Article

Feminism & Psychology

Feminism & Psychology
1–21

DOI: 10.1177/09593535221149166
journals.sagepub.com/home/fap
SAGE

Refugee women's pregnancy and childbirth experiences in the US: Examining context through a reproductive justice framework

Autumn Kirkendall
University of Cincinnati, USA

Anjali Dutt
University of Cincinnati, USA

Abstract

Maternal health in the United States is an area of immediate concern. The compounded disadvantages and unique global positions of refugee women highlight the need for research that explores the experiences of refugee women during pregnancy and childbirth. The present study examines how contextual factors shape pregnancy and childbirth experiences for Syrian, Afghan, Congolese, and Karen women living in Clarkston, Georgia, US. Qualitative data were collected via focus groups facilitated by community interpreters. We used a reproductive justice framework to center women's desires, needs, and experiences, and to highlight the importance of structural factors in the findings and analysis of this study. Using codebook thematic analysis, three themes were developed: (1) isolation and alienated knowledge, (2) gendered disparities and structural inequities, and (3) community support and precarity. The findings reflect both the diversity and constancy of women's experiences and highlight how the context of the US impacts women's ability to exercise agency during pregnancy and childbirth. Systemic change is needed to improve women's access to tools that increase their capacity to exercise agency both during pregnancy and childbirth, and beyond.

Corresponding author:
Autumn Kirkendall, Edwards Center 1, 66 Corry Blvd., Cincinnati, OH 45219, United States.
Email: kirkenak@mail.uc.edu

Keywords
maternal health, refugee women, agency, reproductive justice, pregnancy, childbirth, United States

Maternal health in the United States has been identified by medical researchers, health care providers, and activists as an area of immediate concern (Greenwood et al., 2020; Ross & Solinger, 2017). Compared globally, the US has a higher maternal mortality rate than economically similar nations (CIA World Factbook, 2018). Within the US, there is racial disparity with Black, Indigenous, and Asian women experiencing higher maternal mortality rates than White women (Petersen et al., 2019). Additionally, women who do not speak English experience worse outcomes than those who do (Sentell et al., 2016). Research is needed to gain insight into the experiences of women[1] who are disadvantaged in maternal health care, with the goal of identifying pathways to improve minoritized women's well-being.

Over the last decade, the number of forcibly displaced people worldwide has nearly doubled from 41 million to 79.5 million (UNHCR, 2019). Although in recent years the US federal government has dramatically limited the number of incoming refugees, over three million refugees have been resettled in the US since 1975 (USA for UNHCR, 2020a). Many refugees are women of childbearing age, thus many resettled refugees will experience pregnancy and labor in the US (UNHCR, 2020). Refugees are often People of Color (PoC) in the US, many do not speak English comfortably, and encounter other forms of hostility and discrimination which have concerning implications for maternal health and well-being (Shaw et al., 2022).

Although some refugees were considered racial and/or ethnic minorities in their home countries, this is not the case for all. However, in the US, race is particularly salient due to a long history of racial marginalization and discrimination (Alexander & Mohanty, 1997) and refugees therefore share experiences with PoC who are not refugees and/or native to the host country, including the consequences of racial segregation. These consequences include difficulty accessing transportation, and feeling unsafe where they live (Dutt et al., 2022). Many refugee women have limited English language proficiency, which has implications for access to healthcare (Floyd & Sakellariou, 2017). In addition to these difficulties, refugee women have unique experiences due to forced global movement. These experiences may include targeted violence, family separation, dangerous conditions during migration and escape, and exploitation (Hilado et al., 2021). The compounded disadvantages and unique global positions of refugee women highlight the need for research that explores the specific experiences of refugee women during pregnancy and childbirth.

Research on refugee women's maternal health, although limited, raises several concerns regarding their health and well-being. Compared to the general population, refugee and asylum-seeking women are more likely to experience mental health disorders, maternal mortality, preterm birth, and congenital anomalies (Heslehurst et al., 2018), and have lower rates of obstetrical intervention, later initiation of prenatal care, and greater initiation of postpartum care (Kentoffio et al., 2016). Such differences suggest unique circumstances in which refugee women are pregnant and give birth,

with significant consequences for their health and well-being. Deeper insight is needed to more clearly understand factors that impact the context in which refugee women in the US experience pregnancy and birth (LaMancuso et al., 2016).

Accordingly, our study examines how contextual factors shape pregnancy and childbirth experiences for Syrian, Afghan, Congolese, and Karen women living in Clarkston, Georgia, US. In collaboration with a local refugee support organization, the first author conducted focus groups with women from these communities who were connected to a maternal support organization. Of particular interest in our analysis was how the local and global context impacted women's agency. Since refugees are often portrayed as recipients of care, rather than as individuals with knowledge and capability to inform their own well-being, we used a reproductive justice framework to center women's desires, needs, and experiences in the findings and analysis of this study.

Reproductive justice and psychology

Reproductive justice activists and scholars emphasize the importance of a person's context in shaping their reproductive health. The reproductive justice framework centers on the gap between protecting rights and ensuring access to reproductive health (Ross & Solinger, 2017). Women of Color (WoC) activists in the US conceived the reproductive justice framework to address the systemic disparities in accessing reproductive health experienced by WoC. Disparities associated with reproductive health go beyond the medical domain, and are interconnected with manifestations of economic, gendered, environmental, and racialized oppressions (Ross & Solinger, 2017, p. 75). Reproductive justice thus aims to address the intersecting oppressions which shape women's lives.

Reproductive justice also centers the needs, desires, and experiences of WoC, making women's agency a primary focus. In the limited research on refugee women and maternal health, much of the focus is on barriers to adequate care as measured by, primarily outcomes-based and quantitative, Western medical standards. Indicators may include, for example, the number of prenatal visits, communication with a doctor, or insurance status (Declercq et al., 2020; Herrel et al., 2017; Kentoffio et al., 2016). Although these barriers are important, this rather narrow conception of refugee women's health assumes a Western medical goal for health (outcome-focused rather than experience-focused) and may overlook the goals women have for themselves, their families, and their communities (Dutta, 2008; Fine, 2011; Kumar, 2020). Understanding how women exercise agency and how their agency is enabled or inhibited centers women's experiences and incorporates the broader context that shapes experiences, in line with the principles of reproductive justice.

Psychological research on agency typically conceptualizes agency as an individual characteristic that is reflected in a person's attitudes or behaviors (Rutherford, 2018). This research tends to focus on a person's sense of agency—whether a person feels like they have agency—regardless of their capacity to exercise agency. This individualized focus reflects predominant notions of agency in the US that center a decontextualized individual, oftentimes overlooking important relational and contextual aspects of agency. Regardless of whether or not someone feels agentic, there are factors outside of the individual which shape

their ability to exercise agency. Some psychological researchers argue that agency is shaped by ecological factors and relationships (Gergen, 2009) and should be understood as situated and relational (Riger, 1993; Rutherford, 2018). Feminist research on reproductive agency highlights the ways in which global power dynamics and social class impact how agency is executed (Chadwick, 2017; Uyheng et al., 2020). These conceptions of agency invite psychologists to consider the diverse ways agency is enacted and shaped.

Understanding that psychological research practices reflect predominant power dynamics, reproductive justice provides an orientation to conduct research with refugee women that works to actively undo harmful scientific practices. Refugee women generally come from the Global South, which includes Africa, Asia, the Middle East, and Central and South America. These regions have been impacted negatively by the hegemonic power of the US, and the Global North more broadly, due to historic and persisting resource extraction and racialized policies that promote internal conflict (Mignolo, 2011). In a globalized world, conflicts that result in displacement are either directly or indirectly a result of economic and political power exerted by the Global North, and when resettled, refugees are often in Global North nations where they are considered outsiders (Haque & Malebranche, 2020). Additionally, Global North knowledges dominate psychological research, meaning that the knowledges and power of Global South women are largely unacknowledged (Macleod et al., 2020). Psychological research with a reproductive justice framework provides an orientation for studying refugee women's experiences with pregnancy and childbirth in the US in a way that centers women's experiences and aims to avoid further contributing to marginalization or oppression (Chrisler, 2012; Eaton & Stephens, 2020; Morison, 2021). A reproductive justice framework challenges conventional practices in psychology that harm and alienate non-Western populations. This is accomplished by supporting non-Western and women-centered lenses, critiquing power inequities, and understanding individuals as embedded in systems (Eaton & Stephens, 2020).

The purpose of this study is to understand how contextual factors in refugee women's lives impact their experiences of pregnancy and childbirth in the US. The context we focus on in this study includes participants' families and local communities, the built environment, health care facilities and policies, support organizations, and local and state resources for refugee women. While global and national contexts—including immigration policy, conflict resulting in displacement, and imbalances in global power shaping how knowledge is dispersed—also impact women's lives, these are beyond the scope of the study. By focusing on refugee women's experiences and the contextual factors that impact their pregnancies and birthing, we aim to provide insight into what changes are needed for more just, meaningful, and satisfactory healthcare realities for diverse refugee women.

Method

Partnership and study design

This study was conducted in collaboration with Embrace Refugee Birth Support, a program of the non-governmental organization Friends of Refugees, in Clarkson that

supports refugee women through pregnancy and labor with health education classes and patient advocacy. Program evaluations indicate that refugee women who participated in Embrace programming were less likely to be induced for labor than their peers who had not received support from Embrace (Mosley et al., 2021). These findings suggest Embrace programming is associated with positive pregnancy and labor outcomes. The directors at Embrace were interested in knowing what services women found valuable and what Embrace could do to improve their services. The first author was a research intern for Embrace at the time of data collection and designed the focus group protocol with input from the directors and five community interpreters employed by Embrace. The specific roles of community interpreters appear in Table 1. Community interpreters were refugees or immigrants from the communities they worked with at Embrace. Institutional review board approval was obtained prior to commencing the study and focus group protocols were approved by community interpreters.

Focus groups were chosen as the data collection method because being around others with a similar experiences can provide a sense of comfort, especially when discussing negative experiences or expressing dissatisfaction (Herrel et al., 2017). Additionally, the purpose of the research was to inform higher level change within Embrace and within US healthcare, and focus groups can elicit a wide range of experiences and opinions. Moreover, smaller focus groups allow for in-depth exploration of refugee women's experiences of systems of care and their insights into how these systems may be improved. By examining these experiences among women from four different refugee communities, insight is gained into the shared experiences of refugee women currently residing in the same area, and differences in experiences due to their specific identities and circumstances.

Four focus groups were conducted by a community interpreter with the first author present, one with each ethnic/regional group represented: Syrian, Afghan, Karen, and Congolese (Quintanilha et al., 2015). These four groups reflect the refugee communities Embrace primarily served in 2017 and 2018 when the study was conducted. Community interpreters facilitated conversation by asking focus group protocol questions and follow-up questions. Some community interpreters interpreted for the first author after each participant's response and others summarized the responses for each question. The community interpreters all had established relationships with participants through their roles as Healthy Moms instructors and as patient advocates during women's pregnancies. Because all four community interpreters who conducted interviews had been active in participants' lives during their pregnancies, participants could easily reference specific instances and experiences with shared understanding with the community interpreter. This was the case in all four focus groups with each community interpreter, including the male interpreter for the Congolese group. Written and verbal consent was obtained prior to each focus group. Consent forms were available in Arabic, Dari, Karen, and Swahili, and participants were informed that they could skip any questions they wished. Participants were given a package of diapers to thank them for their involvement in the focus groups, and community interpreters were paid for their time as part of their roles as community liaisons.

Table 1. Community interpreter roles.

Community Interpreter	Focus Group	Protocol Feedback	Translated Consent Form	Recruitment	Conducted Focus Group	Translation	Transcription
Muzhda	Afghan	x	x	x	x	x	
Dareen	Syrian	x	x	x	x	x	
Mu Naw	Karen	x	x	x	x	x	x
Obed	Congolese	x	x	x	x		
Hope*	Congolese					x	x

Note. In some cases, the community interpreter translated the audio while the first author transcribed.
*pseudonym

Participants

Thirteen women participated in the focus groups: three Syrian, two Afghan, four Karen, and four Congolese. Table 2 provides further participant characteristics. All 13 had given birth within a year of the focus group and had participated in Embrace's Healthy Moms class. All the participants were relocated as refugees to Clarkston, a small suburb situated within the metropolitan area of Georgia's capital, Atlanta. Clarkston has a large refugee population and has been a hub for refugee resettlement since the 1980s.

Although it is not possible to detail the atrocities that necessitated migration of each group, some historical context provides insight into the backgrounds of the participants at the time of data collection. The Syrian civil war began in 2011 and has left 12.7 million Syrians displaced, with half fleeing the country (USA for UNHCR, 2020b). Many remain in Syria as internally displaced migrants, and a small percentage have been resettled from refugee camps to the US. Continued conflict in Afghanistan has resulted in civilian displacement for the last 40 years with many resettling in the US (Amnesty International, 2019). The Karen people are an ethnolinguistic group that has been living on the border between Myanmar and Thailand in refugee camps for decades (Cheesman, 2002). Notably, in the focus groups, Karen women said they are from the Thai refugee camp Mae La. In the Democratic Republic of the Congo, widespread conflict, violence, and disease has caused displacement for decades (IRC, n.d.). Political and economic instability continues to impact Congolese people's lives even during times of minimal conflict.

Table 2. Participant demographics.

Participant (Pseudonym)	Ethnicity	Where are you from?	Years in US	Number of Children	Number of US-Born Children
Nazia	Afghan	Afghanistan	3	1	1
Amina	Afghan	Afghanistan	2	3	1
Masuda	Syrian	Syria	1.34	3	1
Ibna	Syrian	Syria	1.25	7	1
Salma	Syrian	Syria	0.92	2	1
Lah	Karen	Thailand	2	2	2
Moo-A	Karen	Thailand Mae La Refugee Camp	7	3	1
K'Paw	Karen	Thailand Refugee Camp	2.5	7	1
Htoo	Karen	Mae La Ooo (Refugee Camp)	2.5	4	2
Imara	Congolese	Congo	3	6	3
Kwau	Congolese	Congo	1	3	1
Najuma	Congolese	Congo	1.5	6	1
Mzuzi	Congolese	Congo	-	7	1

Analysis

The analysis was informed by a structural intersectional approach to reproductive justice framework and centered women's experiences and the structural systems which impacted their experiences (Grzanka & Schuch, 2019). This analytic approach brings attention to the systems of power present in refugee women's lives (Morison, 2022). Data analysis was conducted by the two authors, and two undergraduate research assistants. All the team members identify as women, none are refugees, nor have they given birth. Some have recent histories of immigration to the US. The first author volunteered for Embrace for several months, prior to conducting this study.

Focus group transcripts were analyzed inductively and deductively using codebook thematic analysis (Braun & Clarke, 2006, 2021). Our codebook was guided by questions about what was impacting women's agency, and how women exercised agency. We also developed codes by noticing what comprised and impacted women's experiences, and how they described their experiences. Prior to reading the transcripts, the coding team, which included the first author and the two undergraduate assistants, read literature about refugee maternal health and reproductive justice. Thereafter they read the transcripts and engaged in a reflexive conversation about assumptions, relevant experiences, and biases regarding pregnancy and labor, the experiences of refugees, and the data. The team revisited this conversation throughout the coding process.

Through conversations about initial codes, a codebook was created which was then applied to each transcript, first independently by the coders and then discussed as a group. These discussions solidified the codebook and generated further insights into the data. After coding all the transcripts, the authors developed three themes through continuous discussion. These themes were formed via iterative consideration of the raw data, the codes, and insights that emerged during the coding process (Braun & Clarke, 2021; Srivastava & Hopwood, 2009). Themes were reviewed with the transcripts until they adequately reflected all the data.

Results

The purpose of this study was to understand how the context in which refugee women exist impacts their experiences with pregnancy and childbirth in the US. Our findings are organized into three themes: (1) isolation and alienated knowledge, (2) gendered disparities and structural inequities, and (3) community support and precarity. These themes reflect both the diversity and constancy of women's experiences and highlight how the context of the US impacts women's ability to exercise agency during pregnancy and childbirth.

Theme 1: Isolation and alienated knowledge

The women described feelings of foreignness and loneliness when explaining their experiences with pregnancy and birth in the US. Although most of the participants had lived in the US for over a year, and were likely permanent residents, many expressed a

continued feeling of not belonging. This sense of foreignness is expressed explicitly in the Syrian focus group when Masuda says, "every woman wishes her family could be beside her and her siblings. We still feel foreign." Referring to herself and others like her as "foreign", Masuda's explanation reflects a feeling of being in a liminal space, separated from the people who are closest to her and thus alienated in her current state. Her statement was in response to a question related to what would make the experience of giving birth in the US better for her. In emphasizing her desire for family, she underscores the importance of relationships during pregnancy and childbirth in a foreign space, and a sense of isolation given their current absence.

Many of the women, particularly in the Afghan and Syrian focus groups, expressed loneliness that was associated with not having family close by. In the Afghan focus group, Nazia said, "I was alone too, and I did not have enough experience on how to raise the babies." This quote is part of a conversation in which the women shared that being alone was one of the greatest challenges of their pregnancy and childbirth. In Nazia's quote, being alone and having knowledge about how to navigate pregnancy and birth are connected. Throughout all the focus groups, women expressed needing and desiring support, particularly because they felt they lacked adequate experience or knowledge to navigate the newness of pregnancy and childbirth in the US. Since they were isolated from their family members and culture, the women were separated from sources of knowledge they would have relied upon in their transition with a new child. Feelings of foreignness were thus bolstered by, and demonstrated through, feeling a lack of knowledge about pregnancy and childbirth in a US context.

Further demonstrated in the focus groups was a feeling that knowledge about pregnancy and childbirth was context dependent, which had implications for the women's agency. Previous research has demonstrated that a patient's knowledge about their medical condition is contextually valued and dependent on social factors such as class (Young et al., 2020). Most of the participants (12) had given birth before, and for most (11), their previous births were prior to moving to the US. However, despite this experience, the women felt their knowledge was not applicable in the US. In the Karen focus group, the women discussed differences between births in the Thailand Refugee Camp and their most recent birth in the US. K'Paw said:

> I had good experiences with all six of my kids in the Thailand refugee camp. My seventh baby was born in [Georgia, US] a few months ago. It was up to the doctor what they would do because this was my first baby that was born in America, and I didn't know anything. [Whatever] the doctor or the nurse told me to do during pregnancy and labor I did it all. All six of my children that were born in Thailand, my water broke naturally. [In the US] I accepted all the procedures that the doctor would do to me.

Despite having given birth to six children, K'Paw expresses that because she was in a different environment, she did not know what to do during childbirth and deferred to the doctor. The dissonance she describes is powerful given her experience with six previous births and illuminates challenges around agency posed for some women giving birth in

the US for the first time. Refugee women were unfamiliar with the process of childbirth in the US because it was different from what they had experienced in their previous context. This unfamiliarity and distancing could have profound impacts on women's agency, demonstrated when K'Paw says: "I accepted all the procedures that the doctor would do to me." In the US context K'Paw did not feel knowledgeable, and felt she had no other choice but to accept procedures.

In the absence of familial ties and recognition of the knowledge that the women possessed about pregnancy and childbirth from their prior experiences, organizations played a crucial role in supporting women. In addition to an unfamiliar approach to pregnancy and childbirth, many of the women were unfamiliar with the US health system, including insurance, frequent prenatal appointments, and the built structure of medical centers. For example, Najuma explained:

> To me, if it wasn't for this organization, I wouldn't know how to use automatic doors and how to get in and out of elevators to get to higher floors, how to get to front doors and make it to appointments because I used to have very many appointments for me and the baby. Sending me to get there, if it wasn't for the organization, I wouldn't make it there, which door would I use? I couldn't tell.

Aspects of the built environment like door locking mechanisms and floor numbering systems vary globally and make navigating physical buildings difficult. Organizations such as Embrace provided a necessary service which the women expressed gratitude for in each focus group. The organization served as a liaison for women in many instances, by anticipating challenges refugee women would encounter, and could assist with navigating structures, resources, and expectations. The breadth of support the women felt they needed was reflected when Najuma said, "we were still visitors, and we didn't know where to start from [at the beginning of pregnancy] … we asked ourselves how we would start but, they [Embrace] really helped us and guided us from pregnancy to birth."

Although some of the women had meaningful local support, challenges prevailed. In their stories about pregnancy and childbirth, the Karen women emphasized the support they received from their local community and friends, which was unique from the other three focus groups. The Karen participants specifically described support from community and friends as important for finding resources and transportation. However, despite this support, the Karen women experienced challenges communicating with providers and having their needs met during their prenatal appointments and childbirth. Although some of the women had local support, even in these instances there remained challenges beyond interpersonal connection and communication that impacted the women's experiences with pregnancy and childbirth.

Theme 2: Gendered disparities and structural inequities

The women's discussions revealed how in addition to the challenge of navigating life in a new country as refugees, other aspects of identity including gender and English language

fluency exacerbated existing barriers during pregnancy and childbirth. Their access to transport and ability to communicate outside their community is limited by gendered norms and expectations regarding access to education and division of labor. For refugee women in the US, these disparities reflect structural inequities that effectively restrict their agency.

The women described experiencing significant challenges with transport during pregnancy and birthing. Many did not have a driver's license and relied on their husbands or male family members for transportation. Their husbands' work schedules often conflicted with times the women needed to be driven to appointments. This is illustrated by an explanation about challenges given by two women in the Syrian focus group: "Salma: 'I suffered before and I skipped many of my appointments.' Ibna: 'Husbands work all the time.'" Even the women who had a driver's license still experienced challenges with transport because the car was needed by their husbands for work. Men are more likely than women to be primary income earners and thus skills and resources associated with facilitating men's access to employment were prioritized due to gendered norms regarding income generation and division of labor.

Similarly, gendered barriers in English language acquisition also impacted the women's experiences with pregnancy and birth. As with the tendency to prioritize men's access to vehicles and driver's licenses, men's greater access to formal education globally and the requirement of English language competency for many jobs in the US means refugee women have lower levels of comfort and ability communicating in English and are less able to attain better paid employment than their male counterparts. In the focus groups, the women explained that they often relied on their husbands to provide interpretation and were left without support when their husbands could not attend the appointment because medical offices often did not have adequate interpretation. Amina, an Afghan woman, explained: "For me also language [was a difficulty] when I was in the hospital. Everyone came to ask me a question, I couldn't answer them. And my husband wasn't there to interpret or translate [the questions]." Many of the women expressed frustration that they could not respond or make requests to their providers when interpretation was not available. This directly impacts the women's agency as they could not explain their experiences and concerns, or advocate for themselves during pregnancy and birth.

The women desired transportation access and English language fluency beyond pregnancy and childbirth, noting how these resources would make their lives easier in many domains, including motherhood. When asked about what would improve their pregnancy and birth experiences, K'Paw responded:

> I would like to learn and speak English a little bit so that it can make things easier for me. The second thing is I want to learn how to drive in the future. I have my permit to drive but I will wait until my baby is a little bit older for me to drive and to go back to school. Also, I would like to work when all my kids are grown up […] It is hard for me as a mother, I don't know how to drive and speak English. I can't go to my kids' school and ask questions when I need to, and I can't communicate with the doctor when I take my kids to their doctor's appointments. It's hard for me.

Obtaining a driver's license and learning English are time-intensive processes; significant childcare responsibilities and the lack of structural social support make gaining these skills very difficult. Thus, although the women desired having a driver's license and English language skills and believed that having such acquisitions would improve their experiences as parents, gendered inequities persisted, making such goals difficult to achieve.

The hegemonic dominance of the English language, both globally and in the US, results in a local US context that does not adequately accommodate languages other than English. Onus is placed on refugees to learn English as quickly as possible to alleviate challenges in resettlement and assimilation (CORC, 2012). In medical settings, English language hegemony is reflected in inadequacies of interpretation services, which do not accommodate languages with many dialects. Under the Americans with Disabilities Act (1990), medical providers are required to provide qualified interpretation for patients; however, women described that this was often not the case. Although interpretation was sometimes available at medical offices, it often was not useful. Without being able to communicate with providers, the women were not able to speak their needs or to ask or answer questions. This was illustrated in the Syrian focus group:

Salma:	Before I met you [the community interpreter at Embrace], sometimes the interpreter [at the medical office] was from a village in Egypt, and we needed an interpreter between us. (General agreement)
Salma:	Sometimes they are from Iraq. We don't understand each other.
Ibna:	Here [Georgia, US], most of the interpreters are from Iraq or Egypt.
Salma:	More than once, by chance, [the interpreter] doesn't understand what I want to say to the doctor. How can I understand?
Community Interpreter:	I've heard this more than once.
Ibna:	Once, I had an Egyptian interpreter and he was angry. For example, I understand what the WIC person [who was speaking in English] says, and the interpreter said, 'I am here to interpret for you, why do you answer [her] instead of me?'. [Sarcastically I responded] 'I can understand what she is saying but I can't understand what you're saying. I can understand English, but I can't understand Arabic'.
Salma:	Me too. I had an interpreter from Iraq, and he said, 'My sister, I can't understand what you are saying.' How can I understand and talk?

Dialects of the Arabic language are not mutually intelligible, and as a result, if the women had an interpreter who did not speak the Syrian dialect of Arabic, then they could not understand their interpreter. The Karen women had a similar issue when they had Burmese interpreters at medical offices. The Afghan and Congolese women also mentioned a lack of any available interpretation at medical sites. English dialects are not as distinct as in other languages, thus the need for regionally specific interpretation is not always understood by interpretation service providers in the US (McWhorter, 2016). Due to the challenges the women faced because of inadequate language services,

many felt that improved language services would make their pregnancies and childbirths easier.

A lack of communication with medical providers had severe consequences for the women's agency, and further marginalized them in the healthcare setting. For example, Htoo, a Karen woman explained:

> If I know how to speak English, then I could ask my doctor to wait and allow me more time for pushing the baby. Since I don't know how to speak the language, whatever the doctor will do, I have to accept all.

Because Htoo cannot communicate with her doctor, she is not only unable to make her requests heard, but she is unable to express concern with the doctor's decisions or actions. These communication barriers constrain the women's agency as they are unable to consent to medical procedures. Women laboring in US healthcare facilities are often distanced from their bodies and decisions are primarily made by healthcare providers (Davis-Floyd, 2003). This is further exacerbated for refugee women as their voices are not heard in a setting that does not accommodate them.

Specific challenges with language and transportation varied across the focus groups; however, the underlying challenges associated with gendered labor division and English language primacy were consistent. The pervasiveness of these challenges reveals their structural nature. Even for women who had some access to transportation or communication, barriers remained. For example, women who had a driver's license needed to work around their husband's work schedules to make medical appointments. Having access to transportation and communication did not undo the underlying gender disparities and inequitable outcomes associated with English language dominance which shaped women's lives.

Theme 3: Community support and precarity

Across all four focus groups, the women described how their relationships with other people and organizations supported their experiences during pregnancy and childbirth. However, they also described a lack of reliability or other mitigating factors that could render the availability of these relationships unpredictable. Consequently, though the women described appreciating relationships that aided their processes with pregnancy and birth, discussion of these relationships was typically accompanied by an explanation of the precariousness of their overarching situation.

For many of the women, interpersonal relationships were important for connecting to support organizations and for finding general support through their pregnancies and childbirths. These relationships were vital because the women felt unfamiliar with pregnancy and childbirth practices in the US and needed language and transportation support. For example, Lah, a Karen woman, described finding Embrace through a friend and the support she received:

> My first pregnancy, I went to [my friend] and she told me there was a program that helped pregnant women. And then I said, 'Okay I would like to go to that program'. But I did not know English, and did they have an interpreter? Yes, [my friend] said the program had an interpreter. Then I came with [my friend] to the Embrace program and I received diapers for my children, and it helped me to save up some money.

Lah found material support through a friend who could vet the program for its applicability to her circumstances. Organizational support would not be as useful if interpretation was not available, and Lah's friend could attest for her that the support from Embrace was worth pursuing. Support from friends and organizations was a relief during this new experience in an unfamiliar and unpredictable context.

Although the women were grateful for help from their communities and organizations like Embrace, an overall lack of systemic support was revealed when they were unable to obtain the resources they needed. For example, in the Syrian focus group, the women talked about difficulties in attending their prenatal appointments due to childcare. Salma described:

> I like to make my appointments to know what's happening. I want to check and be sure about my health. But I couldn't. I took my daughter to the doctor … I have no place to put my daughter. The woman [who was watching my daughter] started studying.

Salma did not have family nearby and was new to the US, having moved just 11 months prior. Childcare was limited and not provided at medical facilities. When Salma's childcare support fell through, her ability to attend to her health was impacted. The sense of precarity the women experienced was underscored as they needed to rely on the availability of individuals to fill structural gaps including interpretation, transportation, and childcare. The precarity of support then prevented them from accessing the professional care and information they desired.

The women also explained that despite having largely positive interactions with organizations, the finite nature of specific policies within the organizations could emphasize the precarity of their situation when practices that had been supportive were no longer available. The women relied on Embrace for transportation and language support. However, in the Congolese focus group, the women were disappointed that this support, along with Medicaid, was not available after the baby was born. Kwau said, "They [Embrace] care about someone during pregnancy and after delivery, all is gone. That's the challenge I find here." This comment was in response to a question about how Embrace could improve their program to better support women.[2] Kwau notes the absence of services once the baby is born, despite still needing language, transportation, and financial support. Many of the others also underscored the paucity of sustainable and systemic support when they noted the detrimental effects of losing services they were relying on after giving birth. Embrace served a much-needed role in the women's pregnancies, however the support Embrace provided was not only necessary during pregnancy, but for refugee women's lives long after birth. When community organizations

become a source for actualizing basic needs, the sense of precarity refugees experience can become intertwined with organizational policies in the absence of broader structural support.

The few sources of systemic support, like Medicaid, that exist for the women also are not sustainably reliable, further contributing to the instability of their resources. Many of the women were enrolled in Medicaid health insurance during their pregnancies, and although Medicaid is provided by state and federal government, it was not experienced as a dependable long-term source of support. Najuma explained:

> After giving birth, they stop providing Medi[caid] assistance. There are moments when someone gets sick when she is still nursing the baby, without medical assistance. All those we see them as problems, so can't they help us in the way of getting treatment.

Medicaid is low-cost health insurance funded by the state and federal government that is available based on specific criteria that vary by state. Refugee women in Georgia are able to get Medicaid health insurance during their pregnancy and up to 60 days postpartum. However, as Najuma details, they do not stop needing medical care after this point. The loss of both Medicaid and the support provided by Embrace shortly after birth meant that the women were left not only without health insurance but also did not have support to find and enroll in other types of health insurance.

Although the women found valuable support through their communities, Embrace, medical providers, and social safety net policies such as Medicaid, the gaps in support highlighted the precarity in the women's contexts both during pregnancy and beyond. Sources of support varied for the women, impacted by how long they had been in the US, the languages they spoke, and the social networks that existed within their communities. Additionally, some support was situationally dependent, like Medicaid and programming from Embrace. The variability of support meant that the women did not have consistent access to resources that were necessary for navigating their pregnancy, childbirth, and general health in the US.

Discussion

We sought to understand how contextual factors in refugee women's lives impact their experiences with pregnancy and childbirth in the US, guided by the reproductive justice framework. Using this framework, which is rooted in intersectionality, helps to illuminate the systematic marginalization which reduces refugee women's power and therefore their ability to actualize agency and make choices regarding their reproductive health. Our findings are consistent with existing literature illustrating that refugee women experience loneliness and alienation (Pangas et al., 2019), gendered barriers to resources and care (Deacon & Sullivan, 2009), and a lack of structural support (Khan & DeYoung, 2019). Unique to our study is the application of a reproductive justice framework which highlights that although support from Embrace mitigated some challenges for refugee

women, local and global systemic failings inhibited women's agency during pregnancy and birth.

Feminist scholars and reproductive justice scholars and activists critique the rhetoric of "empowerment" and "choice", on the basis that these concepts often individualize system level injustices (Ross & Solinger, 2017; Rutherford, 2018). Our findings suggest that the refugee women who participated in the study skillfully exercise agency and navigate complicated barriers to foster well-being for themselves and their families. However, the broader context of their lives includes structural inequities that systematically diminish their agency. Efforts to improve refugee women's reproductive health need to focus on transforming the broader systems that shape women's realities and enable or restrict their reproductive agency.

From a reproductive justice perspective, addressing barriers to agency involves transforming the systems that impact refugee women's lives beyond the events of pregnancy and childbirth. For the human right of reproductive agency to be realized, there is an "obligation of government and society to ensure that the conditions are suitable for implementing one's decisions" (Ross, 2017, p. 174). Our results demonstrate some key areas in which conditions are not suitable for implementing one's decisions, including a lack of familial support, a lack of trustworthy childcare, and insufficient language support. The co-occurrence of English language dominance and lack of accessible language services reduced the women's power to advocate for their needs and desires by impeding their ability to communicate. This has consequences for maternal safety as women are effectively silenced in voicing concerns or asking questions (Tully et al., 2017). Additionally, in the context of restrictive immigration policy, the women in this study faced challenges in finding trustworthy childcare because their families were living across many different regions and countries. Feminist scholars have demonstrated that global economies and movement impact women's reproduction by altering the family structure (Marecek, 2019).

The in-depth analysis of small focus groups has the advantage of revealing commonalities in women's experiences that are shaped by a shared context. However, they must be seen in light of the fact that the women in this study had more formal support than many refugee women in the US, and yet still faced significant barriers. Future research could attend to a more diverse range of experiences by including women who were not part of a support organization to more completely understand refugee women's experiences with pregnancy and childbirth. Additionally, a larger sample within each community would allow for the identification of larger trends within this heterogeneous population.

The US has a large refugee population, and with the continuation of global conflict which results in displacement, the country should expect to accept many more refugees. Currently, many refugee women do not consistently have access to basic resources to navigate their lives. Without reliable access to transportation, communication with healthcare providers, and access to trusted loved ones, women's actualized agency is inhibited, and they have fewer opportunities to advocate for their needs. As a result, interventions aimed at pregnancy and childbirth for refugee women will remain primarily dictated without their voices. Individual level interventions aimed to improve refugee

women's experiences and outcomes are insufficient. Systemic level change is needed to improve women's access to tools that increase their capacity to exercise agency both during pregnancy and childbirth, and beyond. These systems level changes may include expanded public transportation, accessible English language classes, more accountability for providing language services, universal health insurance, and immigration policy reform that expands eligibility for resettlement. Although these changes are not specific to reproductive health, as per the reproductive justice framework, they create living conditions that improve refugee women's ability to exercise agency and thereby profoundly impact their pregnancy and childbirth experiences.

Acknowledgements

We are indebted to the community interpreters at Embrace who made this research possible with their valuable insight and commitment, our sincerest thanks to Muzhda, Dareen, MuNaw, Obed, and the Embrace team. We are grateful to the women who participated in this study for sharing their stories with us. We would like to thank our coding team, Sarvani Vermuri and Greta Davis, for their insight and time. Lastly, we are grateful to the editors of this journal and the anonymous reviewers for their valuable feedback.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Autumn Kirkendall https://orcid.org/0000-0002-0190-658X

Notes

1. Not all people who give birth are women, but the vast majority of research on refugee maternal health is about cisgender women. We use the word "women" in this paper because all of the participants self-identified as women.
2. Currently, Embrace provides postpartum support for women, but it did not at the time of the focus groups.

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Author Biographies

Autumn Kirkendall is a PhD student in the Community and Organizational Research for Action Program in the Psychology Department at the University of Cincinnati. She holds a BA from Macalester College in Psychology and Community and Global Health and a

MA from the University of Cincinnati in Community Psychology. Autumn's research focuses on systemic factors that shape subjective understandings of health, well-being, science, and research. She is particularly interested in research that centers on and responds to the lived experiences of marginalized communities. Her thesis research was supervised by Anjali Dutt.

Anjali Dutt earned her BA at The College of New Jersey and her MA and PhD in Psychology at the University of California, Santa Cruz. She is currently an Associate Professor of Social-Community Psychology at the University of Cincinnati in the Community and Organizational Research for Action Program. Her research focuses on psychological processes that are associated with resistance to oppression and increasing the realization of human rights, particularly in the context of globalization. She collaborates with community organizations to conduct mixed-methods research, exploring how structural changes in communities impact the self-determination, empowerment, and well-being of marginalized communities.