthcare providers at RWHC. The doctor here is attentive to my questions. She listens to me and I trust that she has my best interest because they gave me good treatment when I delivered my baby two weeks ago. That is why I am still coming to this clinic.

In line with Collette's account, several of the women mentioned that they trust the providers at the RWHC. For some of them, they changed their clinics because they did not trust their previous providers.

## **Theme Six: Perceived Discrimination**

Some women in this study claimed to have encountered discriminatory events in the health care system. The women talked about experiencing longer waiting times and poorer treatment compared to other patients, receiving insufficient information about their health problem, and being made to feel contagious. Nshimirimana recalled how she was made to wait for a very long time:

I think the people at the hospital don't like us from Africa. Those people at the front office are not good to me. Twice those people told me to go inside the room and they told me the doctor was too busy that I should go back home and come back later. Because of that incident, I don't trust the people. The other time, I was the first person in line but I was told to go in last. I think those people look down on us. I went there at 2PM and got home at 8PM and I have decided that if they do that again, I'll make trouble. When I told the doctor how come I came in early and was let in last and the doctors said "show me the person", but the person was gone when we got to the front office. The doctor is nice. She said I should tell her next time they treat me like that.

Similarly, Margaret recalled how when she miscarried her first baby in New York, an unsympathetic nurse said to her, “You Africans need to stop getting pregnant if you don’t want to come for prenatal check.” Narrating this experience was still very painful to Margaret, she has not gotten over her miscarriage and felt that the nurse was racist and would not talk to a white person in that manner. Margaret mentions she is very happy with her current healthcare provider, “they are not judging me, and they want to help me.” The impact of perceived discrimination on refugee women’s reproductive health is particularly significant. Most of them are at the lowest level in the social hierarchy; they also lack knowledge of the culture and language of their host communities and are easily intimidated into silence. Hence, when I asked Margaret if she reported the nurse to the hospital authority, she replied, “I don’t think they will do anything, you know these people don’t like us, so what will they do even if I report the nurse...and I don’t want trouble from anybody. People will start saying African woman is bad.”

Participants’ experiences of discrimination encompassed social marginalization at work and bodily marginalization resulting in the perception that African refugees have “strange diseases.” Agnes said,

When they see you are refugee from Africa the people start thinking you were raped. They think you might have AIDS and TB. So that is why people treat you bad. When I come here, they say do this test, do that test. But some people still think I have some disease.

Agnes's account reflects how the perceived image of Africa as a continent rife with diseases and high rates of HIV/AIDS is being extrapolated by some American providers who assume all Africans carry disease and therefore should be treated with extra care. The perception of some healthcare providers does not help the situation as well. Margaret explains that after her miscarriage she was treated like she had some disease. Lamia also recalls that when she was first diagnosed with pelvic inflammatory disease (PID) the doctor told her that it is a common disease with Africans. Lamia asks, "why did she say is common for Africans? I think the doctor is saying that because I am from Africa." Clearly, Lamia's perception of discrimination could have been averted if her provider had been more culturally sensitive in their phrasing and if the notion of Africans as diseased beings was not so pervasive. Although diseases and condition frequencies do vary (for example, sickle cell anemia is more common with people of African descent), this should not invoke some sort of labeling of individuals from certain backgrounds. Clearly, PID is not peculiar to Africans alone.

## **Intersectionality as a Contributing Factor**

In this section, I argue that an intersectional approach illuminates the combination of factors which together articulates the experience of African refugee women. This argument recognizes that refugee women's disadvantaged position in Phoenix arises from the way society treats individuals with certain characteristics and identity. I argue further that African refugee women experience discrimination in a completely different way from African immigrants and other racial groups. This is because African refugee women experience a distinctive form of stereotyping based on a combination of ethnicity/race, gender, class, religion, language, and culture at the macro level, and reproductive health needs, age, displacement, isolation, and marital status at the micro level. An intersectional approach recognizes this complexity.

Attention to the interrelated relationships between these factors as expressed through the context of intersectionality helps us to more fully comprehend the larger social factors influencing refugee women's reproductive health experiences. Clearly, the inclusion of refugee women's views and voices in this study highlights an important aspect of intersectionality, which emphasizes the inclusion of the perspective of marginalized people, especially women of color (Crenshaw, 1991; Collins, 1990).

Gender, race/ethnicity, class, language, religion, and culture interact to influence the reproductive health experiences of refugee women. As discussed in the first three chapters, refugee women have unique needs that are gender specific. When examining the intersection of gender, race, and culture, refugee women often determined that life is more difficult for them because they are refugees, Africans, and women at the same time. Agnes addressed this dynamic when arguing that refugee women from Africa are treated as if they were all rape victims. Agnes believed that the fact that she wanted an abortion marked her as someone who must have been raped in order to not conform to the idea of African women wanting many children. She explained that she never requested rape counseling, “I went there to get this abortion, and the social worker started to ask me if I know the father of my baby...she also asked if the pregnancy was because of rape. That’s why I think she asked me this question because I come from Africa.” Agnes’ account reflects her reaction to constant questioning about rape because of her refugee status. In fact, the first thing she said to me when I started interviewing her was, “I was not raped.” I was truly shocked and later realized that she had heard that question repeatedly from persons of authority and has come to translate that question as stereotyping of Africans.

While Agnes' experience was unique because she was the only participant who was considering an abortion, most of the participants were conscious about violating gender norms. In some of these cases, these women placed unnecessary pressure on themselves trying to act in a culturally appropriate way in spite of how they feel about the situation. For instance, during Awrala's interview one could see the gender dynamics going on in her family. Awrala's husband hoarded the interview session while she shyly allowed him to respond to questions directed at her. Awrala never objected to anything her husband said, and showed signs of a wife who is expected to listen to the husband and not express her own views.

An important intersecting factor is that most of the women in this study were of low socioeconomic class, a position that places them at the margin of society. The social location of these women places them at a disadvantage with their health care provider. They belong to a class of people whose primary or only reproductive health access is through public facilities. Most of the women in this study received reproductive health services at what could be thought of as primarily a public institution. All but two of these women depended on Arizona Health Care and Cost Containment System (AHCCS) - Arizona's Medicaid agency- for their health insurance. Typically, the type of treatment and care one



receives in a public health facility is different from that in a private clinic. However, in this study these women were better served in public institutions where they are guaranteed of translation services. One of the participants switched from a private clinic to the public facility because the providers at the private clinic asked her to bring her own interpreter. Hence, private clinics might have dealt with these women in a more discriminatory manner, treating them only if they provided an interpreter at their own expense.

Whether as an identity or as a belief system, religion is rarely included among the intersectional matrices theorists typically study. The prevailing assumption seems to be that religion is categorically different from traditionally ascribed identities like race or gender or from a socioeconomically defined category like class. This may partly stem from the fact that scholars tend to overlook how identities are formed and shaped by religion. For example, the Muslim women in this study were secondarily disadvantaged because their religion remains on the margin in America. Unlike the Christian women, Muslim refugee women narrated experiences with employers and random individuals who would cast suspicious look at them because their dress visibly identified them as Muslims.

Another related and interwoven contributing factor is the fact that the women were mostly uneducated and lacked English language skills, leading to their social isolation. Their interaction with other factors such as religion and culture played a significant role in defining the experience of refugee women. The intersection of any combination of these identities creates each woman's pre-migration and post-migration experiences of reproductive health care, discrimination, and disadvantage: a unique situation of "multiple jeopardy" (King, 1988; Smedley and Nelson, 2003). Inevitably, they all experience some sort of discrimination, but in different ways. Hence, there's no one central figure of what African refugee women should look like or what their reproductive health experience should be. Each woman experiences reproductive health in a unique way, which might be difficult to generalize across all African refugee women. As shown in the themes, some women are more likely to experience discrimination than others, partly because of their religion.

Intersectionality points toward the critical view of African refugee women becoming Othered in an unfamiliar healthcare environment. For these women, it is not solely because of their pre-migration or post-migration experiences that they are unable to access reproductive health services independently. It is because refugee women are defined by these experiences each day of their lives, and they

typically lack a social network and are socially isolated. For women in this study, their displacement and resettlement to the U.S. were the catalysts for self reflection. Their experiences formed a major life turning point. As they recounted their experiences during the interviews and reflected on their challenges, many of the women concluded that their reproductive health experiences are shaped by the confluence of gender, race, class, language, culture, and religion. Most of the women were able to make connections about the multiple areas of discrimination they faced.

The experiences and perspectives of refugee women who participated in this study reveal the relevance of intersectionality as a theoretical framework in refugee women's study. This chapter explored six themes that impact on refugee women's reproductive health. These themes have provided knowledge about the ways African refugee women conceptualize reproductive health and the influences to their well being in a new country and culture. The views of health care providers and how they handle the challenges associated with providing care to African refugee women will be discussed in the next chapter.

## Chapter 8

### EXPLORING THE PERSPECTIVES OF HEALTH CARE PROVIDERS

*We take care of them because they are more needy than other patients. They have language barriers, we have difficulty with interpretation. And then they want car seat, and we have to make arrangement with the social worker to get them a car seat. And then they want a ride home, they don't have money to go home, and then we arrange for a taxi to take them home.*

- Saba (RN)

The quote above describes some of the issues African refugee women experience. For these women, resettling to the U.S. often comes with its unique challenges on how to navigate the health care system in which they find themselves. Since this dissertation adopted a holistic view of reproductive health needs, I included providers who care for African refugee women. This chapter is divided into two sections. The first part addresses two questions from the research questions posed earlier in chapter three: 1. What challenges do healthcare providers face with African refugee women? 2. How do healthcare providers provide culturally appropriate care to African refugee women? The last section explores the nature of patient-provider relationships focusing on the themes that

emerged in the study, as well as how non-Western patients are Othered in the U.S health care system.

Based on the interviews, the providers identified three major themes on their challenges and how they provide culturally appropriate care to African refugee women: language and interpretation issues, culture issues, and continuity of care. Although I explore these challenges in greater detail below, it is important to note that respondents consistently stressed that RWHC was unique in the sense that it strives to provide refugee patients with culturally appropriate care and has reduced some barriers for refugee women, which is not the case in other clinical settings. Indeed, during my fieldwork at RWHC I observed its multicultural atmosphere, there were several volunteers who spoke different languages and they assisted the refugee women with the logistics and would sometimes chat with them to make them feel relaxed and comfortable. I became friendly with some of the volunteers during the course of my fieldwork. Also, during quarterly RWHC coalition meetings, I learned that the clinic was established to “provide culturally grounded and linguistically appropriate care to the growing refugee and immigrant populations in the Phoenix metropolitan region” (pamphlet distributed during the quarterly meeting in June, 2010). Also, several refugee women in this study mentioned that they are happy with RWHC because the doctor listens to

them. Zahra (from Somalia) also mentioned that she prefers RWHC to other clinics because the doctor does not rush labor, the doctor is patient, and she allows you to keep trying, she says. Most of the women were also referred to the clinic by friends who have had positive experiences. The unique service grounded in cultural and language competencies offered at RWHC makes it a popular choice among refugees. As Brenda (RN) stated, “In the past it was sporadic when they would show up in labor, but since we have the refugee clinic they are more frequently coming now.” Brenda’s statement shows that the refugee women are aware of the services available at RWHC.

### **Language and Interpretation Issues**

Although not unique to African refugee women, language and communication difficulties and the need for interpretation services are consistently noted in the literature as a barrier to health care, and have been noted to be one of the most significant barriers to accessing care (Morris et al, 2009; Bulman and McCourt, 2002). Medical intervention and appointments with patients who speak little or no English may require extra time to accommodate interpretation, as well as making sure information is accessible and understandable. This is necessary in order to avoid errors and miscommunication which might have dire health and social consequences. Brenda explains:

Personally, I think language more than culture is the biggest barrier to care because I can respect someone's beliefs and culture but if I can't communicate with them then I can't understand what their culture and beliefs are so there's a lot of assumption going on, more like speculation... it's hard to overcome because sometimes we don't have live interpreters and our translation service is not a two-way phone so you have to hand the phone back and forth so it takes even longer to ask questions.

Virtually all providers interviewed for the study shared the same views with Brenda. They all agreed that language was a huge barrier to providing care to African refugee women. Saba (RN) noted that it is difficult for refugees to understand the procedure of the hospital because of language barriers. She laments that "there is so many teachings we want to do but we can't because we don't know their language." In many instances language difficulty was perceived as preventing the African refugee women from expressing their views on health. According to Brenda, African refugee women become easily apprehensive and might appear "rude" because they cannot communicate their health needs to the provider. Judy (CNM) states that "when they finally get here, they have no way of communicating their views. We have to do some guessing sometimes."

The need for effective interpretation and translation services was frequently mentioned. Although RWHC provides live and telephone interpretation services for non-English speaking refugee patients, other health care institutions do not believe it is their responsibility to be accessible to patients through provision of interpretation services. As Betty (OB/GYN) explains:

As much access to translation services and I think having a live person translate is more helpful. I think related to the cost of providing care insurance companies won't reimburse you for additional time. You don't get paid if you spend extra time with someone because you need to use a translator. You don't get reimbursed more for that and that's a disservice because that makes physicians not want to take care of patients they can't communicate with. They don't wanna spend that much time because in the end it's gonna be another routine OB visit even if you spend an hour talking with the patient or 20 minutes. If insurance providers could see the value of patient education even if it takes some time to provide that education that would be an incentive. I think having people like... who are not only fluent in multiple languages but are also culturally more aware of what the patient is experiencing and their perception is really helpful.



Betty's account reveals that while telephone translation is available through a call line, most health insurance plans typically do not cover translation costs and the extra time physicians spend with such patients, placing the expense on the individual or health care facility. The lack of interpretation services in some health care facilities means that African refugee women must be able to provide their own interpreters to accompany them to the hospital, which may not always be possible for them especially as they are yet to be socially engaged with their host community.

Translation services may sometimes prove difficult because of the various dialects among African refugees. Judy explains that while majority of their patients are Somalis, they sometimes encounter translation difficulties because of the different dialects. Tiffany (RN) adds that attending to patients who do not speak English or the national language of their country of origin takes a little longer. Betty explains how they communicate with refugees with dialect problems:

I have had usual cases where the patient does not speak the same dialect at all. You know we have a lot refugees coming from rural areas. We have had to use a third person and a translator to communicate. So the patient

brings a friend/family member who speaks the dialect and their national language and the person then interprets to the phone translator etc.

Also, translation services may have communication issues as some interpreters choose not to translate verbatim to the patients. Betty describes her experience with a telephone translator:

I have had an experience with a translator, when we were trying to get a patient consent to a c-section using an interpreter phone, in this culture we have tell to the patient all the bad things that could happen during the surgery like bleeding and infection. The interpreter didn't want to tell the patient all the bad things that could happen. We insisted that this is what he had to say and he later said he had told her. But ultimately, I don't speak the language and don't really know if he did. I have no way to know if he was really doing what I asked him to do or not.

Sometimes, the interpreters tend to censor what type of question providers can ask a patient. Karen (social worker) explains that she had translation issues with male interpreters and Muslim women. She recounts that an interpreter once told her it was inappropriate to ask a patient about domestic violence. Karen had asked the question because the patient had signs of physical abuse, but the interpreter refused to ask the patient about it. Similarly, in my fieldnotes, I noted a similar

encounter with one of my interpreters. She mentioned that it was inappropriate to ask the refugee women about their ethnicity. She explained that ethnic sentiments have been a cause of conflict in Burundi and that Burundians do not divulge such information openly. Like the health care providers, I had no way of knowing what the patient thinks about the question. Rather, I had to depend on the view of the interpreter, which may not necessarily be that of the refugee women.

Issues with translation (or lack thereof) may delay appropriate care when the need for care is acute. When live interpreters are available, the refugee patients prefer a live interpreter to a telephone interpreter as the live interpreters are people from the local community who are linguistically and culturally aware. However, the live interpreters are not enough and cannot provide services in all African languages, hence the need for telephone interpretation. Also, in the absence of professional live interpreters, ad hoc interpreters such as family members and friends are commonly used in clinical encounters with refugee patients. The use of friends and family can be problematic as patient confidentiality is compromised and they may not be familiar with medical terms thereby leading to wrong translation and misunderstanding. There are also issues of gendered power dynamics within the family, such as husbands making reproductive decisions for their wives. Husbands with a hidden agenda may

misrepresent the patient's decision. One of the ways to get around husband-  
interpreters is to involve a third party when a sensitive issue is being discussed.

Judy states:

I try to use a third party when a sensitive issue such as STD is being  
discussed. Yeah, you don't want to cause any problem between them. I've  
seen that in even English speaking couples. I mostly use the husbands  
when nothing serious is going on, routine checks, but if there's something  
important that comes up I usually wait for an interpreter and grab the  
phone.

Similarly, Karen (social worker) explains her encounter with husband-  
interpreters:

I usually ask the husband to leave the room then I use a third party  
interpreter to confirm that she really wants the husband to be her  
interpreter. It makes it a little clumsy but I won't take the husband's word  
for it and I haven't had any resistance to that from the patient. They  
always appreciate that and thank me for asking. But sometimes the  
husbands are resistant.

In short, professional interpretation is an important way of making reproductive health services accessible to refugee patients who do not speak English, especially in cases of extreme patriarchal control by the husband.

Language issues are very complex and extend beyond interpretation to include recognition of literacy levels. Most African refugee women who attend RWHC have greater issues with literacy than other African immigrants and are less likely to have a good command of English language and do not have the vocabulary to describe their reproductive health concerns, all of which complicate diagnoses, follow-up care and instructions. Health care providers may not understand what the patient is expressing, particularly if statements are wrapped within the cultural norms and desires of clients (Lawrence and Kearns, 2005). As such health care providers may be faced with reduced ability to communicate with their patients, leading to unmet needs on the part of the patient:

Well, one example is a few weeks ago we had an Arabic speaking African refugee patient and we do have a translator, but we did not just understand what she was asking about, and the translator was not sure about what she was saying. She was saying “maya maya” which means water, she was asking about urine sample because each time they come in we always ask them to give urine sample, she wasn’t comfortable using the word “urine”

in her native language, she was calling it water as a polite term (Betty, OB/GYN).

### **Culture Issues**

*Most of these refugee patients come from cultures where prevention is totally unbeknownst to them and their view of health is “can I function today? If I can function today then am good, and if I can’t function that day then am sick” - Judy (CNM)*

Messias (2011) notes that all health care encounters involve some form of transcultural exchange, but that cultural barriers and degree of difference between immigrants/refugees and health care providers are amplified significantly (p.158). Cultural barriers to reproductive health care can be influenced by patient beliefs and providers’ perceptions. Currently in Phoenix and across the U.S. many health facilities are not culturally competent in their practice and therefore are unable to attend to the needs of non-Western patient populations (Vissandjee, 2001). Several of the providers in this study mentioned that they encountered cultural barriers with refugee patients. The role of culture in reproductive health practices and beliefs among African refugee women is important because it determines when and if they seek adequate care promptly. Brenda recounts that many refugee women show up late for prenatal care. She explains:

I think maybe in their culture it is ok not to go for prenatal care early in the pregnancy. Maybe, they don't trust our health system so they end up seeking prenatal care late. So, they tend to have illness that could have been prevented or maintained earlier in their pregnancies.

Additionally, part of the problem is the "culture of medicine" in the U.S. which is premised on the universal patient body with very little recognition of the cultural and social identity of that body. As noted by the refugee participants, there is also a need to understand the religious and spiritual context of health. Religion and spirituality are often enmeshed in cultural norms so much that it is hard to distinguish the difference, if any. Judy describes how religion and culture are fused together as part of refugee women's cultural beliefs. She states:

Culturally, I think these women do not believe they should come to the hospital for prenatal care early in their pregnancy. Most of them are anemic when they show up. They don't understand that vitamins will make them better. I have gotten to a point where I tell them that this pill will make your body strong because everyone loses blood when they have a baby and you want to be sure that you are strong. I am not sure why they are resistant to vitamins. Maybe because when they take it they are not usually sick. The vitamins are free so it's not a cost barrier...I also

learned that some of the Somali women don't like pork for religious or cultural reasons so when I write their prescription I make sure I mention that so that they are given the ones without pork products.

In line with previous studies, Judy's account shows that anemia is a common pre-migration disease with African refugee (Toole, Waldman, & Zwi, 2001). Also, various religions have some known taboos. It then makes sense that Muslim Somali refugees will reject vitamins that have pork content.

Another way cultural differences come in the way of care is on the issue of refusing providers' recommendations. Many providers describe African refugee women as being suspicious of their recommendations. Judy describes an encounter with a Sudanese refugee:

I don't look at culture as something different. I try hard to adhere to their request. That's part of providing care. But, I had a pregnant Sudanese patient who was very resistant to every provider. She literally stopped seeing every provider but me because all they would tell her is that the baby wasn't doing well and she was very forthright about that she wouldn't do anything they would tell her to do. I don't know maybe she didn't want the baby for all that matters. Even when the perinatologist would tell her what to do she would refuse and said it was God's will and



if the baby was meant to die it will and if not God will watch out for me and that was literally put into wording into her chart just to make sure. For us in our culture it is a difficult thing to understand. I'm sure some of their cultural beliefs are grounded in the mindset that God will protect them and their baby instead of believing the medical system will.

Another perception of health care providers about African refugee women is that most of them come from cultures where the provider is expected to make decision without consulting the patient. Betty explains:

Something that comes up is that in our culture the way we see physician. I see my role as to give you options. So you can do this, you can do nothing, you can take some medicine, you can have surgery, or you can do nothing now and come back to see me in a few months. But, some of the refugee patients are more used to the paradigm way: you are the doctor you are supposed to tell me what to do. So the concept of giving them the choices can be sometimes overwhelming.

Providers typically expect patients to make an "informed decision" based on the recommendations presented. However, the refugee women tend to not only have cultural reservations but sometimes lack the language skill to engage in long term

conversations with the provider, which ultimately is responsible for their refusing certain treatments.

In addition, cultural modes of privacy and discomfort with the gender of the provider may create barriers to care:

The women are very private...they don't want a pap smear because they don't want a speculum inserted in their vagina. After I show them a visual of how pap smear is done, they just say no. I try to inform them that we are doing the check to make sure they don't catch anything. But most of the time, they decline... I think they need to go beyond prenatal care and learn things they need to know about their reproductive health and bodies (Judy).

One role culture plays was an issue when we had a male nurse. The patients preferred a female nurse and it was brought in the report (Daniela, CNM).

The above quotations from Judy and Daniela raise the questions of privacy and gendered expectations among refugee women. Four other providers re-echoed the same view as Daniela. They felt a huge barrier related to culture was gender matching for female refugee patients demanding to be seen by female health care providers. Also, most refugee women who decline or do not see the benefit of

having a pap smear as long as they are able to “function” just fine. Getting them to accept the medical value of a pap exam, particularly since this is not common in the culture they are coming from, becomes a challenge on the part of the provider whose western views of medicine believe in “finding something early” to prevent dire health consequences.

Another challenge confronting health care providers who treat African refugee women is that these women arrive in the U.S with various pre-existing conditions that require extra care. Several refugee women were circumcised prior to their arrival. Most U.S. medical institutions are not trained on how to provide culturally appropriate care to circumcised refugee women. However, the providers in this study claimed to be culturally aware as regards to treating circumcised refugee patients. Judy asserts that:

We do not schedule them for a c-section simply because they have had a circumcision. We are allowing them to have natural birth. The c-section is only going to be for failure to progress or fetal distress. The dilemma came for birth for a Sudanese patient when where she was sewn back together began to open up, she said it was ok that we should allow it to tear. So we had to cut where the circumcision had been done and sewed it

up afterwards...This is one of the few institutions that try not to do c-section for routine basis for anything.

Betty relates similar perspective on treating circumcised women. She states:

I haven't had to do a c-section on anyone because they are circumcised. But, there are instances where patients have refused c-section, not because they are circumcised, because of religious and cultural reasons about being able to have more children. But, most of the time if you try to explain what is going on and why you are recommending it and talk to them, the patients are willing to go ahead with the surgery.

Returning to studies mentioned earlier in chapter two conducted by Essen et al (2002a, b), and Johnson et al (2009), providers in this study do not perceive circumcision as a threat to natural birth. The quotes from Betty and Judy illustrate that although circumcised women require culturally sensitive care; this does not prevent them from having natural birth. In addition, Betty explains that "as far as pap smear goes, you can tell that most of them have been open enough to use the speculum."

For providers engaged with African refugees, the importance of culturally competent care is even greater compared to the general population. Cultural competence on the part of health care providers is needed in order to attend to and

care for the unique needs of refugee patients. Refugee women often require health care providers who are knowledgeable about their experiences. This is especially important because of their lack of English language skill.

### **Continuity of Care**

Another theme that emerged from the data is that of continuity of care. Most providers interviewed perceived African refugee women as withholding information that is needed to manage their health. Many of the providers interviewed assert that refugees do not give them any information regarding their health unless they keep on probing them. Several of the providers discussed with me that they experienced challenges due to lack of continuity of care among refugee women who have moved from their birthplace through refugee camps and ultimately to their final destination, with different levels and types of reproductive health care at each stop. Even though most refugees are subjected to pre-departure medical screenings, and post-arrival screenings, most medical screenings focus on infectious diseases and do not typically include screening for diseases of the reproductive organs or educating women on reproductive health issues.

The lack of prior medical histories means that providers have to reconstruct reproductive health histories of each refugee patient in the short consultation window, sometimes resulting in “frustration” on the part of the

patient. These issues combined with language and cultural issues could lead to misdiagnosis or delays. In my field notes, I noted a discussion with Karema (a Somali refugee who is also a registered nurse at a different health care facility in Chandler, Phoenix Metro Area). She did not want to be part of the study because she felt her provider status would conflict with her refugee identity. However she shared some of the challenges she faced with fellow Somali refugees:

Continuity of care is difficult with my people (referring to Somali refugee women). They come here with no previous medical record. It is not cultural for them to ask providers questions. They just remain silent about previous medical history. I have had a patient who began prenatal care at six months pregnancy and she was anemic. I don't know if it is a system failure in that case because her sponsoring agency is supposed to tell her how to seek help especially as she's pregnant.

The issue of continuity of care is worsened by the fact that most of the refugee women do not have primary care physicians to coordinate their health treatments. These women depend on public health facilities which means they will have to interface with multiple providers.

Part of the problem with lack of continuity of care is that it strains patient-provider relationships and raises issues of trust and openness because refugee

women may not feel comfortable sharing personal details with someone they are not familiar with. Karen explains:

We just say “oh, Somali refugees” and then we don’t know anything else about them. I think it will help to have more details about them. It can be coordinated through one office. I don’t need to ask them the same question over and over in order not to put them through the trauma of reliving their past.

Lack of trust between refugee patients and health care providers is a barrier to care. The barrier exists at all levels: individual, institutional and community. Trust between providers and patients requires time and open communication, which may be more challenging for refugee women who are also dealing with language barriers. Trust will be further complicated if the refugee patients get the feeling that the providers are suspicious of them. Three providers mentioned that the social worker was very suspicious of refugee patients when it comes to the issue of a car seat, and that it makes the patients uncomfortable. The state of Arizona requires that newborns be discharged only to parents who provide a car seat in the clinic. Parents who do not provide a car seat will not have their babies released to them until they do so. So, during my interview with Saba (RN), I revisited the issue of car seats and I was surprised at the tone of the conversation. She states:

Oh yeah. The car seat issue. If they don't bring their own from home, the hospital sells the car seat for \$40 in cash but they used to give free car seat for patients who need it but they don't provide car seat anymore. But, every time I have a refugee patient they don't usually have a car seat or they don't have enough money to buy, which is \$40. I think they need to prepare before having a baby. We give free car seats to patients who really need it for financial reason. I don't know why every refugee patient doesn't bring car seat.

As noted by Hynes (2003) making space for trust should be a priority, with trust between provider and refugee serving to reinforce health. Saba's response to the issue of the car seat could be interpreted in many ways, one of which is the fact that she thinks the refugee patients are taking advantage of the system. Clearly, such preconceived notions on the part of the provider will affect the way they relate to patients and probably affect the patient's views and willingness to open up on personal health issues.

### **On the Question of Patient-Provider Relationship**

This section addresses the question of the patient-provider relationship in regards to African refugee women's interaction with health care providers. The earlier sections of this chapter and the previous chapters have examined the views



of both African refugee women and health care providers in Phoenix, Arizona. By doing so, it has begun to unpack and differentiate the unique health barriers faced by African refugee women as opposed to a more broadly defined foreign born population. While RWHC (the primary site for this study) attempts to respond to the needs of African refugees, providers and patients have been stressed by some of the barriers they encounter.

The providers in this study revealed that they experienced some challenges providing care to African refugee women due to language/interpretation issues, culture, and lack of continuity of care. Providers asserted that refugee patients have different ways of perceiving health stemming from cultural differences. Consistent with commonly held assumptions about culture as a barrier to providing care to refugee populations, the providers tended to interpret refugee women's personal preferences as cultural issues. For example, several providers discussed their experiences with quiet and fearful patients as exclusively a cultural issue:

I know their culture is different from ours and sometimes they are very guarded in what they perceive. I can't explain the cultural differences to them because it is hard to get them to communicate on that deep of a level because of communication issue (Jessie).

Like people from Somalia can be more fearful that we gonna do something they don't want us to do. I think it's a cultural thing (Brenda).

I had a patient from Africa. I think she is from Liberia...she spoke English. She was very quiet and nodded to every question I asked her. She really appeared too quiet and I guess it is in their culture not to ask providers questions (Daniela).

The above quotes reveal how providers decide on whether a refugee patient's behavior is culturally situated. Although in some situations, quietness and fear may represent a culturally specific way of conveying respect to people in positions of authority, interpreting patterns of quietness and fear as a cultural problem tends to draw attention away from the power inequities that may be shaping how refugee patients relate to providers who are in positions of influence.

Also, the behavioral pattern of quietness and fearfulness is further complicated by the power dynamics in refugee camps, where most of these women migrated from. Karema (a Somali nurse) explained how refugee women's quietness was the result of patterns of paternalism and authority characteristics of refugee women's camp life:

About refugee women being quiet and fearful, it comes from having spent all your life in a refugee camp, where you are told how to live, how to

...speak, and your life depends on the benevolence of camp authority, and this has gone on for so many years.

Hence, what may be perceived by some health care providers as a “cultural thing” can take on a different meaning when considered in light of the ongoing power inequities, and how these influence refugee women’s relationships with health care providers.

To assume that refugee women’s individual manner of interacting is necessarily a function of “their culture” overlooks the significance of how their pre-migration history shapes their post-migration experiences. Thus, providers must strive to remain attuned to refugee women’s pre-migration and post-migration experiences and how these affect their clinical encounters. Fear may be the result of something much deeper than their health needs and have little to do with culture per se. Karema explains:

These women carry that fear with them because they are new to America. It took me so many years to get over the fear of being deported, which most refugee women are fearful about when dealing with people in positions of authority...There’s a refugee woman who came to our clinic for prenatal care and didn’t disclose her HIV status even the new patient form asked for the information. So, after we told her that we will need her

consent to do HIV test as a routine practice in our clinic, she then told me that she had done the test in the past and it was positive. I asked her why she didn't say it in her report. She said she was afraid that she may be deported.

Apparently, refugee women's "fearful" pattern of interaction should not be reduced to a cultural issue. In raising the issue of how providers interpret refugee women's cultural beliefs, I am by no means perpetuating a dichotomous analysis of African refugees as "victims" and health care providers as "oppressive"- an approach which tends to circumvent the complexities involved in providing care to refugee women. Rather, I am concerned with how providers' perspectives about refugee women influence their relationship with refugee women. When examined in light of broader Western assumptions about Africans and the postcolonial relations between African countries and the U.S (the needy nations of Africa versus the all-powerful U.S), clinical encounters that may seem quite innocuous may actually represent the ongoing ways in which those marked as "Other" are marginalized in routine patient-provider interactions. Therefore, how providers (and patients as well) interact with those viewed as the "Other" must be interpreted within broader histories and relations of power, past experiences and the background knowledge that each party brings to a clinical encounter.

Further, providers' focus on refugee women's culture could unintentionally turn specific health conditions into "ethnic" problems leading to racialization and cultural essentialism of reproductive health conditions. Thus, refugee women are blamed for their "deficient culture". For example, most providers referred to refugee women's cultures as being responsible for their delay in seeking prenatal care. Linking "refugee women-provider" encounters to broader social contexts is particularly important given the power differential that exists for refugee groups who have experienced historically generated forms of marginalization and displacement in their countries of origin, and who continue to experience pre-migration difficulties characterized by discrimination based on gender, ethnicity, language, religion, culture and class. I argue for a postcolonial feminist approach to patient-provider relationships, an approach which recognizes that the reproductive health needs of African refugee women must be addressed within not just the cultural, but the social and historical contexts of their lives. In the next chapter, I situate the relationship of African refugee women and health care providers within a postcolonial feminist framework.

## **Conclusion**

The perceptions of health care providers in this study echo those observed from national studies. Language issues remain a huge barrier to providing care.

Both the providers and refugee women revealed the difficulties of language, which impacts service provision on the part of the health care provider and can lead to misunderstanding on the part of refugee women. In fact, cross cultural language competency on the part of both provider and patient affects relationships all the way through consultation.

Most barriers to reproductive health care observed in this study are not necessarily unique to African refugee women when compared to the broader immigrant population. However, barriers assume an added urgency given the greater challenges of refugees, as they deal with complex and interconnected issues they face in their host communities without any form of family network and support. For example, while culturally competent care is required for both immigrant and refugee patients, providers working with refugees must better understand the refugee experience and the case history of that patient, a difficult task in the relatively short consultation period. Similarly, language is not just a refugee issue. But, refugees are more likely to be illiterate, to have limited command of English, or to lack the vocabulary to describe their needs and concerns.

Although refugee women narrated instances where they felt discrimination, surprisingly, none of the health care providers mentioned

institutional representations of refugees and other forms of discrimination and marginalization of refugee women. However, reference to other health care facilities where providers request that patients bring their own interpreters suggest that institutionalized discrimination exists within the health care system, which may lead to marginalization of refugee patients and poor reproductive health outcomes as providers avoid “time-consuming” patients. Clearly, as stated by one of the refugee women in the previous chapter, discrimination based on ethnic origin has detrimental effects on health.

## Chapter 9

### CONTINUING THE DISCOURSE: POSTCOLONIAL FEMINISM

Postcolonial feminist theory helped me to conceptualize the intersecting forces that influence African refugee women's reproductive health experiences and how healthcare providers perceive refugee women's reproductive health care needs. This theoretical framework provides an understanding of how the views of refugee women may be shaped by their displacement and resettlement experiences. It also supports my argument that each refugee woman's reproductive health experience is impacted by history (both her own and the world's) and that we must take into account the context of their pre-migration and post-migration situations. As shown in the last two chapters, my analysis of the data revealed that refugee women and health care providers encounter challenges when accessing/delivering reproductive health services due to several factors that influence their interaction.

Postcolonial feminism is an essential way of looking at the conditions that shape refugee women's relationship with health care providers. In developing my argument, this chapter is divided into two subthemes: culture, and racialization. The section that follows focuses on the issue of culture by drawing from the interview transcripts which conceptualize "difference" in a western clinical



setting to be a cultural problem. I argue that understanding the micro politics of power and the macro dynamics of institutional discrimination in health care settings is fundamental to analyzing patient-provider relationship. Postcolonial feminism's focus on Western constructions of non-Western women makes it a powerful analytical framework for this study.

### **Culture**

One of the most compelling contributions of postcolonial feminist theory is the problematizing of the concept of culture as neutral and static belief systems that are passed on from one generation to the next. The conceptualization of culture within postcolonial feminism is that it is intensely dynamic- constructed within historical, political, economic, and social contexts. The way one interprets culture has far reaching implications for understanding everyday clinical encounters between patients and healthcare providers (Anderson, 2005). Culture is often conflated with race and ethnicity and treated as a static determinant of health behavior. Culture is usually coupled with notions of fixed beliefs, difference, "otherings," and binaries of superiority/inferiority (Ahmad, 1993). Those assigned to the category of refugees may be seen to have different cultural beliefs from the mainstream population that stand in the way of their reproductive health and adherence to biomedical systems of care. The object of health care

providers thus becomes in a sense the conquest or surmounting of cultural backwardness. This kind of cultural essentialism about refugee patients can have negative consequences for their well being.

Cultural essentialism has the tendency to assume that all African refugee women (or all Somali refugee women, for example) have the same cultural issues. During my study, I found an overwhelming uniformity of views among healthcare providers and a persistent tendency to make assumptions about the cultural beliefs of their refugee patients. There is a subtle ongoing process of “othering” the refugee patient in the health system which emphasizes cultural difference in explanations of how mainstream populations would react to a certain situation compared to a refugee patient.

However, on the part of the refugee patients, I found that several women spoke from a personal point of view rather than from a fixed cultural location. While acknowledging the role of culture for refugee patients, I argue that healthcare providers must also pay attention to individuality and diversity among African refugee women. This, I believe, provides a starting point for examining points of engagement between postcolonial feminist theory and patient-provider relationship theory. Indeed, Uma Narayan (1998) points out that one of the ways to resist cultural essentialism is to focus on the historical and political context and

processes by which certain values and practices have been deemed a component of a certain culture.

Chandra Mohanty (1991) provides insights into the analysis of inequities that are based on the essentializing gaze of culture. My exploration of Mohanty's work provides a framework for understanding how non-Western culture is constructed within a Western space. The circumstances and conditions under which non-Western cultures are constructed are a critical part of understanding patient-provider relationships, especially when the patient is non-Western. During my field study and data analysis, I realized that when culture is invoked in health care settings, in no circumstances is it Western Anglo-American culture that is being put in question. Rather, "culture" in the healthcare setting refers to belief systems and behaviors of non-Western people as they are put under a western biomedical gaze. The essentializations of culture in the health care setting are not benign, but have far reaching consequences in the context of providing care to refugee patients.

Far from speaking with a unified voice, refugee patients had different and far more nuanced views on culture. In some instances socioeconomic factors were responsible for their decisions regarding care. For example, while responding to the question of the cultural relevance of traditional herbs, Marthe explains:

Back in Africa, I was using the health facility when I had a job. But when I did not have a job, I started going to herbalist because it is cheap. They are very good; they can cure many sickness with herbs. So I don't have any cultural preference, I use hospital when I have money.

Interviewer: Do you have any cultural preference here in the U.S?

Marthe: No, not at all. Although I had small problem before I got AHCCS, but now that I have insurance I go to the hospital.

What stands out in Marthe's explanation is the way in which she shows an understanding of how to utilize both herbal and Western medicine. This suggests that refugee women's underutilization of services and delays in seeking medical help cannot be reduced to a cultural belief. Rather, we must begin to ask whether these women's lack of familiarity with the health insurance system in the U.S is not a greater hindrance to their wellbeing than some putative concept of cultural resistance.

Some refugee women may not be aware that they can receive medical benefits for little or no fee, especially if they qualify for government funded health benefits. Karen (social worker) describes her encounter with a Somali refugee:

I had a patient who could not breast feed for medical reasons so using the bottle was not her view of the role of a mother. I worked with the patient to make her understand we know she wants to breastfeed the baby but she can't but that the bottle is good for the baby. The baby needs it for brain development. We actually had to keep the baby here for failing to thrive and the baby was bottle fed but each time they take the baby home and come back for weighing the baby will be underweight. So we had to involve the CPS. But things have worked out now because the culture is different. In Africa they will use the bottle but the difference with our culture here is that they hoard food in Africa. Being afraid that they will not have enough food and getting them to understand that WIC is there, and that doctor will write out the prescription for WIC and you keep getting the formula. They don't have to hoard it; they don't have to save it. The baby needs what the baby needs. They don't have to pay for it. So this is some of the cultural problems we have with some patients here.

The notion of culture invoked in Karen's account is problematic. There is an inherent conflation of socioeconomic factors with culture. A critical analysis of her account shows an attempt to "Other" the non-Western in today's healthcare system. Often, when the notion of culture gets thrown around in health care

settings, it obscures other factors that contribute to the health of the “culturally Othered”. Here, we see Karen refer to “hoarding” as cultural, yet the practice might be better understood as socioeconomic, and extremely situational.

Another provider, Brenda, describes her views on culture, “Personally, I can respect someone’s culture, but if I can’t communicate with them then I can’t understand their culture and so there’s a lot of assumption going on, more like speculation.” Making assumptions is part and parcel of everyday life. However, when unquestioned and unchallenged, and in the absence of critical reflexivity, there can be devastating consequences for patients and their families. Lynam et al. (2003) have noted the consequences to patients when health care decisions are guided by assumptions based on cultural and racial stereotypes. From Tiffany’s statement above and observation during my field work, it is clear that culture in health care settings is mostly interpreted as anything unfamiliar to the mainstream population. Hence, culture was a common theme stated by all healthcare providers interviewed for this study. I am not by any means suggesting that culture is not an important aspect of caring for refugee populations. Rather, I argue that over-generalizing culture poses problems to both refugee patients and health care providers in the sense that providers make wrong assumptions about why a refugee patient responds to care in the way that she does.

The refugee women interviewed in this study acknowledge negotiating culture as a challenge. In fact, chapter six discussed the theme of *living between two cultures* in the accounts of refugee women. However, the point deduced from the accounts of these women is that culture is dynamic and not static, and the tension involved concerns trying to live between two cultures, and attain some sort of balance. I argue that a static notion of culture tends to alienate the self from the illness process thereby suggesting that refugee women's, for example, are only shaped solely by their culture.

I find Homi Bhabha's notion of hybridity compelling, particularly as it relates to reproductive health care in the context of African refugee women. I understand Bhabha to be arguing that when cultures (for example, Western and non-Western) come together they create a "third space- a hybrid" which enables other positions to emerge. Bhabha (1990) argues further that the notion of cultural hybridity gives rise to something different, something new and unrecognizable and engenders a new era of negotiation of meaning and representation (p.211). Indeed, I find the negotiation of meaning an important factor in the relationship between Western health care providers and non-Western patients. Bhabha notes that hybrid identities challenge essentialist assumptions in a discourse of difference. But, as Parry (1994) reminds us, negotiation should be considered in

the context of power relations along different axes of gender, race, and class, and, I would add language and all other factors that shape refugee women's experiences. It would be naïve to assume that refugee women and all other groups perceived to be on the margin stand on equal footing with Western healthcare providers in Western health care institutions, and are able to negotiate new cultural meanings on neutral ground. As shown in the last two chapters, refugee women enter into the role of patient from a marginal position, especially if they are unable to speak and communicate in the language of their health care providers and have to depend on third parties for interpretation. Thus, neither the health care providers nor the refugee patients are able to negotiate meaning if either party lacks the language of communication.

Gayatri Spivak (1988) succinctly asks: Can the subaltern speak? She argues that subalterns must speak for themselves, instead of relying on Western intellectuals. Drawing from Spivak, I argue that to hear the voices and views of African refugee women, healthcare providers need to reflect on the impact of overgeneralizing cultural issues as well as the effect of imposing their biomedical and cultural interpretations on refugee women's reproductive health. As Meleis and Im (1999) aptly point out "it is more than culture that shapes the marginalized women's experiences, it is the extent to which they are stereotyped, rendered



voiceless...and ordered around” (p.96). Allowing refugee women express their views provides a balanced perspective on why they are open or not open to certain reproductive health services. As Charuni explains,

I don't have any cultural preference. If I am sick, I just want the doctor to treat me. When I was going to the clinic at McDowell the doctor will be shouting on my head. They were thinking I don't speak English. They will say go there, go here and they don't allow me to tell them what is wrong with my body. One day I decided that if they will not listen to me I will not go there again. That is how I came here (RWHC).

Clearly, Charuni's account shows that listening to patients allows them to be heard. Hence, the problem is not whether the subaltern can speak. Actually, the subaltern does speak and has been doing this for a long time; however, the structural inequities prevent her from being heard. Consequently, applying postcolonial feminism to this study illuminates the importance of cultural beliefs to reproductive health care, but also allows us to challenge cultural essentialism as well as explore other ways to interact with refugee patients without automatically reducing every differing view to something culturally motivated. By reducing every perceived difference to cultural essentialisms healthcare providers assume that they know another culture. This approach is problematic because it views

culture as fixed and static and applicable to all members of a particular group (Browne & Smye, 2002). It can be assumed that African refugee women's cultural experience of reproductive health care can be linked to social, economic, and political factors that constantly interact with mainstream society's values. I now turn to the issue of race/ethnicity as it relates to African refugee women's relationship with health care providers.

I argue that to understand the relationships between refugee women and health care providers, we need to integrate intersectionality and postcolonial feminist perspectives for two reasons. First, the intersectionality perspective, as shown in chapter 7, helps us to understand the uniqueness of refugee women's experiences that is stratified by ethnicity/race, class, culture, language, religion, and social location. Second, refugee identities are also often constructed in a complex set of historical processes that accentuate differences between refugees' culture and the dominant health care culture. Often, providers portray the biomedical culture as superior to that of refugees. A feminist postcolonial perspective allows us to examine the homogenization and essentialization of African refugee women, and suggest that Western biomedical cultures should also be subjected to critical analysis.

## **Racialization**

Race is a colonial construct which remains relevant in constructing postcolonial identities. Race/ethnicity as postcolonial identity denotes the formation of cultural boundaries. It establishes power over a group of people who are perceived to be inferior. Ashcroft et al (2000) note that the idea of superiority generated through racial constructs adapts easily to dominance. Race remains one of the dominant forces of postcolonial identity. Ashcroft et al (2000) define race as a “classification of humans into biologically, physically, and genetically specific groups” (p.198). Race is related to the rise of colonialism because the division of humanity is inextricable from the need of colonizers to establish power over certain people. Anderson (2006) suggests that we use the concept of racialization as process, rather than race as a category, as an analytical tool in health care research.

Historically, western depictions of Africans are potent sites where racialized meanings are constructed. African refugee women can be understood as specific contexts where meanings of Africa are re-produced in global dialogue:

The image of the African women in the mind of the world has been set: she is breeding too many children she cannot take care of and for whom she should not expect other people to pick up the tab. She is hungry, and

so are children. In fact, it has become a cliché of Western photojournalism that the African woman is old beyond her years. She is half naked; her drooped and withered breasts are well exposed. There are flies buzzing around the faces of her children; and she has a permanent begging bowl in her hand (Aidoo, 1998, p.39, cited in Patricia Hill Collins, 2000, p.241).

This image uncomfortably depicts Western representation of the African woman, particularly African refugee women whom are photographed or videoed with loads on their heads and children on their backs trekking to an unknown destination. Hence, the African refugee woman has become a symbol of despair and destitution in the eyes of the western media. Reminiscent of Aidoo's "African woman who is breeding too many children she cannot take care of," Margaret's (refugee from DRC) account of her miscarriage and the insensitive remark from a health care provider illustrates the process of racializing African women.

A racialized American refugee policy was designed to keep African refugees within Africa. As the few "lucky" ones make it to the U.S they are faced with the sudden reality of racial discrimination. In my interviews with twenty African refugee women in the U.S, experiences of racialization were retold in very poignant ways, especially as they had to deal with racialization for the first time. Some of their accounts stress their racial innocence as they resettled to the

U.S: “Everything here is about race, they don’t like Africans” (Agnes, Liberian refugee). Accordingly, the twenty participants offered similar stories that affirmed the existence of racial stereotypes. Some of them felt undermined by the ways that their race was used to discriminate against them at work. In chapter 7, I discussed the ways refugee women’s post-migration experiences shape their encounters with health care providers. Similarly, my interviews with healthcare providers reveal how issues of culture, race, language, and gender are embedded in the interactions. Questions of who legitimately belongs, difference, and othering have become common determinants of health, and influence refugee women’s individual understandings of their host community.

Some of the participants noted that the social identity ascribed to them in America does not speak to their lives and experiences as individuals. Marthe said, “Yes, I am a refugee from Africa... I am from Burundi, but I am Marthe.” Indeed, Marthe’s statement speaks to the need for us to move beyond racial categorization and look into the lives of specific individuals to understand what their unique lived experiences are. As Brah (2000) has argued, until we come to the realization that we should not structure oppression in hierarchies, the dismantling of and deconstruction of race will continue to be superficial. I argue that instead of using racialization as an essentializing tool, health institutions could use it as a way of

improving race relations so that the racially different other is not reduced to an inferior position.

Although racializing processes can affect anyone, they have dire consequences in situations of unequal power relations, where individuals are constructed as inferior and needy. African refugee women are more likely to experience racialization in the health care system because of their race/ethnic origin. Their inability to communicate fluently in English makes them vulnerable to the systems of racialization. While displacement and migration have contributed to the experiences and views of African refugee women interviewed in this study, power dynamics articulated through categories of race and culture are a huge influence in the ways health care institutions represent African refugee women. In my interviews with providers, distorted images of Africa were used to affirm racialized ideology. For example, I find the criteria used by some providers to describe African refugees to be problematic. Seeking to know the impact race had on care, I asked the providers how they are able to identify who is an African refugee woman. Saba (RN) had an interesting description:

Usually those small poor countries black people come from e.g. Ghana. You can make out by their dressing. They have a specific way of dressing. That is how you know they are refugees.

Interviewer: What about non-refugees who dress the same way.

Saba: Those ones are different. When you see refugees you will know them.

Hall (2003) points out that the creation of stereotypes plays a role in the representation of racial difference. This stereotyping reduces some groups to a few simplistic images. Thus, Saba's account reflects a stereotypical image of Africa as "poor" and thereby people who look a certain way are racialized into that fixed category.

While Saba's account shows how refugee patients are racialized by some health care providers, not all providers in this study use the same criteria in identifying refugee patients. Tiffany (RN) explains, "Usually, when I look at their admitting information it would say refugee clinic. That usually denotes they are refugees. There's also an indication that they speak certain languages as well."

In Tiffany's account, language becomes a form of racialization. Not only does speaking a different language provide difficulties for both refugees and providers; often, it becomes a weapon of "Othering" the culturally different thereby leading to racialization. I would concur with Ahmad (1993) in arguing that the construction of race and the process of racialization have profound consequences for health care delivery. As mentioned in chapter six, refugee women experience

discrimination based on race. Postcolonial feminist theory provides the framework to challenge the construction of race. It directs attention to race and racialization as socially produced through the historical, socioeconomic and political processes of colonialism and imperialism. Saba's reference to those "small poor countries black people come from" politicizes the concept of blackness. As stated, Saba invokes the notion of blackness from a political and economic perspective.

During my participant observation at the RWHC, I observed a racial/ethnic othering going on among the patients. I collected the following fieldnote during one of my observation:

As I walked into the reception area at the clinic, it was a very busy Monday. This was my first day at the clinic, the women sat in what I saw as ethnic/racial parameters. Africans sat together, Burmese sat together, and so on. I felt out of place since I didn't know if I could fit into the African group because of the ethnic differences I had with the Africans present at clinic. After a few minutes of visually scanning through the room I saw a Black woman sitting with a visibly pregnant young lady. I walked up to her and asked if she's from Africa, she smiled and said yes. Donyen became my first participant and "recruiter" as well. We started



talking and she told me she's from Liberia and I told her I am from Nigeria. At the mention of my country of origin I noticed a sudden relief from her and she started talking to me about her church, before she left she told me "you can come to my church and talk to the women, they will listen to you because you are one of us." You know, "we don't want to talk to people because these white people are spying us. If you don't do something, they are calling CPS immediately to take your children."

I was pleasantly surprised that my ethnic identity gave Donyen a strong sense of connection to me and she was able to tell me things that she may not disclose to a white person. Did other refugee women feel that way? Several of the women warmed up to me once they learned of my African origin. However, I observed that while refugee participants found it easy to relate with me based on continent of origin, getting information from them required more than a continental affiliation. Most of the refugee women who spoke to me expressed their concern about trusting unfamiliar people. This interview excerpt illustrates to an extent how "space" (reception area) becomes a tool for racial/ethnic solidarity. This is what qualitative researchers call "insiderness," where I saw myself being "ethnicized" and considered an insider. The upshot of insiderness is that it creates patterns of social inclusion/exclusion based on people's ethnicity. As described

earlier, the way people sat around the reception area and Donyen's account both show how racial/ethnic identity affects the healthcare system. For example, each time an African patient would be called in to the consulting room, I noticed that the medical assistant who usually calls them in is African.

Another encounter that I noted in my fieldnotes was during my interview with Nshimirimana at her home in Phoenix. I used an interpreter during this interview. When I asked Nshimirimana if she had experienced racial barriers while seeking reproductive health services, she replied:

I don't think discrimination will ever finish. One time I went to the clinic at McDowell, the woman in the front and her friend were looking at me and laughing at me because of my English. I was very angry that day. Even the other time I apply for a job, they didn't give me the job. My application was put on the side. It was really sad. Even this job that I am doing now is disturbing my health. They only give me thirty minutes off.

Nshimirimana's account illustrates the impact of racism on health through the prism of labor interaction as well as interaction with health care systems. Whether racism takes the form of remarks such as "laughing at," or employment discrimination and harsh working conditions, the experience is devastating to peoples' self esteem, health, and eagerness for social interactions. Racism shapes

African refugee women's perceptions of mainstream society by reinforcing feelings of social rejection. It also influences refugee women's relationship with providers.

### **Constructing the American Health Care System**

In recent times, many health care facilities and programs across the country are designed to help health care providers appreciate the diverse ways health problems are expressed. In RWHC, for example, providers are trained to develop sensitivity and understanding of cross-cultural meanings and expressions of ill-health. One problem with this approach is that cultures are essentialized in different ways. By emphasizing shared norms and values among cultures, as well as describing cultures as bounded by these beliefs and practices, health care providers risk othering refugees by defining them solely by their cultural difference. One consequence of this is that the ways people are defined, labeled, and disempowered are left unchallenged and the label becomes the socially constructed identity of such populations within the health care system.

The construction of the American health care system also may be part of the challenges African refugee women are grappling with and this may have great influence on their reproductive health decisions. The health care system cannot be separated from the broader economic, social and political contexts (Anderson and

Reimer-Kirkham, 1998). As mentioned earlier, the difficulties experienced by refugee women cannot solely be explained as a cultural issue. The structure of the health care system must be taken into consideration to understand the real difficulties refugee experience. Health care providers are trained to practice within a health care system that has deeply embedded institutionalized prejudices and beliefs. Thus, the norms and culture of the American health care system can be major factors across all levels, not only for refugee women, but for health care providers, as well.

Gayatri Spivak once famously noted that much of western attention to the Third World consists of “white men saving brown women from brown men.” (1998). Using this quote as a point of departure, I argue that the American health care system can be constructed as “white male” while the biomedical gaze cast upon African refugee women and their “culture” reflects a form of colonialization of the African female and “rescuing” her from the barbaric culture that prevents her from attaining her reproductive health needs. The western biomedical model of care assumes and reinforces disempowerment of women survivors of war and conflict, which further victimizes them individually and collectively. Several refugee women in this study complained of being diagnosed with depression even though they do not believe they are depressed. Postcolonial feminism provides a

framework that acknowledges differing world views and its core deconstructs the “othering” often perceived in western medicine. This othering inadvertently supports the re-victimization of refugee women found in the biomedical model of care.

## **Conclusion**

Based on my research findings, I argue that healthcare providers should rethink approaches variously glossed as culturally appropriate or competent. This chapter has shown the analytical relevance of postcolonial feminist theory to research in the area of interaction between African refugee women and health care providers. Postcolonial feminism has been particularly influential in this study because it provides the analytical lens and vocabulary for considering the colonial past and the neocolonial present as the context in which health care is delivered. Postcolonial feminism helps to critically examine the racialization and “othering” of African refugee women in health care settings. Awareness of postcolonial perspectives will help health care providers put into context refugee women’s life experiences and intersecting social relations. These social relations shape perceptions of health and provide the ability to manage complex health issues.

Indeed, the relevance of respecting the cultural beliefs of other groups cannot be overlooked or ignored. However, I have argued that this understanding

and respect for others' cultures must be complemented by creating space for dialoguing with patients and making meaning of their illness through their narratives. Contrary to the academic belief that once health care providers are trained in cultural sensitivity they will be able to address the health needs of non-Western populations, the concept of cultural sensitivity needs to be broadened to include the histories and contexts that shape reproductive health experiences. And it is crucial that providers subject their own culture, including western biomedical culture, to critical scrutiny as well.

## **Chapter 10**

### **CONCLUSION: LOOKING TO THE FUTURE**

What seemed like a specific research question and relatively small topic, the reproductive health experiences of African refugee women, has led me to explore the nature of their relationship with healthcare providers as well as combining theoretical perspectives with the review of literature and data analysis. All these various sections of this study come together in the lives and experiences of the African refugee women who are at the center of this study. The experiences of these women and the perspectives of health care providers in this study provide crucial insights about patient-provider relationships. The continuous resettlement of African refugees in the U.S. adds a particular dimension to the concern of providing culturally appropriate care.

As this study has shown, African refugee women are very diverse and have various needs and concerns. Interviews revealed language/interpretation issues, perceived discrimination, and living between two cultures as some of the issues these refugee women and their health care providers have to contend with in reproductive health contexts. The ability for both parties to keep interacting in the face of these challenges was noted. In this sense, the persistence of refugee women to learn American ways as well as their openness to accept different forms

of medical treatment are seen as strategies taken by some of the refugee women living between two cultures. Their personal accounts and those of the providers in this study illustrate the need to reassess the health care system to provide for those patients for whom it was not originally designed.

Refugee women and providers in this study articulated experiences and a world that were mediated by gender, class, culture, language, race, among other factors. Generally speaking, the reproductive health experiences of African refugee women reflect some of the major impacts of pre-migration and post-migration experiences, which include displacement, discrimination, violence, poor school completion, and lack of formal employment. Women's access to reproductive health services entails complex negotiations of living between two cultures. While one cannot make generalization based exclusively on the views of a small group of African refugee women and health care providers interviewed for this study, it is safe to claim that their personal accounts provide insights that could contribute to a better understanding of patient-provider interactions in the context of reproductive health care in general.

This study allows us to conclude that the reproductive health experiences of African refugee women are characterized by a number of factors such as language and interpretation issues, culture issues, perceived discrimination,



isolation, lack of continuity of care, among other factors mentioned earlier in this study. Compared to voluntary immigrants, refugee women's experiences are unique because of their total dependence on an unfamiliar system from the first day they arrive in the U.S. Typically, voluntary immigrants have some form of social or familial network in the cities they migrate. All the refugee women in this study were brought to the U.S by the UNHCR after passing all necessary U.S asylum medical tests and interviews. Except for those who moved to Phoenix from their initial cities for resettlement, all the refugee women in this study did not have a choice in deciding where in the U.S they wanted to live. Lack of social networks further isolates these women who are not familiar with the basics of living in America.

Reproductive health care illuminates the gendered needs of refugee women. The position of being a refugee combined with their social location impacts women's experiences of reproductive health. The gendering of refugee women's experience ranges from the use of husband-interpreters, male telephone interpreters, to their preference for a female provider; refugee women's access to reproductive health care is thus obviously a gendered area of concern. The theme of living between two cultures also reflects a gendered negotiation in which refugee women are reminded of their culturally defined roles as mothers whilst

trying to learn American ways. Several of the women in this study lamented about the cultural expectations and “Americanized” children they have to deal with.

### **Implications for Future Research**

This study started with an interest in learning more about African refugee women’s reproductive health experiences. Unfortunately, only refugee women and health care providers were included in this study, which limited further investigation of interpreters’ views as well. The views of interpreters require further research. Replicating this study with the inclusion of interpreters would provide a deeper meaning of the issues discussed in this study. My experience with an interpreter who censored what I could or could not ask refugee participants shows the amount of influence and power these individuals have over refugee women’s lives. Examining the views of live and telephone interpreters would provide a more detailed understanding of some of the interpretation issues mentioned earlier in the study.

Women’s reproductive access and experiences in refugee camps is another area of further exploration in relation to the pre-migration and fleeing experiences of refugee women. The fact that all twenty of the refugee participants in this study have lived in at least one refugee camp before resettling to the U.S. shows how refugee camps have been a huge part of these women’s pre-migration

experiences. Conducting further study at refugee camps would contextualize historical factors that led to the displacement of these women and their families.

While this study's goal was an understanding of refugee women's reproductive health experiences in connection with their interactions with providers, there is also a need for a greater understanding of the role of men in refugee women's reproductive health decisions. Including the perceptions of males would provide a more concrete analysis of the social support networks of families, as well as the gendered expectations in their households.

### **Concluding Remarks**

This study has shown the factors that shape African refugee women's lives and relationships with health care providers in the context of reproductive health care. The views of African refugee women in this dissertation show that their reproductive experience is influenced by a complex historical, social, and political formation shaped by pre-migration and post-migration experiences of displacement, processes of adjustment in their host communities and lack of language proficiency. Most of the refugee women in this study witnessed or experienced unimaginable horrors of conflict and the "entrapment" of refugee camps. It is my hope that this dissertation provides a more complete perspective of refugee women's reproductive health needs than already exists. There are

many ways that refugee-provider encounters can be productive for both parties. I have found that listening to refugees' perspectives is enriching and a useful approach to understanding their health needs. More than culture; sometimes, it takes a careless or "stupid" question to decipher the real reason behind a patient's health views. I conclude this dissertation with a statement from Marthe (a refugee participant from Burundi):

Everything is good. The only issue is that we ask ourselves questions and we don't have anybody to address such questions. They say call the police, but what can the police do? The problem of job – we go to the resettlement agency and they tell us you have been here three years so take care of yourself. How are we going to live without working? If you don't work and you have all these assistance you still can't afford money to buy personal stuff like clothes. If I had a job I will not be concerned but now am depressed. Prior to our coming to the U.S, we were told that as soon as we get here that we'll get a job, but now 3 years has passed and I still can't find a job. When we ask for job, they ask do you know how to use the computer? Do you speak English? Tell them that we don't need pity...we need job. African women, we want to work!

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APPENDIX A  
SEMI-STRUCTURED INTERVIEW GUIDE

Participant's # \_\_\_\_\_  
Interview date: \_\_\_\_\_  
Location: \_\_\_\_\_  
Time: \_\_\_\_\_

**1. Sample Questions for Refugee about their Pre-Migration and Post-Migration Experiences.**

1. What did you do while you were in your country of origin?
2. What memories do you have about your life in your home country prior to your migration?
3. How have these memories impacted your life?
4. How do you keep in touch with affairs in your home country?
5. In what ways do you celebrate your cultural heritage?
6. How do you think your home country has changed since your exile?
7. What does being a refugee mean to you?
8. How would you describe your experience as a refugee?
9. How has the refugee situation affected gender relations between refugee men and women?
10. How do you negotiate power relations within the family?
11. How has being a refugee impacted your life?
12. Did you live a second country before coming to the United States?
13. Tell me about your experience since you migrated to the U.S?
14. What does coming to the U.S mean to you?
15. How do you see yourself in the U.S social space?
16. What are some of America's cultural and medical aspects that have influenced the way you think of your well-being?
17. How has America influenced your life in general?
18. Can you tell me how being a refugee has changed your life?

**2. Sample Questions for Refugee Women regarding Reproductive Health.**

1. What does reproductive health mean to you?
2. How has being a refugee influenced the way you think of your reproductive health?
3. Can you describe how you feel visiting a health care provider for reproductive health services?
4. What do you think of American health care providers?

5. How do you think your health care provider can improve on the services rendered to you?
6. Can you describe a specific experience you had while visiting a health care provider?
7. How have American medical practices influenced your reproductive health behavior?
8. What types of reproductive health services do you receive on a regular basis?
9. Do you trust your health care provider?
10. What are the circumstances that make you uncomfortable with your health care provider?
11. Have you ever disagreed with your health care provider about a specific reproductive health issue? How did you resolve it?
12. How often do you think your doctor or other health provider listen carefully to you?
13. How often did doctors or other health providers explain things in a way you could understand?
14. How often did doctors or other health providers show respect for what you had to say?
15. How often did doctors or other health providers spend enough time with you?
16. What are some of the issues that might prevent you from seeking reproductive health care?
17. What is your most reproductive health issue? How do you cope with it?
18. How effective is the reproductive health care you receive?
19. What other sources do you use for your reproductive health related information?
20. How do you think the reproductive service rendered to you can be improved?

### **3. Sample Questions for Health Care Providers.**

1. When did your clinic/hospital/organization begin offering services to African refugee women?
2. What motivated your clinic/hospital/ to work with African refugee women?
3. Do you charge refugees a fee for services?

4. What kind of services or programs has your clinic/hospital/organization offered to the refugees?
5. What types of outreach does your clinic/hospital use to?
6. What is your primary role/specialty in providing reproductive health services to refugees?
7. How do you identify a patient as a refugee?
8. In what languages do you provide services?
9. How would you describe your role as a healthcare provider for refugees?
10. What particular reproductive health service do refugee women request most?
11. How would you describe refugee women's openness and comfort level with you?
12. How would you describe refugee women's knowledge level regarding their specific reproductive health issue?
13. To what extent do you think culture plays a role in the reproductive health care perceptions of the refugee?
14. What other factors do you think influence refugee reproductive health views?
15. Can you recount a time when a refugee woman disagreed with you regarding a specific reproductive health issue? How did you handle the situation?
16. What barriers to providing reproductive health care services to refugees have you experienced? Do you have suggestions for eliminating these barriers?
17. What medical information resources do you rely on for specific reproductive health issues presented by African refugee women?
18. What do you consider the most important reproductive health needs of African refugee women in the Phoenix area?
19. How do you think your clinic/hospital can improve the services offered to refugee women?
20. What is most the difficult and challenging aspect of serving refugees?


APPENDIX B

ARIZONA STATE UNIVERSITY'S INSTITUTIONAL REVIEW BOARD

APPROVAL LETTER.

Office of Research Integrity and Assurance

**To:** Ann Koblitz  
West Hall

*sv* **From:** Mark Roosa, Chair   
Soc Beh IRB

**Date:** 05/06/2010

**Committee Action:** Exemption Granted

**IRB Action Date:** 05/06/2010

**IRB Protocol #:** 1005005132

**Study Title:** A Qualitative Research to Understand the Reproductive Health Experiences and Perceptions of Afri

The above-referenced protocol is considered exempt after review by the Institutional Review Board pursuant to Federal regulations, 45 CFR Part 46.101(b)(2).

This part of the federal regulations requires that the information be recorded by investigators in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. It is necessary that the information obtained not be such that if disclosed outside the research, it could reasonably place the subjects at risk of criminal or civil liability, or be damaging to the subjects' financial standing, employability, or reputation.

You should retain a copy of this letter for your records.



APPENDIX C

MARICOPA INTEGRATED HEALTH SYSTEM'S INSTITUTIONAL  
REVIEW BOARD APPROVAL LETTER



MARICOPA  
INTEGRATED  
HEALTH SYSTEM

*Count on us to care.*

**Institutional Review Board**

**William S. James, M.D.**  
Chair, Institutional Review Board  
Director, MHS Psychiatry Residency  
Training Program  
[William\\_James@mhsoodirectors.com](mailto:William_James@mhsoodirectors.com)  
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**Debbie J. Wilson**  
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Phone: 602-344-5881  
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June 28, 2010

**To:** Mary Jatau  
Department of Obstetrics and Gynecology

Christa Johnson, M.D.  
Department of Obstetrics and Gynecology

**From:** David A. Drachman, Ph.D., Vice-Chair  
Institutional Review Board (IRB)

**RE:** 2010-054: A Study of African Refugee Women's Reproductive Health Experiences in the Greater Phoenix Area

**CC:** Blanca-Flor Jimenez  
Colin Irving

Your project, identified above, has been determined to be exempt from continuing IRB review based on The Code of Federal Regulations Title 45, Part 46 – Protection of Human Subjects. The specific sections are identified below.

(3) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if:

- (i) the human subjects are elected or appointed public officials or candidates for public office; or
- (ii) Federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

If you change the protocol from that described in your submission, the changes should be submitted to the IRB for re-review to assure that the activities continue to qualify as exempt.

DD/djw

You may not continue the study beyond the expiration date above. You must apply for reapproval 45 days in advance of the expiration to allow adequate time for IRB review.\* After your study has been conducted you must submit a final closure report.\*

\* Instructions and forms for reapproval and closures are available on the CopaNet.

*Affiliated with the University of Arizona College of Medicine and the Mayo Graduate School of Medicine*

APPENDIX D

AFRICAN REFUGEE WOMEN INFORMATION LETTER

Date \_\_\_\_\_

Dear Research Participant:

I am a graduate student under the direction of Professor Ann Hibner Koblitz in the Women and Gender Studies Program in the School of Social Transformation in the College of Liberal Arts and Sciences at Arizona State University. I am conducting a research study to understand the experiences and perceptions of African refugee women in regards to their reproductive health care. The study is designed to explore the nature of the relationships and types of interactions you have had with health care providers regarding a specific reproductive health issue. The study will also explore how your pre-migration and post-migration experiences have influenced you in different ways and its impact on your reproductive health.

I am inviting your participation, which will involve a one-on-one interview and filling out a very short questionnaire. This questionnaire will take about 10 minutes. You will not be asked to provide your name on this questionnaire; I will assign a code number to each questionnaire to protect your identity. You are free to skip any question on the questionnaire or skip the entire questionnaire altogether. The interview will last approximately 90 minutes, depending on how much you would like to discuss. I will be interviewing 20 individuals between the ages of 18-55. I will be happy to interview you at a public or private location that is convenient for you. In addition, I may ask if you would mind doing a follow-up interview. This would be entirely voluntary on your part, and it would occur within approximately six months of the initial interview. The follow-up interview would address questions that have been generated from my developing research hypotheses. You have the right to not answer any question, and to stop the interview at any time.

Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. You must be between 18-55 years of age to participate in the study.

The benefits of this research to participants would include the enjoyment they might derive from sharing and reflecting on their thoughts and feelings about reproductive health with an outside party. Participants may also enjoy assisting a professional researcher. Participants may feel empowered by contributing to research that seeks to create more positive experiences for African refugee women who are dealing with various reproductive health issues.

Your participation has no known risks. Although the study has tried to avoid risks, some questions may be uncomfortable or upsetting. Some people may feel anxious

or shy discussing their reproductive health issues, and pre-migration and post-migration experiences under the presence of an observer. You should only participate in the interview and share personal experiences to the degree you feel comfortable.

Everyone participating in the study will be assigned a code number. Your name will not be asked in this study. In order to protect your privacy, you will be reminded not to use the name of others when describing situations. Instead, you should describe such individuals using the relationship status such as friend, husband, daughter etc. Your responses will be confidential. The results of this study will be used in my dissertation. The information may also be used in reports, presentations or publications but your name will not be used.

I would like to audiotape this interview. The interview will not be recorded without your permission. Please let me know if you do not want the interview to be taped; you also can change your mind after the interview starts, just let me know. The audio tapes will be secured in a locked file cabinet in my office at Arizona State University; all identifiable markers will be erased immediately. The interview will be transcribed, and transcripts and audiotapes will be destroyed at the end of the study within 12 months.

If you have any questions concerning the research study, please contact the research team at: Mary Jatau: 480-686-7244 or [mjatau@asu.edu](mailto:mjatau@asu.edu); or Ann Hibner Koblitz: 4809658483 or [koblitz@asu.edu](mailto:koblitz@asu.edu). If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788. Please let me know if you wish to be part of the study.

APPENDIX E

HEALTH CARE PROVIDERS INFORMATION LETTER

Date \_\_\_\_\_

Dear Study Participant:

I am a graduate student under the direction of Professor Ann Hibner Koblitz in the Women and Gender Studies Program in the School of Social Transformation in the College of Liberal Arts and Sciences at Arizona State University. I am conducting a research study to better understand the perceptions and experiences of African refugee women with regards to their reproductive health. The study is also designed to explore the nature of the relationships and interactions between health care providers and African refugee women regarding their reproductive health.

I am inviting your participation, which will involve a one-on-one interview to share your professional experience as a reproductive health service provider to African refugee women. I will be interviewing healthcare providers who have experience rendering services to African refugee women. The interviews will last approximately 90 minutes, depending on how much you would like to discuss. I will be happy to interview you at a public or private location that is convenient for you. In addition, I may ask if you would mind doing a follow-up interview. This would be entirely voluntary on your part, and it would occur within approximately six months of the initial interview. The follow-up interview would address questions that have been generated from my developing research hypotheses.

There are no guaranteed direct benefits from taking part in this study. Although there may be no direct benefits to you, the possible benefits of participating in the research would include the enjoyment you might derive from sharing and reflecting on your professional experience with an outside party. You may also enjoy assisting a professional researcher.

Your participation has no known risks. Although the study has tried to avoid risks, some questions may be uncomfortable or upsetting. You should only participate in the interview and share experiences to the degree you feel comfortable.

Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty.

Everyone participating in the study will be assigned a code number. Your name will not be asked in this study. To protect your privacy and that of others, you will be reminded not to use names when describing situations. The results of this study will be used in my dissertation. The information may also be used in reports, presentations, or publications but your name will not be used.

I would like to audiotape this interview. The interview will not be recorded without your permission. Please let me know if you do not want the interview to be taped; you also can change your mind after the interview starts, just let me know. The audio tapes will be secured in a locked file cabinet in my office at Arizona State University; all identifiable markers will be erased immediately. The interview will be transcribed, and transcripts and audiotapes will be destroyed at the end of the study within 12 months.

If you have any questions concerning the research study, please contact the research team at: Ann Hibner Koblitz: 4809658483 or [koblitz@asu.edu](mailto:koblitz@asu.edu); or Mary Jatau: 480-686-7244 or [mjatau@asu.edu](mailto:mjatau@asu.edu). If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788. Please let me know if you wish to be part of the study.



APPENDIX F  
DEMOGRAPHIC QUESTIONNAIRE

Assigned interview code # \_\_\_\_\_

Date \_\_\_\_\_

Location \_\_\_\_\_

1. In what year were you born?  
\_\_\_\_\_
2. What country are you originally from?  
\_\_\_\_\_
3. Which ethnic group do you mostly identify with in your country of origin?  
\_\_\_\_\_
4. When did you arrive the United States? \_\_\_\_\_
5. How many people in your household arrived the United States with you? \_\_\_\_\_
6. When did you arrive Phoenix? \_\_\_\_\_
7. How long have you been living in Phoenix? \_\_\_\_\_
8. What is your zipcode?  
\_\_\_\_\_
9. Do you identify yourself with a religion? If yes, what religion?  
\_\_\_\_\_
10. What is your marital status?
  - a) Married
  - a) Widowed
  - c) Separated
  - d) Divorced
  - e) Single
  - f) Other (please explain) \_\_\_\_\_

11. What is your partner's /spouse's occupation? \_\_\_\_\_
12. Do you have any children, including stepchildren or adopted children?  
No  
Yes, biological children: (Ages : \_\_\_\_\_ )  
Yes, step children: (Ages: \_\_\_\_\_ )  
Yes, adopted children: (Ages: \_\_\_\_\_ )  
Other (please explain): \_\_\_\_\_
13. What language(s) do you normally speak at:  
Home? \_\_\_\_\_  
Outside the home? \_\_\_\_\_  
With your friends? \_\_\_\_\_
14. How far did you go in school before your migration? \_\_\_\_\_
- 15.
16. What other educational or professional qualifications have you obtained in the United States?  
\_\_\_\_\_
17. Are you currently employed? If yes, what is your occupation? \_\_\_\_\_
18. If you are not currently employed, what is your source of income?  
\_\_\_\_\_
19. What kind of health insurance do you have?  
a) None  
b) AHCCS  
c) Private  
d) Group  
e) Other (please explain) \_\_\_\_\_