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Abstract

The purpose of this anthropological research is to examine and analyze the intertwined geopolitical complexities of the lived sexual, reproductive, and maternal health and healthcare experiences of female Congolese refugees in flight. These experiences are examined at three pivotal points of refugee flight: during protracted conflict and violence, in displacement, generally in neighboring East African countries, and during resettlement in Western contexts. Data were collected using two anthropological methodologies - targeted life history interviews and semi-structured qualitative ethnographic interviews. Supplemental data from related studies, reports, and literature reviews were also used for population-level information. Collected data were analyzed through the lenses of political economy, structural violence, and cultural hegemony.

Using these frames of analysis, this research brings new insights to the interdisciplinary fields of refugee and migration studies with particular emphasis on the cultural and social considerations in a political economy lens of analysis. More specifically, it brings new insights to enhance the efficacy, sustainability, and subject-focused nature of East African refugee maternal health and healthcare policies. I argue that such policy enhancement must be led by the voices, experiences, and histories of those they are meant to serve - Congolese refugee women. Moreover, I suggest that this approach be protected and funded by a multilateral coalition of refugee-focused women's health and healthcare agencies and initiatives at the grassroots to the global scale. Thus, an overarching goal of this research is to contribute to the decolonization of the Western-centric knowledge and power structures at play in the institutions and organizations meant to support the health and healthcare of Congolese refugee women and refugee women in general.

THE GEOPOLITICS OF REFUGE AND REPRODUCTION:
MATERNAL HEALTH AND HEALTHCARE OF CONGOLESE REFUGEE WOMEN
IN FLIGHT, DISPLACEMENT, AND RESETTLEMENT

by

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Dissertation

Submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy in Anthropology

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Additionally, I am truly thankful to Richard Hunt, my High School principal, and continuous supporter and advocate for refugee communities in Central and Western NY. He frequently took groups of us students to volunteer to teach ESL at the nearby refugee center in Utica, NY. This partnership with refugee communities as a teenager formed my deep-rooted reverence for displaced communities from an early age.

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Introduction

The topic of refugees being resettled in Western states is consistently discussed and debated on the world stage. Some approach the topic with a humanitarian lens and push to welcome these individuals into their countries after having already experienced unthinkable, compounded trauma and anguish. Others take a more conservative approach to refugee resettlement by setting limited quotas of refugees allowed to resettle per year. Still others have case-by-case views on global displacement which are influenced by any number of factors from how organized religions view refugees to their ability to positively impact the economy of the hosting country/region (Radulescu, 2022). Therefore, the purpose of this research speaks to the American and global immigration debate. Specifically, my research provides an American and global audience with a richer context of where these East African refugee groups are coming from geopolitically, historically, and socioculturally. My goal for this research is to take a step out of the theory of refugees and conflict studies and into the reality of everyday traumas and issues that female refugees face at various stages of flight. As I discuss in the following chapters, fleeing a geographic location of war does not mean that the war and its tools and wounds of violence are left behind.

Furthermore, my work goes beyond the study of refugees to include a broader context and documentation on the study of rape. I wanted to understand this refugee group, their issues with fertility, and sociocultural contexts in displacement and resettlement but in order to do that, I first had to learn about the trauma of warfare and rape. Unfortunately, the current refugee literature does not go into detail on this significant issue in refugee flight that causes reverberations into refugee maternal health in displacement and resettlement. Therefore, I go into detail on the anthropology of rape in Chapter I. Chapters I and II also detail first-hand accounts

from my informant on her unimaginable experiences with sexual violence and rape in the context of civil war in the DRC and during displacement.

Information on Congolese Displacement

The protracted conflict in the Democratic Republic of Congo (DRC) is one of the most severe and longest global humanitarian and human rights crises of modern times. The ongoing conflict is a perpetuation of centuries of civil unrest fueled by colonial and neocolonial resource extraction and oppression, ethnic tensions, military and rebel factions, and mass sexual and physical violence. As of December 2022, there were 1,026,077 refugees and asylum seekers who were forced to flee the DRC (UNHCR DRC Data Portal, 2023). Chapter I provides a historical overview of the conflicts that have resulted in the magnitude of displaced individuals.

The ongoing violence has also led to a significantly high rate of internally displaced persons (IDP) of more than 5.2 million people. Of this internally displaced population, 2.9



Figure 1: History of U.S. Refugee Admittance since 1975. Pew Research Center. (Krogstad, 2019)

million people were displaced in the eastern provinces in the DRC, the region of the ongoing Kivu Conflict, mainly Ituri, North and South Kivu and Tanganyika. This is the largest IDP crisis in Africa and one of the longest humanitarian crises in known global history. The crisis has been further compounded by the COVID-19 pandemic, ongoing Ebola outbreaks, and grave food insecurity in 2020, affecting 15.6 million Congolese and leaving 4.7 million suffering from severe malnutrition.

Congolese individuals forced into flight, mainly from the eastern Kivu provinces, generally flee to neighboring Uganda (UNHCR RRRP, 2023). By November 2022, there were 473,529 Congolese refugees and asylum-seekers, or 46.8% of the Congolese population, living in Uganda. Other countries that Congolese individuals frequently flee to include Burundi, Tanzania, Rwanda, and Zambia. The percent of the Congolese population living in those countries as of November 2022 is, respectively, Burundi (8.6%), Tanzania (7.9%), Rwanda (7.1%), and Zambia (5.6%) (UNHCR DRC Data Portal, 2023). Record numbers of Congolese local populations continue to be forced to flee from the protracted conflict and violence in the DRC, largely caused by political economic instability and ethnic tensions linked to the effects of European colonial and Western neocolonial exploitation and degradation.

Data on Congolese Refugees in the US

While a portion of this research examines Congolese refugee resettlement in Western countries, the empirical data collected for this research came from ethnographic interviews with Congolese refugees who were resettled in the U.S., specifically. Thus, in exploring why the health and healthcare of displaced and resettled Congolese refugees is an urgent contemporary issue, we must examine the data around recent U.S. refugee policies on Congolese refugee resettlement.



Figure 2: Source: CGTN Africa, 2022

History of Congolese Refugees in the U.S.

The United States Refugee Admissions Program (USRAP) began resettling a limited number of Congolese refugees in the U.S. in 2000, mostly coming from Tanzania. According to the CDC (2021), between 2008 and 2013, roughly 11,000 Congolese refugees were resettled in the U.S. from 36 countries. U.S. states with high Congolese refugee resettlement numbers include New York, Texas, Arizona, and Kentucky. In 2012, there was a new initiative by the U.S. Bureau of Population, Refugees, and Migration (PRM) to resettle roughly 50,000 Congolese refugees in the U.S. between 2013 and 2018 (The Centers for Disease Control and Prevention (CDC), 2021). Between 2014 and 2019, the United States resettled an estimated 50,000 refugees from the Democratic Republic of Congo (DRC) (Carolan, 2010, p. 408). While this goal set by the PRM to increase the number of incoming Congolese refugees was statistically met, partially under the Trump Administration, other incoming refugee populations were drastically limited by the same Administration partially due to reasons rooted in religious intolerance (Fullerton, 2017; Waikar, 2018).

Trump Administration's Restricted U.S. Refugee Resettlement Policies

After Trump's inauguration in early 2017, refugee resettlement in the U.S. dropped to historic lows (see Figure 1). According to Pew Research Center data (Krogstad, 2019), the U.S. had previously admitted more refugees every year than all other countries combined. Furthermore, this sharp decline in the U.S. admittance of refugees occurred at a time when the number of refugees globally was at the highest level since World War II. However, despite overall lower numbers of refugee admittance under the Trump administration, in 2019, refugees from the DRC outnumbered those from any other country, with around 13,000 Congolese refugees being admitted. A partial reason for this could be Trump's crackdown on admitting refugees from Muslim countries with the DRC being of predominantly Christian faith. In 2019, 79% of admitted refugees identified as Christians (Krogstad, 2019). Thus, while the rate of admitted refugees to the U.S. had sharply declined during Trump's administration from 2017-2020, Congolese refugees were still the most resettled refugee group in the U.S.

When Biden's administration took office in 2021, he raised the 2021 budget year refugee admissions cap from 15,000, the Trump administration's refugee cap, to 62,500 (Shear, 2021). However, in budget year 2021, the Biden administration only admitted 11,411 refugees - a far cry from the 62,500 cap (Constantino, 2021). The caps set for budget years 2022 and 2023 were raised to 125,000 each year, but fewer than 20,000 refugees were admitted in budget year 2022, which ends at the end of September of each year (Watson, 2022).

What does this all mean for Congolese refugees? The health and security of Congolese refugees, mainly women and children, remain dire in the context of the protracted Kivu Conflict, compounded with various epidemics and a recent natural disaster, leading more Congolese than ever into forced flight and seeking resettlement to areas where other family and friends have

already been resettled in the U.S. and in other Western nations. It is imperative that the US reaches, and subsequently raises, the cap on refugees each budget year.

Congolese Refugees in Syracuse, N.Y.

The Congolese refugee women interviewed for this research were all resettled to Syracuse, N.Y., a medium-sized city located in central New York State in the northeastern United States. Between 2000 and 2016, more than 10,000 refugees resettled in Syracuse (Baker, 2016). In 2020, 114 refugees and special immigrant visa arrivals from the DRC resettled in Syracuse (otda.ny.gov, 2020), with almost 30 Congolese families living in the city in 2020 (Eckillia, 2020). Many of the Congolese refugees currently living in Syracuse were displaced due to the ongoing conflict and violence in the DRC, fled to international refugee camps or were internally displaced, sometimes for decades, and have just recently begun to be resettled in Western states. Syracuse, N.Y. has only recently seen an influx of Congolese refugee resettlement in the past five to six years, beginning around 2016. All of the Congolese refugee women interviewed for this study were resettled in the U.S. in 2015 or later, with 75% resettled in 2018 or later.

Congolese Women and Sexual Violence: Impacts in Flight, Displacement, and Resettlement

As these data show, the ongoing violence and conflict in the DRC, resulting in unprecedented numbers of Congolese IDPs, asylum seekers, and refugees fleeing to neighboring countries and/or migrating for resettlement to the U.S. or to other Western nations, is one of the most pressing humanitarian and human rights issues of modern time. A critical issue within the broader mass Congolese refugee flight is the health and healthcare of Congolese refugee women. Congolese women are often the victims of some of the most deplorable acts of violence, generally sexual violence, in the protracted conflict in the DRC.

Sexual violence is such a deeply systemic issue in the DRC that the country has been labeled the “rape capital of the world” (UN News, 2010). A 2011 Congolese household survey estimated that “1.69 to 1.80 million Congolese women had been raped in their lifetime” (Bartels et al., 2012, p. 341). In 2020, the UN reported approximately 1,053 cases of conflict-related sexual violence (UN Secretary General, 2020) though official numbers are continuously hard to collect since many incidents of sexual violence go unreported due to the inaccessibility of clinics for rural populations, sociocultural taboos including shame and social discrimination, and fear of further violence in a largely patriarchal system (van Wieringen, 2020, p. 1). Incidents of sexual violence leave in their wake devastating trauma, mental health disorders, sexually transmitted diseases, children of rape, and social ostracisation, among many other repercussions to the survivors (Johnson et al., 2010; Babalola et al., 2015; Kabengele Mpinga et al., 2017; Kelly et al., 2017; Sahin, 2021).

As detailed in Chapter 1, the effects of sexual assault, violence, and trauma are manifold and leave lasting ripples on the health of Congolese women throughout their already impossible flight from their homes, families, and communities. These physical, mental, and emotional traumas follow them through displacement (Chapter 2), and/or into resettlement (Chapter 3), with external factors equally influencing the state of the healthcare they receive through these health experiences at each stage of migration. As an example of the need for an in-depth intersectional analysis of Congolese female refugee-specific health experiences, in the DRC in particular, gang rape is used, largely in conflict zones, by armed military personnel, government and militant forces alike.

While most researchers call gang rape a weapon of war, and others insist that it be redefined as a strategy of war (Buss, 2009; Maedyl, 2011; Baaz and Stern, 2013), it is deeply tied

to gendered norms of masculinity and power, structural violence against women, and Congolese and East African cultural norms. I address the nuances between these conceptualizations of gang rape later in this chapter. Further, to address such a sociocultural and region-specific issue as this, only an ethnographic analysis with contextual data can comprehensively approach this issue to provide a thorough analysis on the issue to build sustainable counter policies.

Geopolitics of Refugee Maternal Health and Healthcare

There is currently limited data available regarding the cultural and social contexts of the sexual, reproductive, and maternal health and healthcare backgrounds and experiences of Congolese refugee women who have been displaced and/or who have resettled in Western states (Hawkins et al., 2021). Most contemporary studies on these topics, as well as efforts made, tend to be one-dimensional and field-specific, coming from professionals in the fields of public health, international development, human rights, and/or humanitarian aid. Similarly, broader research conducted on the state of Congolese local population-level security tends to focus on the strategy and logistics of government, militant, and international forces, the fight over natural resources in the Kivu region, and the corresponding geographical location of certain Congolese local populations in respect to these militant forces and their respective war efforts.

Enter social science research and specifically, the multifaceted field of anthropology. Employing the perspective of the political economy of health, an extension of Eric Wolf's anthropological framework of political economy¹, we can look at these fields, Congolese cultural and social factors in public health and Congolese and broader geopolitics, not side by side but in combination with the various other contextual factors that overlap and compound to create the

¹ Political economy encompasses a broad spectrum of approaches within and across disciplines. I am drawing on Wolf's historical political economy, which he pioneered and was a "leading practitioner" in Anthropology (Ortner, Sherry B. 2006. *Anthropology and Social Theory: Culture, Power, and the Acting Subject*. Durham: Duke University Press).

complex backgrounds of and circumstances around the sexual, reproductive, and maternal health and healthcare of Congolese refugees resettled in Western states.

While anthropologists traditionally focus on the cultural and social milieus of indigenous, marginalized, and/or underserved populations, a political economy lens allows social scientists to incorporate these aspects in conjunction with the microscopic - grassroots, ethnographic, first-person perspectives *and* the macroscopic - the contexts of these experiences including the logistics of protracted, globalized conflict, transnational migration, influences of world affairs and state interests, and nationalist ideologies. All of these factors *must* be incorporated to complete a thorough examination and analysis of a topic as complex and multidimensional, that spans geographies, cultures, time, and multistate stakeholder politics, as the sexual, reproductive, and maternal health and healthcare of female Congolese refugees in the West.

Call for Refugee Voices in Displacement & Resettlement Policy

Only in recent years have the world's largest humanitarian, peacekeeping, and security agencies made actionable steps, though often small in scale, to incorporate the voices, perspectives, and opinions of displaced individuals into refugee policy dialogue and regulation (Tete, 2012; Castro, 2018; Jahre et al., 2018). As I will argue throughout this dissertation and show through ethnographic evidence, a comprehensive, political economy frame of analysis of the complexities of refugee contexts is not feasible without situating at its core the voices, perspectives, and experiences of displaced peoples. Though the next logical step to informing refugee policy would be to directly leverage refugee women's experiences and opinions, the ultimate goal should be for all other current stakeholders to step aside and create the space for refugee women to become the primary policymakers as it regards refugee policy in any geopolitical context. These individuals, directly affected by the effects of colonial capitalism and

protracted conflict and violence in their indigenous lands stemming from ongoing neocolonial power grabs, should be the only decision-makers in the construction of refugee policy.

This redistribution of power from dominant nationalist and capitalist forces to the historically and systemically marginalized by sex, class, and geography, in the rise of what Liisa Malkki calls the Western world order of nation states (1995), can and should begin today. Global refugee crises and transnational migration are at an all-time high, with media outlets capturing and documenting these crises. This in turn provides more awareness of the atrocities experienced by those fleeing conflict zones and the most vulnerable among these populations - women and children.

Regarding Congolese refugee sexual, reproductive, and maternal health and healthcare specifically, it has been just a few short years since a spotlight has been placed on the necessity of incorporating voices of displaced women in the construction of such health and healthcare refugee policies (Sahin and Kula, 2018; Sahin, 2021). In the development and humanitarian fields, this is referred to as “community engagement” and “inclusive participation”. For example, a 2015 report by the UN Secretary-General’s *Every Women, Every Child* political movement states as one of its nine “action areas”: “Promote enabling laws, policies and norms; strengthen community action; ensure inclusive participation” (UN Secretary General, 2015, p. 7). Though I am left with many questions around what the “enabling laws, policies, and norms” that the community action and inclusive participation is for, and though they are most likely influenced by the UN and not local women, acknowledging the need for stakeholder buy-in at the grassroots level is a small yet crucial first step.

Similarly, the Inter-Agency Working Group on Reproductive Health in Crises (IAWG), comprised of hundreds of representatives from the UN and NGOs, specified in their 2018

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM) that “needs are best met through involving affected communities in every phase of action: from assessing needs to designing programs, from launching and maintaining programs to evaluating their impact” (IAWG, 2018). Furthermore, in 2019, the World Health Organization and the Partnership for Maternal, Newborn, and Child Health (PMNCH) co-organized a High-Level Briefing titled *Aligning Women’s, Children’s and Adolescents’ Health and Well-being in Humanitarian and Fragile Settings*, stating a commitment to involving refugee women in the creation of such targeted policy (PMNCH, 2019, p. 2). While these are a step in the right direction, much remains to be done to move key stakeholder voices to be the *only* voices involved in the structuring of policies for displaced persons.

Methodologies

In this section, I will briefly review the methodological approaches that I used to collect my data for both the life history interviews and the semi-structured interviews. I will then describe the research protocol that I employed in collecting data for the semi-structured interviews, including field site information and the process that I used to find participants for this research and the participation criteria.

Targeted Life History Interviews Approach

In the spring and summer of 2021, I conducted six targeted life history interviews with a Congolese refugee woman, my informant, pseudonym *Engjy*. I met Engjy in Syracuse, New York in early 2021 at a refugee community event and after various subsequent discussions about her background and skillset, and about my background and research, I asked her if she would be willing to work with me and share certain parts of her life story with me in this research capacity. Engjy graciously and courageously agreed to share her deidentified life experiences. These

experiences focused on her past experiences with sexual, reproductive, and maternal health, healthcare, and security early on in life and during multiple, complex pregnancies, labor/deliveries, and postpartum experiences in displacement and resettlement contexts.

Life History Interview Protocol

Each interview was scheduled at least 2-3 days beforehand. Her experiences were discussed in six, 60+ minute life history interviews. Further, the interviews were conducted over the span of several months in 2021. The interviews took place in local Syracuse coffee shops and eateries in private spaces to ensure confidentiality. These interviews were recorded on a password-protected cellphone, transcribed, and deidentified from all personal markers so as to protect the anonymity of the refugee woman. The participant is fluent in English and therefore did not require a translator. The refugee woman was compensated with a \$25 gift card for her participation in each interview.

Life History Interviews Description

The questions for the targeted life history interviews were ethnographic in nature and mainly employed the anthropological life history interviewing method. Early life history methodology use in anthropology dates back to anthropologist Paul Radin when he published various autobiographies of Winnebago men in the early to mid 1900s.

He not only had his native collaborators write their own life histories but also, in an era in which anthropological texts tended to present culture as separate fragments, often frozen in time, Radin based his writings on the peyote cult on the lives and actions of specific individuals (Radin 1914). Thereby he prefigured by many decades a focus on process and practice (Nash and Buechler, 2016, p. 5).

Though Radin made clear his collaboration with the Winnebago men, this acknowledgement was overlooked at a time when anthropology was focused on objectivity and scientific writing which saw issues like gender, class, and ethnicity as “impediments to unbiased

examination” (Nash and Buechler, 2016, p. 5). Nash and Buechler go on to explain that today, when used with a social network approach, where life histories are “viewed as linked to the lives of concrete others, including the anthropologists who initiate the research projects, the life history methodology is conducive to the exploration of ever-widening circles of relationships” (Nash and Buechler, 2016, p. 4). As Engjy’s targeted life history will reveal in future chapters, these broader circles of relationships reveal layers of power and structural inequalities at different points in her life.

The following provides more details on the logistics of life history interviews: The anthropological life history interviewing method involves the individual being studied narrating their life story and focusing on periods or events that they find most significant, what Caughey calls “rich points” (Caughey, 2006), as well as their plans for the future.

The opening section serves as something of an icebreaker in the interview while providing a broad overview of the life as a whole. Next, the participant focuses in on a series of key events (nuclear episodes) in the story. For each event (e.g., a life story high point, low point, turning point, early memory), the participant recalls what happened in the event, what he or she was thinking and feeling, how the event resolved itself, and what, if anything, the event may mean in the context of the person’s life story. ...Next, the interview considers the future: What might the next chapter of the life story be about? What goals and plans for the future does the narrator set forth?” (McAdams, 2016, p. 39).

Personal narrative identity has been defined by McAdams as

the internalized and evolving story the person constructs to explain how he or she came to be the person he or she is becoming. ...The stories we tell ourselves in order to live bring together diverse elements into an integrated whole, organizing the multiple and conflicting facets of our lives within a narrative framework which connects past, present, and an anticipated future and confers upon our lives a sense of inner sameness and social continuity – indeed an identity (McAdams, 2016, pp. 34-37).

Adding further detail to this methodology, Goodson adds that if conducted successfully, “the life history...forces a confrontation with not only other people’s subjective perceptions, but our own also” (Goodson, 2016, pp. 6-7). This certainly resonated with me as interviewing forced me to

reflect on my own subjective perceptions from my perspective as a mother who came into this maternal role from a very different background and positionality

Rich Points in Narrative Analysis

A key element to the importance of studying narratives is to uncover the idiosyncratic “rich points” that organically surface in conversations, as John Caughey notes in *Negotiating Cultures and Identities: Life History Issues, Methods and Readings*. Caughey defines rich points as “anything that catches our attention about what our research partners says or does” (Caughey, 2006, p. 55). He explains that

What we find moving or fascinating, that which bothers, shocks, or disturbs us is based on the ways of thinking about the world that we have been enculturated to use. These reactions point us outward to the alternative ways of seeing, evaluating, and acting, and they also point back inward to the assumptions and patterns of our own cultural conditioning (Caughey, 2006, p. 55).

Therefore, in focusing on our reactions to the idiosyncratic in individual interview responses, we can try to interpret the responses through the eyes of those we interview while identifying our limited interpretations and understandings of the same questions we are asking. The question isn't whether there is subjectivity or bias in the questions we are asking or topics we are researching. Of course, questions posed by Western intellectuals often either implicitly or explicitly seek to understand a given topic, issue, or focus of Western culture². However, we can better explain those we study by methodologically identifying our biases in the questions we ask, how we ask them, and in tuning in to our reactions to interview responses. This allows us to better understand the perspectives, values, norms, etc. of those we collaborate with for research. While some social researchers believe that having too great a focus on the idiosyncratic may jeopardize the identity of our research collaborators, this is the very nature of anthropological research - to identify the issues that are important to those we study.

² Insight contributed by Dr. Hans Buechler, committee member for this dissertation research.

Semi-structured Interview

16 Semi-structured Interviews - Completed March 2021

In March 2021, I completed the collection of 16 ethnographic interviews for my dissertation research on refugee maternal health experiences - seven interviews with Congolese refugee mothers and nine interviews with refugee support professionals. All individuals interviewed resided in Syracuse, N.Y. at the time of the interviews.

Research Protocol

IRB Approval

All semi-structured interviews received IRB approval prior to commencement through the Syracuse University Institutional Review Board (IRB)³.

Research Questions

The main research question for my semi-structured qualitative interviews with resettled Congolese refugee women was: What are the lived sexual, reproductive, and/or maternal health and healthcare experiences of Congolese refugee women while displaced in East African refugee camps and in resettlement in Syracuse, New York? Further, how do these experiences affect both a micro and macro level, refugee experiences in flight, displacement, and resettlement in the West as they pertain to maternal health and healthcare?

Interview Stages, Interview Team, Field Site, Informed Consent, Stage 1 and 2 Protocols Semi-structured Interview Stages, Research Protocol

³ The Syracuse University Human Research Protections Program's primary mission is the protection of individuals who are the subjects of research. Syracuse University is committed to follow the ethical standards described in the Belmont Report, and all applicable federal, state and local regulations and university policies and procedures. The HRPP at SU sets forth the structure, policies, and procedures to implement this mission and commitment. The program provides Institutional Review Board (IRB) oversight, administrative support, and educational training for investigators and research staff to ensure that Syracuse University research complies with federal and State regulations, University policy, and the highest ethical standards. The processes of education, review, and monitoring serve to ensure the safe and ethical conduct of research that will protect human subjects in an atmosphere of mutual trust and integrity in the pursuit of knowledge and human benefit (<https://researchintegrity.syr.edu/human-research/>).

In the first stage of the interviews, my research partner and I collaborated with seven pregnant and postpartum (who gave birth within the past year) Congolese refugee women through ethnographic interviews to gain insight into their lived experience of pregnancy and childbirth in Syracuse, NY. Through these interviews, we gained a greater understanding of the lived experiences of Congolese female refugees during pregnancy and labor/delivery at Crouse Hospital, as well as their pregnancy and birth experiences while displaced in East African refugee camps.

In the second stage of the interviews, we interviewed nine healthcare and refugee professionals who work with refugee women: obstetricians/midwives, Obstetrics residents, and Labor and Delivery nurses. From these interviews, we gained a better understanding of experiences of refugee support professionals from their work with refugee women during pregnancy, labor/delivery, and post-partum.

The research team members included me, Julia McDaniel-Bouley and Gretchen Goble, then-SUNY Upstate Medical Student. We conducted the interviews with the Congolese refugee mothers and healthcare professionals. The research advisory members included the following: from Syracuse University: Robert Rubinstein, Ph.D., MsPH (Professor of Anthropology and International Relations at Syracuse University) and Sandra Lane, Ph.D., MPH (Professor of Public Health and Anthropology at Syracuse University and Voluntary Professor at Upstate). From SUNY Upstate Medical University: Andrea Shaw, M.D. (primary care physician in internal medicine and pediatrics at Upstate), Dr. Caroline Stroup, M.D. (OB/GYN physician at Upstate), and Dr. Michaela Simmons, D.O. (OB/GYN resident physician at Upstate).

The field site for this research was a community based organization, Catholic Youth Organization (CYO), which is a program of Catholic Charities Refugee Resettlement, located in

downtown Syracuse, NY. Catholic Charities provides routine outreach services to ~250 households of recently resettled refugee families in Syracuse, NY that have ongoing needs as they assimilate. The informed consent process consisted of the following: Written informed consent (or oral depending on the context) was obtained for all refugee women and all refugee support professionals. For the refugee women, written informed consent forms were translated verbally by community health navigators into the language preferred by each woman. Short forms on the informed consent process were provided in the woman's preferred language upon request.

Stage 1 and 2 Interview Protocol, Participants, and Methods

Stage 1: Interviews on Lived Maternal Health and Healthcare Experiences with Congolese Refugee Women

In Stage 1, Gretchen Goble and I led the interviews of seven Congolese refugee women who gave birth within the past year in Syracuse, NY at Crouse Hospital. The eligibility criteria for participation included Congolese female refugees, ages 18-45 years old, who live in Syracuse, received prenatal care through SUNY Upstate, and gave birth at Crouse Hospital during 2020. The sites for enrollment in this study were either CYO Catholic Charities Community Center located at 527 N Salina Street or the clients' homes via phone or Zoom. Community health navigators from Catholic Charities Refugee Resettlement Program and members of the research team discussed this voluntary interview program with eligible women.

Once a refugee woman volunteered to participate in an in-person interview, the team members first had a preliminary phone call with her to screen for COVID and confirm the interview 24 hours in advance. Each interview generally ranged from 30 to 60 minutes. They took place either in person at Catholic Charities or remotely via Zoom or phone call based on the preferences of each individual woman. Each interview had three parties present: the research

team members, the refugee woman, and a certified translator matched to the preferred language of the refugee woman. The Zoom calls were password-protected and secure. Where one or more parties did not have access to the appropriate technology for a Zoom call, the interviews were held over a secure phone call with the three parties present. After the interview was complete, the refugee woman was compensated for her participation in the interview, whether partially or fully completed, with a \$25 gift card. Translators were paid \$25 per interview.

Methods for Interviews with Congolese Refugee Women

The questions for this demographic were ethnographic in nature and mainly employed the Spradley ethnographic method interviewing method. The Spradley ethnographic interview method generally involves beginning with a broad question, called the “grand tour question” i.e. “Can you tell me about your experience with pregnancy in Syracuse, NY?”. “A grand tour question simulates an experience many ethnographers have when they first begin to study a cultural scene. Whether the ethnographer uses space, time, events, people, activities, or objects, the end result is the same: a verbal description of significant features of the cultural scene. Grand tour questions encourage informants to ramble on and on” (Spradley, 1979, p. 87).

The interviewer will listen to the response and use that information to create elicitation frames on a “mini-tour”- more focused probe questions to understand the individual’s perceptions and conceptualization of a certain topic. At first, elicitation is exploratory - “As the researcher learns more about a topic and a group, relevant questions regarding meaningful areas for exploration become clearer and questions become more focused” (Johnson and Weller, 2001, p. 1). As the interview progresses, the interviewer uses descriptive questions to elicit “a large sample of utterances in the informant's native language...intended to encourage an informant to talk about a particular cultural scene” (Spradley, 1979, p. 85).

Ultimately, this method allows the interviewer to pick up on repeated words or issues, which represent categories of knowledge in order to identify patterns. These interviewing approaches gave us information about experiences of refugee women and the meanings the women apply to those experiences. The interviews also included means-ends and rationale questions when appropriate to identify information and/or causes of certain behaviors.

Stage 2: Interviews on Perspectives of Refugee Support Professionals

The second set of semi-structured interviews were conducted with nine healthcare and refugee support professionals who worked with Congolese and/or Somali refugee women in Syracuse in the past. We aimed to get representation of different actors so that it represented equally the different roles played by these professionals. Professionals included OB/GYN medical doctors, residents, and labor and delivery nurses. The interviews took place on Zoom. There were two parties present at each interview: the interviewee and the two research team members. Informed consent was obtained through oral consent at the beginning of the sessions. It was made clear to the participating interviewee that their information will be de-identified.

Methods for Interviews with Refugee Support Professionals

The interview questions for this demographic pertained to the general experience that each respective professional had working with refugee maternal health and healthcare. Each professional was asked to provide any relevant anecdotal experience that they feel represents their work within this field of maternal health. The focus involved communication and understanding. Following are examples of questions asked:

What do you see as the major difficulty with communication between providers and refugee patients? Can you think of an example that you've seen (without identification) that illustrates that problem? Is it hard for you to care for refugee women? What did you feel the most

troubled by in trying to give the best care you can give? Do you usually use iPad language line interpreters or family members? Do you feel like you can communicate effectively with refugee patients? Do you feel patients understand you and do you feel you understand patients? Can you recall any times that communication has negatively impacted care? What do you identify as barriers to care of refugee mothers?

Research During COVID-19

This research took place in the context of COVID-19 in the spring and summer of 2021 when most establishments and organizations were either shut down or minimally staffed. Therefore, I was fortunate to be able to collect data in this context. I collected data using the method of life history which allowed me to work with one informant over several months in the geographical area where I already lived. Further, my ethnographic semistructured interviews were also facilitated during this time by virtual interviews or one-on-one, in person with appropriate COVID safety precautions within a commutable distance.

Therefore, unlike most anthropologists at the time, I did not have my travel or preferred data collection methods drastically altered, delayed, or indefinitely ended due to the limitations caused by the global pandemic. Furthermore, as detailed in Chapters III and IV, the context of refugee maternal health and healthcare experiences during the pandemic allowed for unique situations that in some ways organically showed different aspects of cultural norms played out. Examples of these were seen with limited support people during labor and delivery or nontraditional foods eaten during the pre and postnatal periods in the hospital as visitors were limited by strict COVID parameters on bringing in traditional foods for women who had just given birth.

Positionality

My positionality on this topic is complex. Over the course of the last roughly five years, from late 2018 to early 2023, my personal and academic lives have been deeply intertwined. I have included a visual below to illustrate my intimate knowledge and research of this *broader* topic of lived experiences with maternal health and healthcare outside of my formal IRB research and structured interviews. I emphasize *broader* because it is imperative to make extremely clear here that I am in no way comparing my lived experiences with maternal health and healthcare with the refugee women or healthcare professionals that I worked with for my research. I fully acknowledge my privilege in this lived experience and how it has yielded a drastically different experience from the incredible refugee women that I interviewed.

For context, my ethnic background is White and European. I was born in the United States to a socioeconomically middle-class family, and despite an at-times unstable early home life - I and my two siblings were primarily raised by our father, extended family members, and later our stepmother - we went on to receive thorough formal educations and were supported by a tight-knit social community. My formal education and networks have opened doors for me as I advanced in my career. Additionally, I won various grants and funding throughout my early life that allowed me to travel and study around the world. Through these experiences, I gained a deep understanding of the extent of just how privileged my life is in a global context.

Though difficult and revealing, I include this information on the infographic below of my personal maternal health and healthcare experiences to show my positionality with this topic: how my experiences have influenced how I conducted my research and connected with those whose experiences I studied.



Figure 3

Additionally, personal experiences in motherhood fuel my strong stances on how we must address the varying degrees of unspeakable horrors experienced by those interviewed. My personal experiences in this space have therefore influenced how I structured this dissertation to

focus on certain key topics in this field, some of which are generally not included in existing interdisciplinary refugee literature, but which need immediate attention and support. It was a profound privilege and honor for me to have been able to conduct this monumentally important research while I moved through my own motherhood journey though still with a drastically divergent positionality from the women and mothers who I worked with on this research. I finish this journey far more informed on various nuances of geopolitical and organizational power imbalances in this maternal health and healthcare space and the urgency with which we must address them.

It is also important to briefly mention the various ways that my past experiences have impacted the perspective with which I study this topic. I first worked with refugee communities when I was a senior in High School when my principal would organize trips to the nearby Mohawk Valley Resource Center for Refugees in Utica, New York where I had the incredible opportunity to teach English to various individuals from different refugee communities. Further, one of the funded opportunities I had to live abroad was as a Rotary International Exchange student when I was 18 years old in 2007-2008. For a year, I studied at a private French boarding school in the Loire Valley, in the heart of France, studying French language, culture, and history. This full immersion experience allowed me to continue formally studying French Language and History as one of my undergraduate majors (International Relations being my other and primary major). This skillset allowed me to go on to teach French in the Southern province of Rwanda where I was funded by the US Government to serve as a US Peace Corps Volunteer.

In this capacity, I also gained a certified professional working fluency of Kinyarwanda, a cousin to Swahili, spoken in rural East African regions. I also served as a Community Organizer and English Teacher during my time in Rwanda. I have a lot to say about the positionality of

being an American French and English teacher in a post-colonial, post-genocidal country where French and English (especially French) are the languages of the powerful, educated elite. In fact, a key component to my positionality on this work, and the driving force behind my interest in the field of Anthropology, ties back to my time living and working in Rwanda and enforcing top-down, Western-driven community-building initiatives and projects that did not incorporate indigenous perspectives, at least not in my experience, and which were not sustainable once the American volunteer, and the US aid funding behind the volunteer, left a given village. I also worked for a year on a USAID Devolution and Women's Rights Project where my team traveled to Nairobi, Kenya, and various rural cities for a few weeks to conduct fieldwork and interview political leaders.

My experience with French and from having lived and worked in East Africa came full circle when I conducted my fieldwork for this research and I was able to leverage my French language and/or my experience having lived and worked in rural East Africa (in addition to the largest connecting point - that I am a mother, myself) to connect and bond with the Congolese women I interviewed (French is still the primary language of the DRC, dating back to the Belgian colonial era). This background most influenced my relationship with my informant as we spoke about delicious East African dishes - *Ugali* and *Mandazi* among them - bonding over our shared dislike of the disorganized East African public transportation system via Twegerane Bus, and various other cultural or regional topics. Mostly, though, we bonded over, and continue to bond over, our respective experiences with motherhood. After my fieldwork, as I was writing my dissertation, she and I were pregnant at the same time and our babies were born just two months apart. As I write this, I am looking at the photo of the two of us next to each other, smiling with our baby bumps, framed on my desk.

Limitations of My Research

My research was not able to explore various other components of refugee sexual, reproductive, and maternal health and healthcare - still a relatively newer subfield in refugee and migration studies. While I did try to provide ample contextual literature, studies, and histories on this broader topic and sub-categories, I could not sufficiently cover other larger topics in the scope of this research. For example, I think that being able to interview Congolese refugee women on their experiences with women's health and healthcare *while* they are living in East African refugee camps in displacement would have been important information to add to this still very new field of study.

While I did ask the Congolese refugee women I interviewed about their experiences giving birth in refugee camps, it was in retrospect and being compared to their experiences giving birth in the US. Additionally, I would have liked to study the spatial organization of refugee camps, how communities are formed, whether there are other ethnic factions and if such factions exist, if they directly impact refugee women's healthcare in the camps. This curiosity stems from brief but powerful personal experiences of abuse in women's healthcare in refugee camps shared by some of the refugee women I interviewed. These are just some of the topics I would have liked to explore with fieldwork in refugee camps that would have added to the lack of literature in this subfield.

Lenses of Analysis

The following lenses and perspectives were leveraged to analyze the data collected from my fieldwork. This research largely uses theories and perspectives of global structural injustice and inequality. The two main approaches that I use under this broader category are political economy and structural violence. Specifically, the structural violence found *within* political

economy. Additionally, certain topics at different points of refugee migration in the context of conflict and health and healthcare also necessitate the use of the theoretical approaches of cultural hegemony and rape through an anthropological lens. Therefore, these theories are also used in this analysis and are presented below.

Global Structural Injustice and Inequality - Political Economy Approach and the Embedded Structural Violence

Political Economy Approach

Political Economy

According to anthropologist Eric Wolf, political economy used to deal with the “wealth of nations” and “the production and distribution of wealth within and between political entities and the classes composing them” (Wolf, 1982, p. 8). In the 18th century, capitalism caused the structure of “state and classes” to be broken down into more fractured social classes since new social groups called for their own voice and rights within the state.

Intellectually, this challenge took the form of asserting the validity of new social, economic, political, and ideological ties, now conceptualized as "society," against the state. The rising tide of discontent pitting ‘society’ against the political and ideological order erupted in disorder, rebellion, and revolution” (Wolf, 1982, p. 8).

Early sociologists then separated the fields of social relations and political economy because they said that the “realm of the social” - ties between individuals, groups, associations, and institutions - are separate from political science, economics, and ideology. Further, they argued that social order/ties will be maximized by increased social relations among individuals and moral consensus. As long as social relations are ordered, social relations will be stable - “the development of social relations and the spread of associated custom and belief create a society conceived as a totality of social relations between individuals” (Wolf, 1982, p. 9).

Wolf argues that the issue with this structure is that social relations are not autonomous - they are impacted by outside economic, political, and ideological factors. If we look for the cause of social disorder only in poor relations between individuals, we miss many other potential factors of social disorder. Further, only looking at poor relations of individuals, sociologists look to fix social relations by endorsing a “proper” structure to family and community life or by enforcing customs and beliefs to follow “common norms”.

At this point, Wolf says, it becomes much easier to “identify society in general with a society in particular. *Society in need of order becomes a particular society to be ordered....easily identifiable with [a] nation-state since social relations have been severed from their economic, political, and ideological context*” (Wolf, 1982, p. 9). Thus, the nation-state is seen as social ties guided by a “moral consensus” outside of economic, political, and ideological influences. Therefore, “social relations take place within the charmed circle of the single nation-state, the significant actors in history are seen as nation-states, each driven by its internal social relations [and where] each society is then a thing, moving in response to an inner clockwork” (Wolf, 1982, p. 9). In the context of my research, refugees, the stateless peoples - the “society in particular”, are seen as in need of order. It is important to note that the version of political economy that I use in this dissertation is just one, earlier interpretation of this frame of analysis, which has various definitions and is leveraged in different ways by various fields of study.

The Political Economy of Health

The lens of political economy is also used to study and hopefully aid in a large number of global social issues from peacebuilding efforts in protracted conflict areas to global health and health policy. This theory argues that in order to understand larger issues in a population, we must examine historical, cultural, social, political, and economic contexts.

Societies are complex and dynamic systems shaped by their historical contingencies as well as their contemporary economics, production and consumption activities, power relations, governance, policies, politics (or institutions), legal rules, culture, values, and ecology. We use the term political economy to describe these aspects of societies, their interrelationships and power dynamics (McCartney et al., 2019, p. 1).

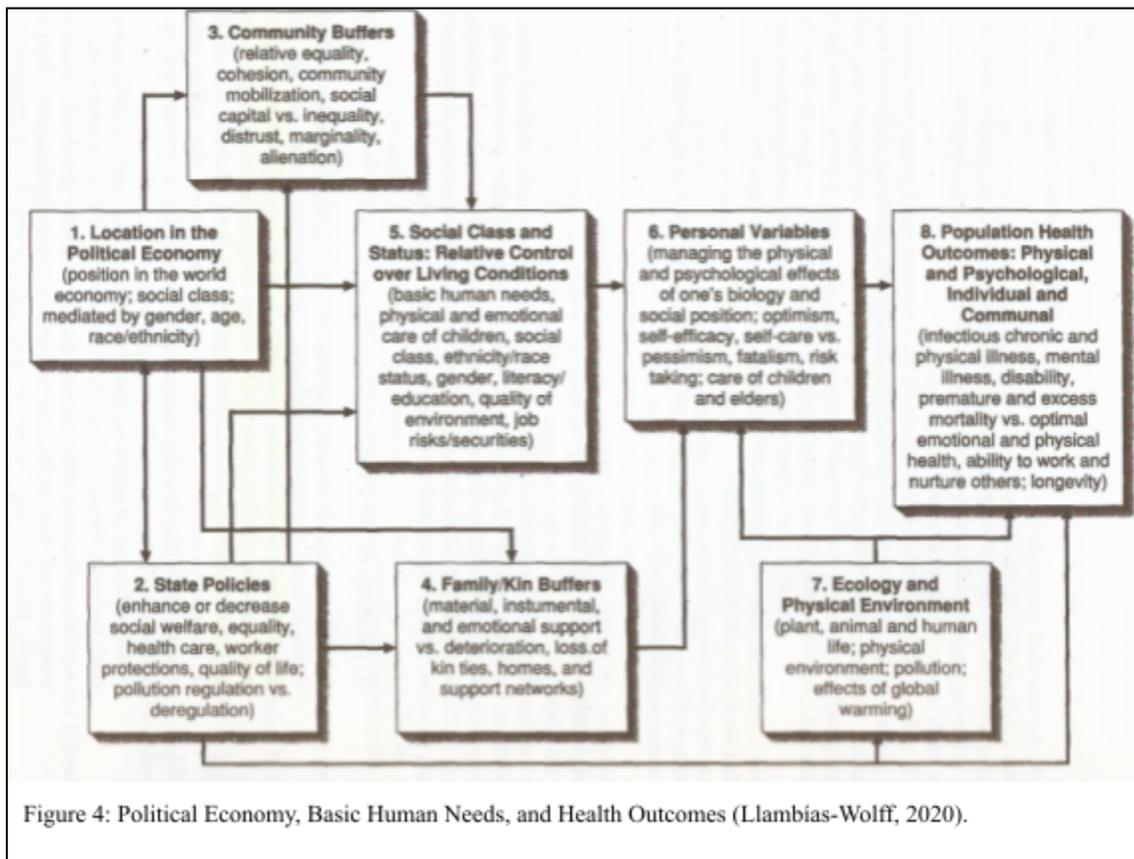
A case study that illustrates a political economy approach to improve deeply systemic issues for a population in a conflict setting is the development work that the Near East Foundation (NEF) carried out in Central Darfur in 2012 and 2014 to promote early recovery through environmental peacebuilding. As A. Peter Castro describes in “Promoting natural resource conflict management in an illiberal setting: Experiences from Central Darfur, Sudan” (2018), the NEF conflict management intervention projects created supra-village associations (SVAs), “multistakeholder institutions for mobilizing project activities and providing a platform for dialogue on reconciliation and mutual problem-solving” (Castro, 2018, p. 167).

Dating back to NEF work in Mali in the 1990s, this SVA model was created to enhance community resource management and employed a community engagement structure and member recruitment process that “promoted inclusiveness while also taking into account existing leadership, institutions, norms, and customs. Both formal and informal leaders were engaged, including tribal and religious authorities, school teachers or other educated persons (both male and female), and community members already engaged in promoting reconciliation and development efforts” (Castro, 2018, p. 167). Castro explains his experience working with the NEF’s SVA strategy as a lead trainer in the inaugural training of trainers (TOT) workshop in Central Darfur in 2012. Specifically, he details the negotiation, mediation, and conflict response workshops that he taught, meant to promote reconciliation and peacebuilding, and most significantly, that they leveraged local customary practices in their content and design:

I served as a lead trainer, which featured segments on conflict analysis, gender analysis, mediation, negotiation, multistakeholder dialogue, collaborative natural resource management, reconciliation, and related topics.

The involvement of the Center trainees and the workshop participants ensured that training drew on customary practices such as *judiya* (local mediation sessions), *ajaweed* (mediators, usually elders, religious leaders, or other local dignitaries), and *rakoba* (an agreement or settlement). The project staff emphasized building on or strengthening existing practices, rather than supplanting them with new ones. The training raised awareness and offered encouragement for reconciliation and peaceful solutions (Castro, 2018, p. 168).

The ultimate success of the workshops came not from forcing a Western, top-down,



homogenous workshop model on community groups and organizations but in its ability to study, understand, and incorporate local cultural customs, social structures, traditions, and voices into the conflict-sensitive programming content and structure.

Moreover, the political economy of health is a nuanced lens of the political economy framework and particularly focuses on the “macro societal determinants impacting health... on the economic and political structures lying at the base of the social production of morbidity or the rate of disease incidence in a population group” (Carrasco, 2008, p. 44). The history, culture, society, and contextual geopolitics of refugee women must be understood in order to improve health and healthcare contexts. Furthermore, as the ethics of contemporary anthropology will argue, this understanding must begin with qualitative, first-hand stories, accounts, opinions, needs, and concerns of the affected population. In the case of this study, of Congolese refugee women.

An example question that this lens might be used to approach would be: Why do refugee women continue to have children despite being older - having “geriatric pregnancies⁴”? In 2018, the average fertility rate of women in the DRC was 5.9 compared to 1.7 in the United States (worldbank.org, 2020). Using the lens of the political economy of health, we would seek to identify the social, political, and economic factors that contribute to these high fertility rates. While these factors are more contextual than decisive, contexts influence decision making. If we examine Congolese refugee women’s natal country’s history of violence, significant numbers of the respective populations have been killed in protracted violence largely caused by destabilized states and ethnic tensions and violence stemming from the era of colonial rule. From this, we can better understand contexts of high fertility.

For example, such violent contexts often lead women to physically repopulate their lost community in their new countries of resettlement (Allotey et al., 2004). Looking at history and economics, we can say that it might have to do with the fact that many East African refugees come from largely agricultural communities which have been exploited by Western capitalism

⁴ A patriarchal term used in the healthcare industry that many have argued be reframed (Rhone, 2021).

for crop exports. More children mean more labor which means a larger crop yield and more crop to sell (Dodoo and Tempenis, 2009). (These needs of physical labor may not be as pronounced during resettlement in the West but the cultural drive to create a large labor force may still exist.) These plausible reasons can help Western healthcare providers understand the contexts behind high rates of “geriatric” East African refugee pregnancies.

Structural Violence within Political Economy

Structural drivers include the distribution of power and resources and built-in structural inequalities. These drivers are systemic and embedded into social and political environments (Kriesberg and Dayton, 2016). In a journal article written for the *International Peace Research Institute*, Johan Galtung describes structural violence as “violence without [a clear subject-object relation], [which] is built into the structure”. He gives several examples:

...when one husband beats his wife there is a clear case of personal violence, but when one million husbands keep one million wives in ignorance there is structural violence. Correspondingly, in a society where life expectancy is twice as high in the upper as in the lower classes, violence is exercised even if there are no concrete actors one can point to directly attacking others, as when one person kills another (Galtung, 1969, p. 171).

A broader example provided by Galtung is the structural violence of inequality found within the way that world economic relations are organized today in a capitalist market. This can be explained by a Marxist framework: “Marxist criticism of capitalist society emphasizes how the power to decide over the surplus from the production process is reserved for the owners of the means of production, who then can buy themselves into top positions on all other rank dimensions because money is highly convertible in a capitalist society...” (Galtung, 1969, p. 171).

Anthropologist and medical doctor Paul Farmer writes about structural barriers in the global community by using the lens of political economy. Farmer uses this lens’ postcolonial

analysis to examine how structures are embedded in former colonies - structures that are rooted in “the enduring effects of European expansion in the New World and in the slavery and racism with which it was associated” (Farmer, 2004, p. 305). Farmer researches modern epidemics in the postcolonial context using a “syncretic and properly biosocial anthropology” to link their association to “poverty and social inequalities [which are] ...embodied as differential risks for infection and, among those already infected, for adverse outcomes including death” (Farmer, 2004, p. 305).

Furthermore, my research is about how current refugee maternal health, mental health, and physical health have roots in extractive colonialism and subsequent political and economic instability, leading to the ongoing conflict in the DRC and in other African countries today. Farmer's work on structural violence within political economy, particularly focusing on historical contexts, impeccably connects extractive colonialism and current issues like protracted conflicts, epidemics, and weak health systems in various regions of Africa. First, his case for the importance of historical context, especially as a cornerstone of a political economy frame, notes its various applications to approaching structural inequalities: “...historical understanding can help us in many ways...decipher unfamiliar and often hostile responses to disease-control efforts...call out outlandish claims from experts and novices alike... [and] help us show respect for [indigenous peoples]. And if history can enlighten us in these ways, we might do better the next time around” (Farmer, 2020, pg. 49).

In the following example from Farmer's fieldwork, he connects a historical analysis to his own research of epidemics in West Africa, connecting extractive colonialism to various modern-day structural issues in the region:

West African epidemics and social responses to them can't be fully comprehended without knowledge of the region's long entanglement with Europe and the Americas.

This is the story of how our world—the Atlantic world that’s long been the nucleus of the global economy—came to be as it is. It’s the story of the all-too-little-recognized precursors to Ebola: slavery and the extractive trades, the feuds they engendered or worsened in West Africa, and their links to diverse epidemics affecting this long-disrupted region.... [a] material legacy. This includes, as noted, **entrenched health disparities, explosive pandemics, weak health systems, and widespread lack of confidence in them. These, more than any specific disease, are the ranking public health problems of our times** (emphasis added; Farmer, 2020, pg. 45-47).

Thus, we must not only look at the history of a region or conflict. We must also connect how that history, and the key players in said history, have led to present-day structural issues which perpetuate pandemics, economic disparities, political instability, systemic sexual violence, and various other structural barriers today. In Farmer’s work, this structural violence rooted in Western colonialism is how Ebola in West Africa continues to plague local populations. In my research, these material legacies and the *ongoing* Western neocolonial extractive practices in the DRC collectively result in structural inequalities for the people of the DRC. This has and will continue to result in internal displacement and forced emigration out of the DRC. In 2020 alone, 5.2 million people were internally displaced in the DRC and roughly 900,000 individuals fled the country (UNHCR DRC Data Portal, 2021). To begin to comprehend and ameliorate the abysmal circumstances for the people of the DRC, we must follow Farmer’s approach and start by examining the historical contexts of the current structural barriers and social responses to them.

Cultural Hegemony Approach

Cultural Hegemony in Western Healthcare

The theory of cultural hegemony was developed by Antonio Gramsci to explain power and class dynamics. In this theoretical lens, the oppressed internally accept a system where they are convinced that their position is what it should be. This allows the “ruling” social class to maintain control and dominance over the “ruled” class (Bates, 1975). In *Controlling Processes* (1997), Laura Nader studies controlling processes, what she defines as “the transformative nature

of central ideas such as coercive harmony that emanate from institutions operating as dynamic components of power”. She follows what she calls “the harmony law” model, which she says “encapsulates coercive compromise and consensus as a form of behavior modification” (Nader, 1993, 1997, p. 712). She argues that there are just as strong microprocesses of control - “how individuals and groups are influenced and persuaded to participate in their own domination or, alternatively, to resist it, sometimes disrupting domination or putting the system in reverse” (Nader, 1997, p. 712).

In her argument, she cites political economy anthropologist Sydney Mintz and his work with sugar and power. He explained that “controllers of society use [complicit power] to constrain the free choice of consumers. The creation of new consumption needs is part of the staging of demands for industrial products and services” (Nader, 1997, p. 711). In this frame, Nader discusses the example of elective surgical breast augmentation for women. Here, the “transforming powers of commerce” and “unregulated capitalism” set an unattainable beauty “standard” and stigmatize those who do not fit this standard (almost everyone), making them believe that they must pay for surgery to inch closer to this standard. They are accepting their own domination without outwardly realizing it. Further, she says that while this procedure is considered by many to be an agentic act of empowerment, in reality, these women are “empowered... to roam in a four-cornered cage of someone else's design” (Nader, 1997, p. 734).

Moreover, in the explanation of his theory, Gramsci explains that phrases like “common sense” are tools to maintain the status-quo of the majority. Yet, what is common to one culture is not to another - making “common sense” very subjective and anything but *common* (K. Crehan, 2011; K. Crehan, 2016). Cultural hegemony can be applied to issues of healthcare access and quality for refugee populations. Hypothetically, if a refugee woman receives subpar care with the

labor and delivery of her child and accepts this level of care because she is a refugee and as such, believes that she is less important in the American healthcare system, this is cultural hegemony. The same goes for refugee women who might think that they deserve less insurance coverage for maternal healthcare because they are refugees and therefore, believe that they are not as “powerful” or entitled to the same coverage as American citizens - it is because they are accepting a notion of domination cultivated and instated by the cultural majority in the United States. It is the notion in the U.S. that those who are not like “us” are therefore inferior and deserving of a lower quality of medical care.

From a political economy perspective, in *Modernity at Large* (1996), Appadurai notes that general fears and anxieties of larger polities culturally homogenizing smaller polities can be leveraged and exploited by nation-states to divert attention from their own hegemonic plans. Thus, they use these fears of homogenization “in relation to their own minorities, by posing global commoditization (or capitalism, or some other external enemy) as more real than the threat of its own hegemonic strategies” (Appadurai, 1996, p. 32). Hegemony is “in the strongest sense a ‘culture,’ but a culture which has also to be seen as the lived dominance and subordination of particular classes” (Williams 1977: 110 as cited in Ortner 1984, p. 149). Therefore, Sherry Ortner argues, “At the core of the system, both forming it and deforming it, are the specific realities of asymmetry, inequality, and domination in a given time and place” (Ortner, 1984, p. 149).

New Research in Adapting Western Healthcare Models for Refugees

Other research has been done on the process of mitigating, or bridging the gap, between traditional models of maternal care in natal countries and purely Western models of care for refugee women. From this, new research on rethinking and rebuilding refugee maternal

healthcare models has been conducted. For example, Njue et al. examine pre-existing models of maternal healthcare for refugees in Australia with exploratory mixed methods to make improvements on service that can be delivered with “available resources, organisational readiness and capacity to implement” (Njue et al., 2020). Ajjarapu et al. (2020) have also begun to address obstetric health disparities among refugee populations in the U.S. by way of training new OB/GYN care providers to be more “culturally humble”.

Njue et al.’s research began by focusing on inequalities caused by “poor communication due to cultural misunderstandings” which leads to “mistrust and reduced utilization of healthcare services”. This research then used a case study from 2017 to improve issues of mistrust, misjudgment/overuse of Cesarean sections, and communication issues with health insurance for maternal healthcare:

In 2017, a Midwest academic hospital [in Iowa], refugee community, and health system came together to form the Congolese Health Partnership (CHP). The CHP was formed to improve access to quality healthcare for expecting Congolese mothers and their families experiencing poor quality of obstetric care. Discussions that arose from this partnership identified issues of mistrust in healthcare providers within the community, worry about misjudgment and overuse of C-sections, and a lack of understanding about health insurance during pregnancy and childbirth. Therefore, it is apparent that understanding the contextual nuances that play a role in these poor outcomes among refugee communities in the U.S. is critical in order to narrow the healthcare gap (Ajjarapu et al., 2020, p. 4).

To address these issues, Ajjarapu et al. say that more than cultural competence, the next generation of OB/GYN physicians need to develop cultural humility when working with patients from diverse backgrounds. As the researchers explain, “Cultural humility forces providers to think about power imbalances that exist between a patient and provider when cultural differences exist” (Ajjarapu et al., 2020, p. 1). Another suggestion to facilitate care for this Congolese refugee community is developing more “community-provider partnerships” to begin to mitigate accessibility and communication issues and address obstetric morbidity. Ultimately, maternal

healthcare for refugee women needs to be as unique as each woman and as dynamic as their respective cultural and displacement backgrounds. Respect, humility, and flexibility must be woven into all stages of care from pregnancy, to labor and delivery, and into the postpartum period to ensure that this population receives quality, equitable healthcare during resettlement.

The Anthropology of Rape & Rape Theory

In the analysis of my research, I do not want to sensationalize rape in the DRC since rape is but one of many concerns in this study in the context of protracted violence. Yet, I want to do everything in my power to shine a light on the severity of this egregious, systemic violence towards women and girls that is ongoing. Therefore, for context, I have included below a historical overview of the study of rape in anthropology to present day, with a focus on the study of rape in conflict.

1970s-1980s - Cross-cultural Analysis of Rape

While the anthropology of rape is not yet an established subfield of anthropology, the formal study of rape within the field of anthropology dates back to the 1970s. Prior to that, from the 1940s to the 1970s, rape was largely considered psychopathological. Following this model, rapists were seen as peculiar, with frequent "castration anxiety" and "feelings of phallic inadequacy" (Baxi, 2014).

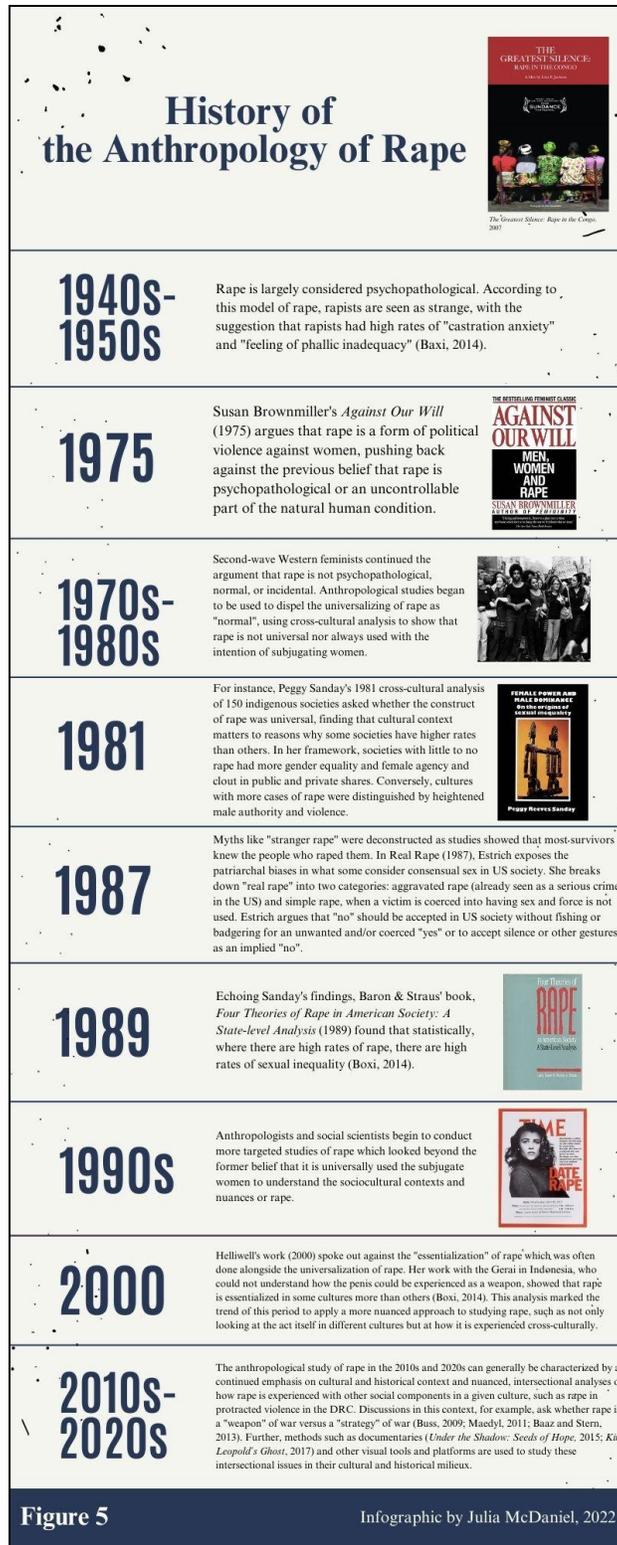


Figure 5

Infographic by Julia McDaniel, 2022

In 1975, Susan Brownmiller's *Against Our Will* (1975) challenged the psychopathological diagnosis of rapists, arguing instead that rape is a form of political violence

against women. She specifically speaks of rape in times of war as an amplification of a preexisting patriarchal, subjectifying culture. Furthermore, in this groundbreaking work, she takes a Marxist approach to the study of rape through the ages and specifically, its use in times of conflict. “Man’s discovery that his genitalia could serve as a weapon to generate fear must rank as one of the most important discoveries of prehistoric times, along with the use of fire and the first crude stone axe. From prehistoric times to the present, I believe, rape has played a critical function. *It is nothing more or less than a conscious process of intimidation by which all men keep all women in a state of fear*” (emphasis added; Brownmiller, 1975, p. 12).

She goes on to provide select, vivid, and contextualized examples from archived journal entries of rapes during specific moments in conflicts throughout history. In each example, she points out how subjugating women by raping them became a system of measurement of success in battle and level of masculinity - where women’s bodies were considered part of the reward for success in battle.

“To the victor belong the spoils” has applied to women since Helen of Troy, but the sheer property worth of women was replaced in time by a far more subtle system of values. Down through the ages, triumph over women by rape became a way to measure victory, part of a soldier’s proof of masculinity and success, a tangible reward for services rendered. Stemming from the days when women were property, access to a woman’s body has been considered an actual reward of war. “Booty and beauty” General Andrew Jackson supposedly named it in New Orleans during the War of 1812....Sexual violence against women was fervently committed in the name of God, although not, we may believe, with His blessing, during the Wars of Religion in France. A remarkable description of one such religious rape, which occurred on December 18, 1567, near Provins, was recorded by Claude Haton, a local Catholic priest and a meticulous diarist. The victim was a Huguenot woman.

It so happened that this LeBlanc and his wife fell into the hands of some soldiers. The soldiers who held the woman did not hold her husband, but others did, and during this time they were not permitted to see or talk to each other. The woman was finally delivered from the hands of these soldiers and put at liberty but only after they had used and enjoyed her at their pleasure and led her through the streets with her feet and legs and head all bare. The only clothing she had on was

an undergarment and an apron ... made of red material all covered with blood. This happened on the 18th day of December.

When they passed by the church of St. Ayoul the poor Huguenot was brought inside. This was between eight and nine o'clock in the morning. At the entrance to the church she was forced to take holy water and sprinkle her face with it and then she was brought before the main altar where a priest was saying mass. Here she was forced to both knees and given a lighted candle to hold during the elevation of the mass.... She was told to ask mercy of God ... for the terrible sin she had committed in straying from the true Catholic religion and adhering to the false Huguenot faith (Brownmiller, 1975, p. 25).

By the end of the 1970s and into the 1980s, the narrative of rapists being psychopathological was replaced by the argument that rape was not normal or, as Brownmiller argued, universal. Cross-cultural anthropological studies of rape in various cultures revealed that rape is not universal and not always used with the intent to dominate, oppress, or commit political violence against women. A reflection of this is Sanday's 1981 cross-cultural analysis of 150 indigenous societies which asked whether the construct of rape was universal, finding that cultural context matters to reasons why some societies have higher rates of rape than others. In her framework, societies with little to no rape had more gender equality and female agency and clout in public and private spheres. Conversely, cultures with more cases of rape were distinguished by heightened male authority and violence.

1990s-2020s - Intersectional Analysis of Rape

From the 1990s to the 2020s, there has been a strong shift to focus on the intersectionality of rape. For example, how different subsets of society see rape and use their opinion of it to perpetuate discriminatory and dangerous racist beliefs. Christine Helliwell was one of the first anthropologists to not only call out the universalization of rape as a racist act, but also one of the first to study the act from an intersectional lens. In her pioneering 2000 piece “‘It's Only a Penis’: Rape, Feminism, and Difference”, Helliwell explained how Western cultures not only

universalize rape but also essentialize, racialize, and sexualize rape. For example, regarding the essentialization of rape, most women in the West fear being raped more than being murdered. According to Helliwell, this is due to the overlap of sexuality and personal identity in Western cultures, where to rape someone is to inflict physical harm while also taking someone's dignity and power.

While any form of violent attack may have severe consequences for its victims, the sexualization of violence in rape greatly intensifies those consequences for women in Western societies: "To show power and anger through rape - as opposed to mugging or assault are calling on lessons women learn from society, from history and religion to defile, degrade and shame in addition to inflicting physical pain. Rapists have learned, as have their victims, that to rape is to do something worse than to assault" (Gordon and Riger 1989, 45; see also Koss and H 1991). Clearly, the intermeshing of sexuality and personal identity in contemporary Western societies--such that Michel Foucault refers to sex as "that secret which seems to underlie all that we are" (1978, 155) - imbues the practice of rape with particular horror for most victims from those societies, since there it involves a violation of personhood itself (Helliwell, 2000, pp. 791-792).

Universalization of Rape and Racial Discrimination

Echoing the same discriminatory and dehumanizing narratives used to dominate and decimate local inhabitants during colonialist expansion, the Othering in the study of rape, mainly from white Western feminist perspectives, assumes that it is universal since if it happens *here*, it *must* happen there.

In addition, because within Western feminist discourse rape is depicted as a shockingly barbaric practice - "illuminat[ing] gendered relation power in their rawest, most brutal forms" (Dubinsky 1993, 8) - there is a tendency to view it as atavistic. Because the practice is widespread in "civilized" Western countries, it is assumed to pervade all other societies as well since these latter are understood as located closer to the savagery end of the evolutionary ladder. This relates very closely to what Chandra Moha has described as "the third world difference": "that stable ahistorical something" that, in many feminist accounts, oppresses the women of Third World countries in addition to their oppression by men (1991, 53).

Under this logic, practices deemed oppressive to women that are not commonly found in the West, such as clitoridectomy and sati, are explained as resulting from the barbarism of Third World peoples, while oppressive practices that are common in the West, such as rape, are explained in universalistic terms. The related tendency within

*Western iconography to sexualize black female bodies (see Gilman 1985) means that rape is readily assumed to be a characteristic of "other" - especially black - societies. **In fact, the link between this racist iconography and the frequency with which white men rape black women in countries like the United States should lead us to be extremely wary of this kind of assumption** (bold added; Helliwell, 2000, p. 793).*

To conclude, the study of rape in anthropology continues to morph as new, intersectional perspectives are considered. Moreover, as the examples above show, rape in conflict contexts is ubiquitous and not country-specific. A topic that requires more research within this field of study is the sociopolitical context of rape in war, such as the topic of this dissertation which, in part, examines rape in conflict rooted in varying intersectional gendered, racial, and sociopolitical factors. Therefore, my research contributes to the recent discussions and studies within various academic social science fields and policy considerations that examine the nuances, compounding traumas, and sociocultural implications for the victims of rape and sexual assault (Petelos et al., 2019; Lugova et al., 2020).

Concluding Remarks

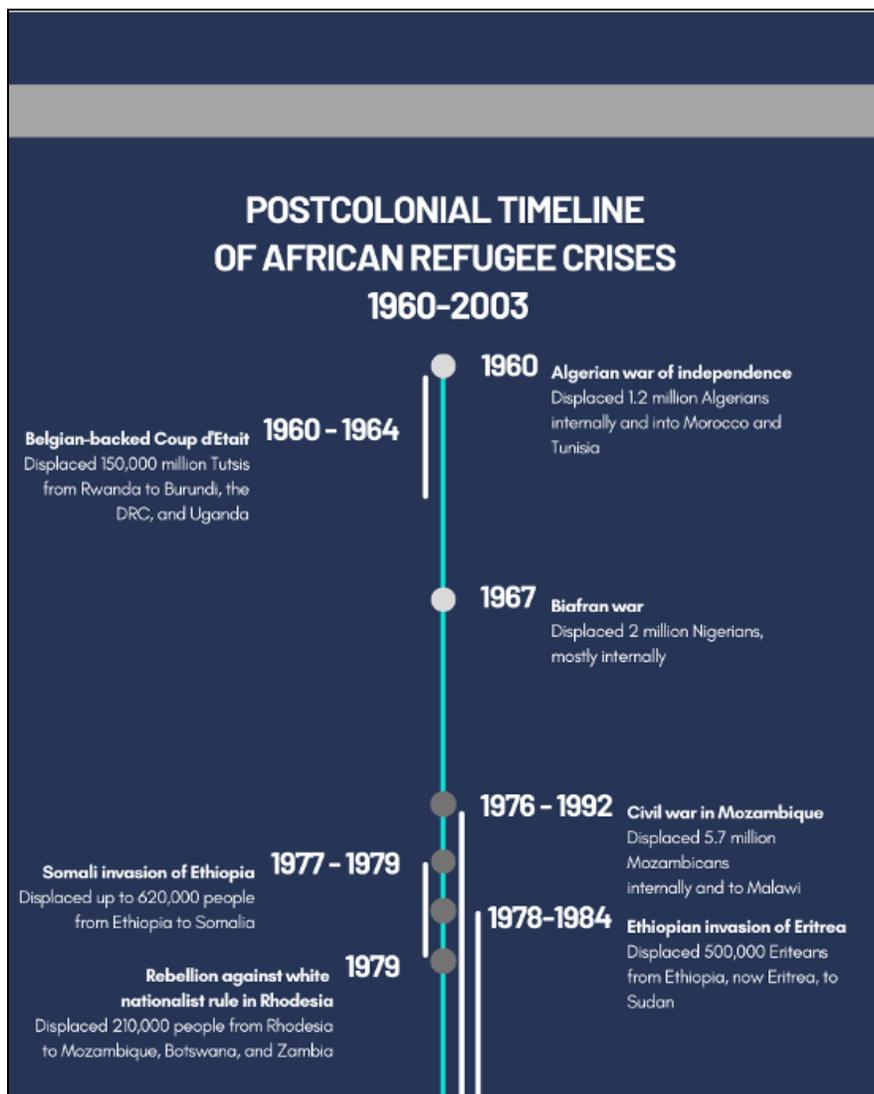
In aggregate, these intersectional, contextualized perspectives can help us to understand persistent and pressing issues that Congolese refugee women either experienced themselves or have a strong familiarity with from their time living in the DRC. This cohesive understanding of select, nuanced aspects of sexual, reproductive, and maternal health and healthcare contexts through personal narratives and broader studies and reports, with the application of the main lens of political economy, is necessary to best understand the complex background that Congolese refugee women come from. Furthermore, it is imperative that this comprehensive, contextualized information is leveraged in the creation of policies specifically aimed to support Congolese refugee women in the next periods of their lives - whether that is in internal displacement,

refugee camps, refugee resettlement, or any number of situations, places, or periods that survivors find themselves in after living in conflict in the DRC.

Chapter I: Experiences in Contexts of Protracted Conflict in the DRC & Refugee Flight

Overview

I begin this chapter with a brief historical overview of refugee flight and displacement in Africa with direct ties to colonial-era rule, degradation, and neocolonial exploitation. I then review various additional intersectional reasons for displacement and forced migration such as ethnic tensions, sexual violence, political corruption, conflicts over natural resources, and other reasons of displacement (famine, drought, food insecurity, poverty, etc.). I then go on to review a history of conflict in the Democratic Republic of Congo (DRC), rooted in many of the same





colonial and neocolonial underpinnings. The protracted conflict has, as detailed below, led to mass forced migration in recent years, with Congolese local populations fleeing within state borders and to bordering countries, mainly to refugee camps.

In Section II, I leverage the perspective of the political economy of health to review key experiences from my informant Engjy's pre-and inter-Congo Wars targeted life history as they pertain to her sexual, reproductive, and maternal health and healthcare. Employing this lens, I attempt to provide a contextualized, comprehensive overview of various intersectional factors

that impact sexual, reproductive, and maternal health and healthcare in the protracted conflict setting in the DRC and which lead to flight. To accomplish this, I mainly focus on the intersectional historical, cultural, and social instances and contexts from Engjy's lived experiences, with a comprehensive overview of the broader political and economic contexts of the DRC conflicts covered in Section I. Further, I employ additional studies, reports, and background literature to show similar effects of these historical, cultural, and social contexts on the health and healthcare of broader populations of girls and women in the DRC.

I: Histories & Contexts: Flight & Forced Migration in Africa and in the DRC

Displacement in Africa

According to the United Nations High Commissioner for Refugees (UNHCR), in 2019, there were an estimated 79.5 million individuals globally who were forcibly displaced from their homes from issues relating to “persecution, conflict, violence, human rights violations or events seriously disturbing public order” (UNHCR, 2019, p. 2). According to the data available, in 2019, 51% of stateless people were women and 48 % were children (UNHCR, 2019, p. 60).⁵ Furthermore, in 2019, almost one-eighth of the world's refugees came from African countries (UNHCR, 2019, p. 19).

Refugees are defined as:

individuals who are unable or unwilling to return to their country of nationality because of persecution or a well-founded fear of persecution due to their race, religion, nationality, membership in a particular social group, or political opinion and who have been granted refugee status by the host country (Miller et al., 2016, p. 484; Roads to Refuge, 2015).

This includes individuals “recognized under the 1951 Convention relating to the Status of Refugees, its 1967 Protocol, the 1969 Organization of African Unity (OAU) Convention Governing the Specific Aspects of Refugee Problems in Africa, those recognized in

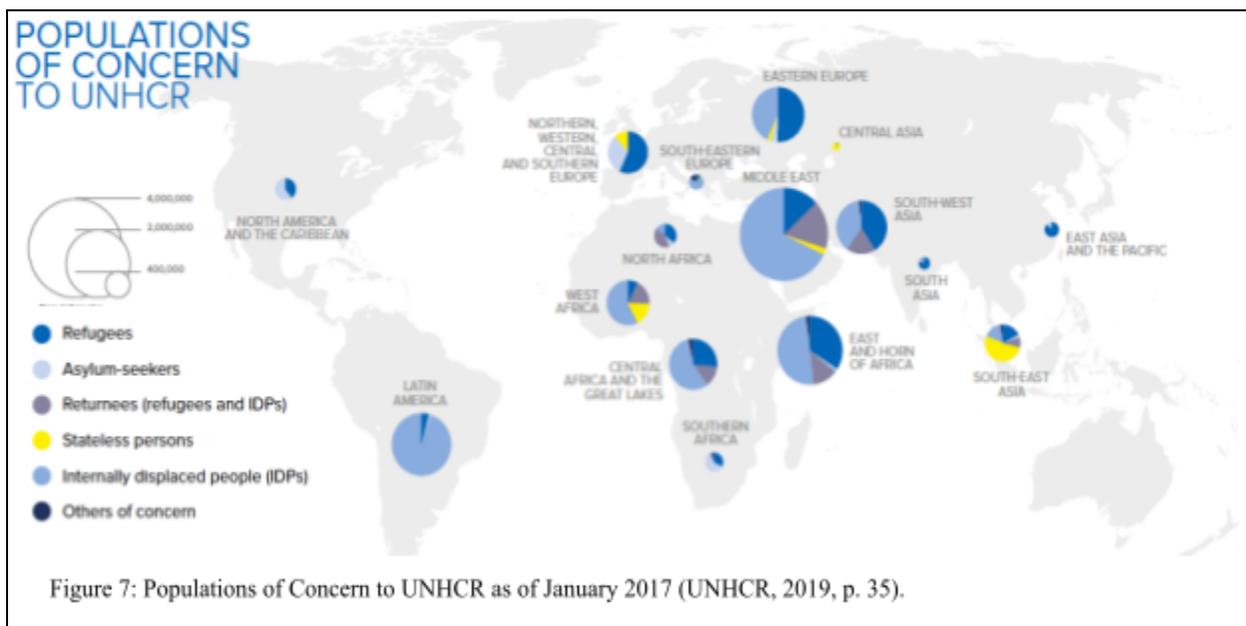
⁵ “Data availability for stateless populations is scarce in most countries when it comes to disaggregation by demographic characteristics. In 2019, sex-disaggregated data was available for 28 of the 76 countries reporting on stateless populations, covering 73 per cent of the reported stateless population” (UNHCR, 2019).

accordance with the UNHCR Statute, individuals granted complementary forms of protection, and those enjoying temporary protection. The refugee population also includes people in refugee-like situations (UNHCR, 2018, p. 54).

Internally displaced persons (IDPs) are defined as:

people or groups of people who have been forced to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights, or natural or man-made disasters, and who have not crossed an international border. For the purposes of UNHCR's statistics, this population includes only conflict-generated IDPs to whom the Office extends protection and/or assistance. The IDP population also includes people in an IDP-like situation (UNHCR, 2018, p. 54).

Displacement and forced migration in Africa is, in large part, due to a long history of colonial rule. More recently, effects of the Cold War rippled into Africa aggravating protracted violence. In the 1900s and 2000s, new conflicts emerged in destabilized states due in part to territorial discrepancies related to resource extraction by countless rebel insurgent groups, with many backed by Western funding (Gatrell, 2013, p. 223-224). Refugees flooding borders from neighboring countries led to further African political and economic destabilization in two ways.



First, the displacement allowed militant groups to form within refugee populations which led to revolts of current governments and/or tyrannical leaders as a means to restore prior regimes. For example, Rhodesian troops would often cross into Mozambique in the 1970s in search of Zimbabwean insurgents. In the 1990s, Chad protected Darfurian refugees, spurring Sudanese forces to cross the border and attack the Darfurian refugee camps (Gatrell, 2013, p. 224). Second, refugees were moving into states with already weak political and economic infrastructure, resulting in food shortages and exacerbated ethnic tensions (Gatrell, 2013, p. 224).

Climate Change & Links to Epidemics

Additional sources of present-day instability and displacement in East Africa can be attributed to the effects of climate change (Munyuli et al., 2013). A 2007 report completed by the Intergovernmental Panel on Climate Change (IPCC) showed that climate change is linked to various causes of African instability which leads to displaced communities:

Africa's major economic sectors are vulnerable to current climate sensitivity, with huge economic impacts, and this vulnerability is exacerbated by existing developmental challenges such as endemic poverty, complex governance and institutional dimensions; limited access to capital, including markets, infrastructure and technology; ecosystem degradation; and complex disasters and conflicts. (Boko et al., 2007, p. 435).

In East Africa in particular, where the agricultural sector accounts for over 50% of GDP, climate change has led to agricultural droughts which lead to food insecurities and subsequent increases in food commodity prices and worsening overall health (Boko et al., 2007, p. 440). This instability, in turn, leads to various ethnic wars and destabilized states, forcing people from lands that they and their ancestors have lived off of for centuries. In Somalia⁶, for example, the militant group Al-Shabab blocks aid agencies that can help with areas affected by drought. This leads to

⁶ Today, Somalia is on the verge of a catastrophic famine (WFP, 2022). This famine is said to be potentially the worst since the 1970s, which was the start of one of the first large-scale displacement of populations in Africa.

increased prices in food which then serves as a veritable recruitment campaign for the militant group (Associated Press, 2011).

A study from South Wollo, Ethiopia in 2006 examined the links between drought and poverty. A political-economic perspective showed that drought affects different agricultural households differently, though not in obvious ways. Specifically, agricultural households with larger political and economic resources before the 1999-2000 drought had improved income generations afterward, benefiting from a larger market of livestock to choose from and rent out post-drought (Little et al., 2006, p. 201). However, poorer households did not suffer as much as one might expect. This is partially due to the contextual sociocultural factors of a strong familial sense of resiliency to recover from disasters quickly and maintain a strong familial bond throughout the difficult period. The researchers also cite a reason for poorer families surviving hard times being the fact that these households rely on local social relations based on kinship for access to resources while recovering from the drought. (Little et al., 2006, p. 216). Taking into account the local cultural and social customs in this instance, we can see the nuances behind post-drought survival for poorer families and their abilities to recover from the economic and personal devastation brought on by droughts.

Another study (Gray and Mueller, 2012) on migration and climate change in Ethiopia found that droughts in rural highland Ethiopia, chosen for the study due to its high rates of poverty and susceptibility to economic, political, and environmental instability, cause long-distance and labor-related moves by men (looking to supplement income elsewhere) but cause *fewer* women to move for marriages. Specifically, women's mobility due to marriage is paused during droughts to avoid the likelihood that the bride-wealth cost will increase. This is because men and women have different periods of mobility during marriage. Women move first

into the home of their father-in-law after marriage and then the couple eventually moves to live in their own home (Gray and Mueller, 2012, p. 141). Therefore, in this case, drought has a nonlinear effect on mobility, where environmental effects can cause large portions of a population to migrate while causing another large portion to be immobile or experience reduced mobility.

Links to Epidemics

Further, the spread of infectious diseases, such as the ongoing outbreak of Ebola in the DRC and in neighboring countries, is also linked to climate change (Ngatu et al., 2016). Without over-generalizing causation, there can be a domino effect where climate change leads to economic stagnation, reducing education rates as more children are pulled out of school to support domestic infrastructures. This leads to a lack of knowledge of how diseases are spread, such as HIV/AIDS contraction, with an estimated 20.6 million individuals in East and South Africa living with the disease in 2021 (UNAIDS, 2022), as well as various impacts to the “human dimension” of the health sector, including “inadequate service management, poor infrastructure, the stigma attached to HIV/AIDS, and the ‘brain drain’” (Boko & et al., 2007, p. 440-442; Tanaka et al., 2008).

Other Reasons for Flight in Africa

While colonial-rooted war, violence, and local and foreign-based corruption have been leading factors of displacement and forced migration in Africa in recent decades, history shows us that the situation is far more nuanced regarding reasons for movement. For example, Peter Gatrell discusses a facet of Somali culture that includes ongoing migration. Aside from war and displacement, he discusses trade in post-colonial contexts as a means of migration (Gatrell, 2013, p. 223). In his article, “Somali Refugees in Kenya and Social Resilience: Resettlement

Imaginings and the Longing for Minnesota”, Ikanda discusses how chain migration and dispersive kinship structures are woven into Somali culture. This cultural component is leveraged in times of hardship, such as displacement, when some family members are in the process of fleeing a conflict and/or seeking refuge in camps and some family members have already been resettled in Western countries. Ikanda cites this cultural attribute for the resiliency of Somali refugees and other refugees who have chain migration built into the cores of their cultures (Ikanda, 2018, p. 579). Thus, there can be push *and* pull factors related to flight in Africa. Pull factors, such as a dispersive kinship structure, can be deeply embedded into cultural norms.

Protracted Conflicts in Africa, Refugee Crises, and Compassion Fatigue

Protracted wars on the African continent due to postcolonial influence have been ongoing since the European colonial period. Furthermore, historically, African nations have collectively had the most displaced peoples in known history. While these ongoing conflicts and refugee crises have existed since the colonial era, only those that have grown in scope and magnitude have gained global attention like the situations in the DRC today (Soderlund et al., 2012). Why is that? With ongoing civil conflict, mass displacement, and human rights violations happening on a daily - even hourly basis, why do only the large conflicts or refugee crises get coverage with even those receiving limited airtime? To answer this question, I look to historians and media experts who argue that ongoing civil unrest and instabilities have become so common - to a point that they are a part of our consciousness. This leads to a phenomenon called "compassion fatigue".

Susan Moeller explains that Western populations have essentially become desensitized to humanitarian crises due to the media's "overpublicizing" such crises in recent history. She argues

that there is a general desensitization as a result of multiple, intersecting, and unacknowledged issues in modern international reporting: “the public’s short attention span, the media’s peripatetic journalism, the public’s boredom with international news, the media’s preoccupation with crisis coverage” (Moeller, 1999, pg. 3). She argues that compassion fatigue causes American news producers and correspondents to choose stories with an ethnocentric lens as it “abets Americans’ own self-interest”. Further, it uses a predictable, algorithmic pattern based on topics that have previously sparked an uptick in viewership, such as malnourished children (Moeller, 1999). Of the many ethical issues with this method of news coverage, using the most vulnerable as clickbait or as highlights of the next news segment creates a secondary crisis in and of itself - a crisis of ethics and global humanity - directly caused by Western population media consumers.

History of the Ongoing Conflict in the Democratic Republic of the Congo (DRC)

The reasons for displacement within and from the DRC are manifold and are linked to centuries of war, political corruption, ethnic tensions, and foreign meddling in Congolese natural resource extraction. Below, I provide a historical overview from the 1400’s to the present day.

The Kingdom of the Kongo - 1400’s - 1800’s

Much of what is known of the DRC’s colonialist history centers around the period of Belgian imperial rule and of King Leopold’s heinous reign of violence and economic extraction ventures before that. However, before Belgium began decimating the region in Central-East Africa, there was Portugal. The Kingdom of the Kongo, a monarchy established at least 100 years before the arrival of the Portuguese, was comprised of 300 square miles of territory that now spans several countries.

Its capital was the town of Mbanza Kongo—mbanza means “court”—on a commanding hilltop some ten days’ walk inland from the coast and today just on the Angolan side of

the Angola-Congo border.... Its monarch, the ManiKongo, was chosen by an assembly of clan leaders. Like his European counterparts, he sat on a throne, in his case made of wood inlaid with ivory. As symbols of royal authority, the ManiKongo carried a zebra-tail whip, had the skins and heads of baby animals suspended from his belt, and wore a small cap. In the capital, the king dispensed justice, received homage, and reviewed his troops under a fig tree in a large public square.

Whoever approached him had to do so on all fours. On pain of death, no one was allowed to watch him eat or drink. Before he did either, an attendant struck two iron poles together, and anyone in sight had to lie face down on the ground.... The ManiKongo appointed governors for each of some half-dozen provinces, and his rule was carried out by an elaborate civil service that included such specialized positions as mani vangu vangu, or first judge in cases of adultery (Hochschild, 1998, pg. 8).

In 1491, Portuguese religious leaders and emissaries made landfall and then the ten-day journey inland to the court of the Kongo king where they set up camp as Portuguese representatives. This interaction was the beginning of the first long-term relationship between Europeans and an African state. The Portuguese were welcomed by the ManiKongo due in part to their possession of firearms and their potential use in managing a peasant uprising at the time. The Portuguese provided weaponry support and built churches and schools. They marveled at the order, precision, and efficiency of the government structure and economics of the Kingdom of the Kongo.

Although they were without writing or the wheel, the inhabitants forged copper into jewelry and iron into weapons, and wove clothing out of fibers stripped from the leaves of the raffia palm tree.... People cultivated yams, bananas, and other fruits and vegetables, and raised pigs, cattle, and goats. They measured distance by marching days, and marked time by the lunar month and by a four-day week, the first day of which was a holiday. The king collected taxes from his subjects and, like many a ruler, controlled the currency supply: cowrie shells found on a coastal island under royal authority (Hochschild, 1998, pg. 10).

At this time, enslavement existed in the Kingdom of the Kongo and across Africa. However, most enslaved persons were captives of war, criminals, or sold by their families to pay debts. Yet, the fact that enslavement existed in Africa prior to the arrival of the Europeans was devastating as it facilitated the European's goals of purchasing thousands and thousands of

enslaved persons and the African leaders' goals of making financial gains from these sales. The Portuguese colonial extraction ventures in Brazil in 1500 led to record numbers of enslaved peoples being purchased from Africa and brought to work in Brazilian mines and sugar and coffee plantations.

During this period, enslaved persons were also brought to work on plantations in the American South, where an estimated 25% of the enslaved individuals working in the cotton and tobacco fields in the southern United States were from equatorial Africa. "The KiKongo language, spoken around the Congo River's mouth, is one of the African tongues whose traces linguists have found in the Gullah dialect spoken by black Americans today on the coastal islands of South Carolina and Georgia" (Hochschild, 1998, pg. 11). From 1500 to the mid-1600s, the Kongo state deteriorated due to the economic and civil degradation brought on by European colonial extraction and mostly by the European slave trade, which then involved the British, French, and Dutch. In 1665, the struggling Kongo Kingdom fought the Portuguese and lost. The ManiKongo was beheaded and the kingdom land was divided and ruled by European colonies into the late 1800s.

King Leopold II of Belgium and the Congo Free State - 1885 - 1908

In 1885, in a secret quest to establish a colony that would capitalize on the rich market of exploitative colonial resource extraction, King Leopold II of Belgium founded the Congo Free State. During this period, fueled by Western greed for imperialist expansion, colonial expeditions and establishments were enormous economic funnels to mother countries. The European colonies viciously stole various natural resources and enslaved individuals and sent them to Europe and North America or to other colonized lands for forced manual labor. Resource extraction was generally through brute force and violence and sometimes through transactions

with indigenous leaders. Toward the late 1800s, European nations, at least outwardly, began to regard the slave trade as a deplorable and inhumane system. This, of course, comes after having reaped the economic benefits of it for hundreds of years. Based on his own experiences working for a Belgian trading company in the Congo Free State region, Joseph Conrad's 1899 famed and controversial novella, *Heart of Darkness*, critiques European colonialist expansion and the open racism, greed, and violence that defined the era.

It was in this historical context that the Congo Free State came to fruition. It was not a colony of Belgium but a private and personal venture by and for Leopold II himself. Driven by a lifelong dream to own a colony, he was not going to be stopped by the fact that there were not any colonies for sale. His solution to this barrier was to resort to the method of deception. He succeeded in taking control of the territory by cloaking his colonial ambitions via a guise that convinced other European nations that he was seeking to promote anti-slavery practices, scientific research and advancement, and charitable efforts in the region. In 1876, the International African Association was founded by the Brussels Geographic Conference, hosted by Leopold II. The guests included European leaders, world explorers, and geographers who collectively voted Leopold II to be the first chairman of the international committee. Unbeknownst to them, this organization was the guise Leopold II needed to conquer the Congo territory without question and move forward with his colonial dream.

Furthermore, Leopold II's quest for a colony in Africa was just as much an effort to expand and strengthen his power as King of Belgium, at a time when monarchies were crumbling globally:

Most annoying to him was that in Belgium, as in surrounding countries, royal authority was gradually giving way to that of an elected parliament. Someone once tried to compliment Leopold by saying that he would make "an excellent president of a republic." Scornfully, he turned to his faithful court physician, Jules Thiriar, and asked, "What

would you say, Doctor, if someone greeted you as ‘a great veterinarian’?” The ruler of a colony would have no parliament to worry about.” (Hochschild, 1998, pg. 38).

The privately-owned Congo Free State was established in 1885 by Leopold II and existed for thirteen years until 1908. During this time, Leopold II and his European leaders committed one of the largest-scale genocides known in modern history. The main exports from the region were rubber and ivory, harvested through the forced labor of indigenous peoples who were only allowed to sell their crops to the state which set the prices of the goods. Most proceeds went directly to Leopold. European companies were given land in the Congo Free State to collect rubber and ivory, granting them the ability to police and discipline any Africans who did not work hard enough. The punishment for not meeting farmed resource quotas resulted in mutilation, rape, and/or death. One of the regional priests recounted the words of a local Congolese man in his hatred for his local state official, Léon Fiévez, who upheld these heinous, unthinkable acts of violence in the name of financial profit:

All blacks saw this man as the devil of the Equator ... From all the bodies killed in the field, you had to cut off the hands. He wanted to see the number of hands cut off by each soldier, who had to bring them in baskets ... A village which refused to provide rubber would be completely swept clean.

As a young man, I saw [Fiévez's] soldier Molili, then guarding the village of Boyeka, take a net, put ten arrested natives in it, attach big stones to the net, and make it tumble into the river ... Rubber causes these torments; that's why we no longer want to hear its name spoken. Soldiers made young men kill or rape their own mothers and sisters (Hochschild, 1998, pg. 166).

Lacking an official census, there is not a way to know the exact death toll of this reign of terror in the Congo Free State. While death toll estimates span from 5 million to 20 million deaths, the frequently cited statistic, partially based on anthropological data, is that half of the population died as a result of these inconceivable atrocities. That would mean that the estimated death toll would be around 10 million though there is no way to verify this. As knowledge of

these crimes against humanity began to spread across Europe, Leopold II offered to “reform” his method of governance of the region but the Belgian parliament annexed the Congo Free State in 1908, taking control of the now-official colony and renaming it the Belgian Congo. Somehow, it is still a topic of debate whether the mass murders and violence during the Belgian Free State amount to genocide. The Belgian government still has not titled it as such. Congolese individuals officially gained independence from Belgian colonial rule in 1960 following an uprising by the Congolese.

The Kivu Conflict: 1960's - Today (early 2020's)

The ongoing regional conflict in the North Kivu and Ituri regions in the northeast of the DRC is often called the Kivu Conflict - a conflict that spans decades with multiple warring parties. This region is where most Congolese are fleeing from today. The conflict partially originates from the Second Congo War (1998-2003), but is rooted in issues dating back to the 1960s and beyond. In 1961, then-Prime Minister of the independent Democratic Republic of the Congo, Patrice Lumumba, was assassinated by political enemies. Lumumba, an independence leader, was best known for his role in the transition of Congo as a Belgian colony to an independent republic.

Many still suspect that the US Central Intelligence Agency (CIA) played a role in his assassination. While not confirmed, the CIA under the Eisenhower administration could have been involved in the assassination in conjunction with Belgian intelligence forces. While the CIA maintains that they planned assassination attacks on Lumumba for fear of Congo getting too close with the socialist USSR, “once even trying to get a recruit to poison his toothpaste or food”, they say that they did not directly partake in his murder in 1961. It was later confirmed that the CIA and Belgian intelligence officials laid the groundwork for Mobutu, the military

officer who became President of the DRC, to overthrow Lumumba, including “fund[ing] anti-Lumumba street demonstrations, labor movements, and propaganda”, financially backing then army chief Mobutu, and advising him to arrest Lumumba. However, JFK was due to take office days before the internal assassination plan to move Lumumba to a Belgian-supported secessionist province to be murdered (Weissman, 2014, p. 16).

Because internal forces in Congo did not want to wait to ask the incoming JFK administration for confirmation of the plan for fear of rebuke of “the Eisenhower administration's hardline policy toward Lumumba”, the forces, in conjunction with Belgian intelligence agents, went ahead with the assassination plan without confirmation from the CIA, the State Department, and the National Security Council. Again, this is all according to CIA records of the event, with full details of the play-by-play still obscured (Weissman, 2014, p. 20). The CIA's actions then backed pro-Western Mobutu, “engag[ing] in pervasive political meddling and paramilitary action between 1960 and 1968 to ensure that the country retained a pro-Western government....these efforts [cost] an estimated \$90-\$150 million in current dollars, not counting the aircraft, weapons, and transportation by the Defense Department” (Weissman, 2014, p. 20).

Mobutu's subsequent misrule in Congo between the 1960s and the late 1990s led to “economic disaster, recurrent political instability, and Western military intervention” where, due to not paying his own military forces, Mobutu's forces were reported to pillage property of private citizens. This laid the groundwork for the First Congo War, termed Africa's First World War, from 1996 to 1997, when the DRC, then called Zaire, experienced a civil war and foreign invasion resulting in Mobutu being overthrown and rebel leader Laurent-Désiré Kabila becoming president.

The internal and foreign invasion forces included former Lumumba supporters and military groups of neighboring nations. This led to “a regional war that would kill more than three and a half million people over the next decade” (Weissman, 2014, p. 20). Thus, while Belgian colonialism laid the groundwork and initially began the political unrest in the DRC, Mobutu, the Cold War, and Western meddling to pursue state agendas perpetuated the unrest in the region into the present day (2023).

Furthermore, the role of Western aid agencies, namely the UN, in the midst of this ongoing unrest since the 1960s was questionable at best. It is important to remain apprehensive of UN involvement in the DRC today in their various activities in the country from Ebola aid to biased refugee camp administration, alleged *and* convicted sexual violence perpetration, and discriminatory refugee resettlement criteria regulations (Mudgway, 2018; Westendorf, 2020) (see Chapter II for more information).

The Second Congo War

The Second Congo War (1998-2003), termed the Great War of Africa, originated from many of the same issues of internal and international forces, from grassroots insurgents to government and non-government army forces, vying for political power, regional control, and access to lucrative natural resources in eastern DRC. While the Second Congo War supposedly ended in 2003, much of the same struggle for said profitable natural resources is ongoing, though with many more regional actors (government, militant, and local citizens) fighting for access to the resources. Between 1998 and 2008, more than nine African countries and international militant groups engaged in a massive struggle for the country’s rich natural resources in this area, such as columbite-tantalite (coltan) - a mineral used to make most electronic devices, leading to

over 5.4 million deaths by 2008. Most deaths were due to disease and malnutrition (Bavier, 2008). This mortality rate is only second to World War II, leading many to call it World War III.

In addition to this staggering death toll, civilian populations, and in particular those who live in the regions where the natural resources are located, often experience the vast majority of acts of violence during ongoing conflicts.

Forced displacement, abductions, killings, recruitment of child soldiers, sexual violence crimes and looting commonly occur (Marriage, 2013:114; Vinck et al., 2008:6). The civilian population lacks human rights in general and political and economic rights in particular due to a dearth of peace, security, monetary means, education, medical services, basic infrastructure and food and water (Freedman, 2015; Marriage, 2010) (Sahin, 2021, pp.3).

An example of these intersectional human rights violations is detailed further below with the local population in the Kivu Region.

A further compounding issue for civilian populations during this ongoing political strife is the simultaneous Ebola outbreak that specifically affects the Kivu region. Throughout this period, the UN was involved at various stages of the war while also providing humanitarian aid. Dr. Séverine Autesserre (2010), expert on war and peacebuilding, suggests that the issue with the 2003-2006 UN peacekeeping mission in the DRC was that it did not focus on local, regional conflicts. Issues such as “grassroots rivalries over land, resources, and political power”, all linked to the ongoing conflict, were ignored. Instead, a “dominant peacebuilding culture” was leveraged to shape strategic intervention from the top down, seeing local peacekeeping efforts as being “unimportant, unfamiliar, and unmanageable” tasks. The result of such grave oversight, detailed below, is that at least a third of the ongoing violence in the Kivu region today can be linked to ongoing regional conflicts between over 120 active militant groups. Yet another example where incorporating and highlighting indigenous and local perspectives and voices, as a

part of employing a political-economic lens for context, could have made a big difference for sustainable and effective peacebuilding efforts.

The Kivu Conflict

The Kivu Conflict can be generally explained by three compounding phenomena in this region. The phenomena can be categorized as political (post-presidential election factions and violence), local (violence between smaller militant groups and Congolese government security forces, violence by various militant groups at the village level, claims to local natural resources, food security for displaced populations), and medical (the Ebola outbreak and lack of humanitarian aid in a conflict zone). These three issues intersect to create chaos in the region (OCHA, 2019).

Following the Congolese presidential election of Felix Tshisekedi in December 2018, various events, including political violence, have compounded to make the situation on the ground in the DRC worse than ever

before (OCHA, 2019). After six months of Tshisekedi as president, violence was generally due to mistrust of the new Tshisekedi regime as he was seen as a puppet for former president Kabila, suggesting a broken “democratic” presidential election in late 2018. Additionally, the areas most affected by Ebola outbreaks are the most vulnerable to attack, with medical aid workers being targeted, drastically limiting public health support (OCHA, 2019).

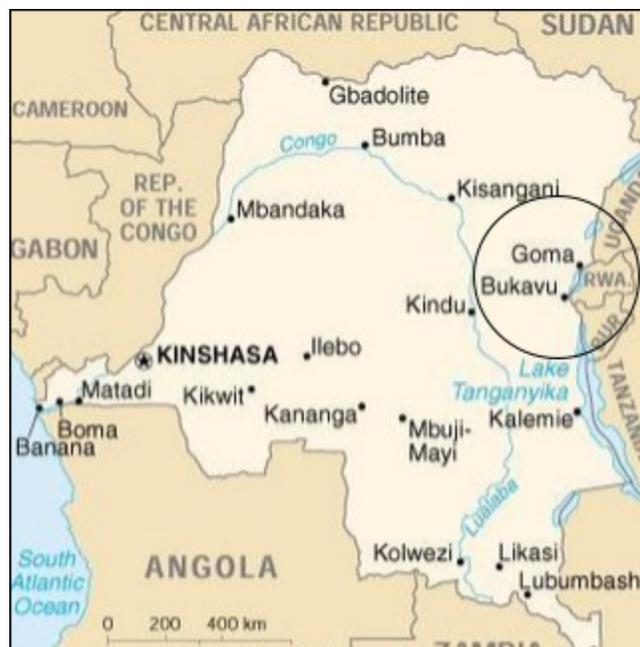


Figure 8: Munyuli et al., 2013 (Circle added to show the region of the Kivu conflict)

The regions especially impacted by these compounding events are Ituri and North Kivu in northeastern DRC, where there are natural resources used in the manufacturing of cell phones and electronic devices and which are being fought over by various armed groups, which then impacts the civilian populations in these regions. Populations in these areas face ongoing armed conflict, village raids, rape, violence, and forced manual labor to extract natural resources. These regions also border Rwanda and ongoing tensions between Hutu ethnic militia groups and the Congolese government have spilled over to also affect these regions, with the militia groups demanding political recognition, land rights, and access to mine natural resources. There are currently 120+ active militant groups with the four major groups being the Allied Democratic Forces (ADF), Democratic Forces for the Liberation of Rwanda (FDLR), Mai Mai Nyatura, and Nduma Defence of Congo/Rénové de Guidon (NDC/R). This is in addition to this region being the epicenter of a vicious Ebola outbreak in an area where humanitarian agencies except for the UN will not operate because it is too dangerous for aid workers. This is a high-level overview of the current Kivu Conflict in these regions of the DRC from January 2019 to today.

II: Sexual, Reproductive, and Maternal Health and Healthcare Narrative Accounts & Supplementary Data Using the Lens of the Political Economy of Health

We have now, at least at a high level, examined aspects of the historical, economic, and political backdrops of the Belgian colonial period, the two Congo War periods, and of the ongoing Kivu conflict that, either directly or indirectly, have and continue to impact Congolese women's sexual, reproductive, and maternal health and healthcare in the DRC⁷. However, a political economy approach is needed to examine the historical, cultural, and social contexts of

⁷ In the DRC, the average age of a first-time mother is 19.8, the maternal mortality rate is 375 deaths in 100,000 live births, which ranks 29th globally. The infant mortality rate is 24th in the world, with 50.7 deaths per 1,000 live births. The fertility rate is 24th in the world, with each woman having an average of 4.45 children (CIA, 2020).

refugee sexual, reproductive, and maternal health and healthcare as these components drastically impact health and healthcare for Congolese women.

This can be accomplished by employing the lens of the political economy of health in contextually examining the qualitative, first-hand accounts of Engjy's experiences that were shared in her life history interviews. As I listened to these stories, I was continuously moved to my core and my heart broke over and over again hearing Engjy's experiences of sexual violence, discrimination, and rape. Therefore, it was a deeply emotional experience as Engjy bravely recounted her unthinkable experiences. At certain moments, I could not hold myself back from tears as she would share the graphic details of her trauma, portions of which haunt her into the present day. It was hard for her to say and hard for me to hear - as it will be for you to read.

Finally, I also include supplementary reports, studies, and literature on how broader populations have similar experiences, as well as to cite additional social, cultural, and historical factors that impact health and healthcare. Therefore, the following section attempts to present select, intersectional cultural and social norms and systems at play, through qualitative and quantitative data, that construct the environments and contexts for the sexual, reproductive, and maternal health and healthcare of Congolese women while they are/were living in the DRC conflict regions.

Pre-War, Pre-Flight Backdrop and Life History Narratives

Pre-War Ethnographic and First-hand Accounts of Life in Eastern DRC (then Zaire)

In an effort to contextualize and better understand Engjy's life history narrative accounts in the following sections, below are select first-hand and ethnographic accounts of life in Zairian cities in the 1990s before the first Congo War broke out in 1996.

South Kivu and Bukavu - Capital, South Kivu province

Congolese author, microfinance organization founder, and human rights activist Sandra Uwiringiyimana writes of her home village in the mountains of the South Kivu province:

Ten years before the flames, I was born in the mountains, a scenic land of jewel-green fields, bamboo trees, and forests inhabited by gorillas, elephants, and chimpanzees. My people lived in small round mud huts with pointy roofs made of dried grass. They raised cattle and farmed the land. My parents grew up in these towering mountains, the Hauts Plateaux, in a province of the Democratic Republic of the Congo called South Kivu (Uwiringiyimana, 2017, pg. 8).

She goes on to describe her childhood experience of ongoing internal displacement from protracted feuds and wars - a reality of many families in the DRC in the years leading up to the First Congo War and thereafter. Uwiringiyimana adds that the migration of her tribe, the Banyamulenge, is largely due to the fact that they emigrated from Rwanda due to discrimination and conflicts there while also in search of green pastures for their cattle as they are largely pastoral. However, she emphasizes that they never found acceptance nor a true home in Zaire - still a stateless people today who now largely reside in refugee camps due to the protracted wars and violence in the DRC and their targeted ethnic minority status within the conflicts (Uwiringiyimana, 2017, pgs. 8-9).

In another autobiographical account of his childhood in the 1990s, Emmanuel Ntibonera wrote of his ostensibly carefree and peaceful childhood in Bukavu, the capital of the South Kivu province that Uwiringiyimana describes above. Similar to Goma, Bukavu is also an east coast lake town - Goma sits at the top of Lake Kivu and Bukavu sits at the bottom. Both cities border Rwanda's west coast. Ntibonera writes of a semblance of political stability in Zaire in his childhood and of the simple joy that he would have in climbing banana trees to gaze at the blue waters of Lake Kivu:

I remember clearly the Congo of my childhood. There was peace then. President Mobutu Sese Seko had been in power for decades, his regime able to quell the small coups that

had threatened it. And, while his regime did not bring much prosperity to the nation (called the Republic of Zaire back then), there was a semblance of stability.

Bukavu sits just beyond dense, green jungles....As a kid I would climb a tree, banana leaves fanning below me in the breeze, and see how the sun, hot in the sky, would glisten off of Lake Kivu, sending gold and blue waves rippling between our neighboring nations. It was such a beautiful country before the great war cast its shadow across my motherland (Ntibonera, 2020, p. 15).

However, history would see that Mobutu was not as benign as this seemingly simple description of the dictator. Michela Wrong, a correspondent who covered Mobutu's final days of power provides this clearer description of the Zairian "president":

...president of Zaire for thirty-two years, Mobutu Sese Seko, showed all the cunning of his namesake -- seducing Western powers, buying up the opposition, and dominating his people with a devastating combination of brutality and charm. While the population was pauperized, he plundered the country's copper and diamond resources, downing pink champagne in his jungle palace like some modern-day reincarnation of Joseph Conrad's crazed station manager (Wrong, 2002).

Despite this true identity of Mobutu being concealed and/or misunderstood by the then-young Ntibonera (likely a common perception of Mobutu by most Congolese youth at the time) - he goes on to add more vivid descriptions of Butare before the First Congo War. He writes of his carefree childhood and his family unit which was of moderate socioeconomic means with his dad owning the local grocery store and real estate.

When I was a child—before the war, before the killing, before the running—survival was not the driving force of my life. I was a normal kid: I went to school, played with my friends, ate dinner every evening with my family, and went to church on Sundays....My family enjoyed a good life. We lived in a seven-bedroom house (Ntibonera, 2020, p. 12).

He further describes the tightly knit community structures of his village - of the generosity and communal spirit of Congolese culture that held the villages together.

Life in my old neighborhood embodied what it means to be a community....Congolese people are very close; we all lived like one big family....Congolese were, and are to this day, just as quick to share a small pot of rice and beans if they knew you were hungry. We looked out for each other....Before the rebels (both homegrown insurgents and illegal foreign armed troops) invaded our cities and many young boys disappeared—forced to

march, carry guns, and kill—children roamed the streets of Bukavu unsupervised, carefree, happy (Ntibonera, 2020, p. 13).

Kinshasa - Capital, Zaire: 1980s/90s Fieldwork on Patriarchal Zairian Culture and the AIDS Pandemic

In 1996, the HIV/AIDS pandemic was especially rampant in East Africa where there were inadequate health facilities to treat the disease due in part to insufficient economic means by the Zairian government and unstable sociopolitical infrastructures. From 1985 to 1990, anthropologist Brooke Grundfest Schoepf conducted HIV/AIDS prevention research in the capital of then Zaire, Kinshasa. Her research sought to examine social constructs around the disease as well as structural conditions that enabled the disease to continue to spread. For example, leveraging pre-existing epidemiological research that said that heterosexual women were the most vulnerable to the disease, her anthropological lens found that the reasoning behind this was multi-dimensional.

Her ethnographic research discovered “the central role of socioeconomic conditions, politics and culture, including widespread and deepening poverty, SAP measures, gender inequality and prevalent constructions of multi-partnered masculinity, in fueling the epidemic” (Schoepf, 2007, p. 1). For example, traditional sociocultural policies were forced on women’s bodies when women were blamed for spreading the virus, continuing the cultural belief that women were “polluted” and AIDS, as with other STDs, was “a women’s disease”. Thus, women were made to uphold fidelity to one sexual partner while their generally older male sexual partners would still engage in sexual relations with other partners, some specifically seeking out younger partners following the myth that sex with a virgin could cure the infection.

Consequently, we can see from Schoepf’s fieldwork conducted in the Congolese capital in the late 1980’s that the HIV/AIDS pandemic in the DRC was fueled in part by a patriarchal culture,

in addition to a lack of structural resources such as medical treatment facilities and financial capital (Schoepf 1991;1993; 2007).

Goma - Capital, North Kivu province

On the northern shore of Lake Kivu sits the city of Goma, capital of the North Kivu province, which derives its name from Swahili for “drum” due to its proximity to the rumblings of the Nyiragongo volcano. It also sits on the border of Rwanda and has a twin Rwandan city called Gisenyi. It was in this picturesque lakeside city where Engjy spent her childhood and where the events detailed below from her life history took place before the Congo Wars and intermittently between and after. As Engjy mentions throughout her targeted life history, the proximity of Goma to Rwanda led to an influx of Rwandan refugees, *génocidaires*, and militants pouring across the border during the 1994 Rwandan genocide and into then Zaire via Goma and other border towns and cities. In 1993, Goma had a population of roughly 131,613 inhabitants which grew to 235,700 ten years later in 2003 (worldpopulationreview.com, 2022). This mass migration would come to haunt Engjy in many ways throughout her life.

With this inundation of Rwandans in Goma came anti-Rwandan sentiments which for some grew from preexisting hostilities towards Rwandans of both Hutu and Tutsi ethnic identities from years of ethnic, geographic, and/or nationalist tensions. Some of these hostilities stemmed from colonial-era feuds and national borders redrawn by colonial empires that slashed through existing indigenous kingdoms and territories and still additional issues originated from before colonial imperialist rule. In this vein, Oldenburg (2015) provides the following historical context which details Goma’s complex transformation during the periods after the Congo Wars and beyond:

Goma has many faces. Already a place of contestation during the years around DR Congo's independence, Goma metamorphosed from a dormant beauty into a vibrant hub

of trade, migration and refuge. Historically seeded conflicts about land and demographics, stiff economic competition and conditions, and unsettled issues of political representation are at the heart of Eastern Congo's conflict nexus.

Since the beginning of the 1990s, Goma was catapulted into global consciousness, owing to the arrival of hundreds of thousands of Rwandan genocide refugees; a cholera epidemic; the successive 'Congo Wars' (1996–97, 1998–2003); and a number of 'rebellions' that threatened to take over the city (Congrès National pour la Défense du Peuple [CNDP] in 2008) or succeeded in doing so (M23 in 2012). Via cross-border trade, Goma is closely connected to its Rwandan 'twin-town' Gisenyi, and is surrounded by the beautiful shores of Lake Kivu. These shores reflect the duality of Goma: for some, they remember historic horrors and dead bodies floating, while for lovers the shore might present a perfect place for a Sunday promenade (Oldenburg, 2015, p. 316).

Most first-hand descriptive narrative accounts of the city of Goma, Engjy's childhood home, from before the war started in 1996 echo similar illustrations...

breathhtakingly beautiful region of brooding volcanoes and misty green valleys, all rolling down to the blue waters of Lake Kivu.... When the tour agencies were still brave enough to include Rwanda and Zaire in their African itineraries, Goma was a favorite destination for tourists visiting some of the world's last mountain gorillas. A pretty little town on the black lava foothills... (Wrong, 2002).

In the early 1990s, when Engjy was attending primary school, Goma's population spanned diverse socioeconomic income levels. At this point, the city of Goma was a booming economic hub and port city due to 1990s neoliberal economics and preexisting Western-based neocolonial resource extraction enterprises. As we will see below with Engjy's father's business efforts, his business was blossoming. Furthermore, in larger cities, shifting sociocultural norms and relatively comfortable economic means meant that girls from middle and upper-class families were attending school in record numbers. As with most public schools in Africa, students were and still are required to purchase and wear uniforms, a policy that generally limited/ still limits girls' school attendance in poorer rural areas. However, in Goma and larger cities in Zaire at this time in the 1990s, more economic means resulted in girls attending school at record numbers in both public and private institutions.

Engjy's Pre-War, Pre-Flight Life History Narrative

Engjy's recounted life experiences before the First Congo War (1996–1997) in general, and her sexual and reproductive safety during this time in particular, further paint a vivid picture of life in Zaire in the 1990s. Her account allows us to examine a different socioeconomic perspective - the life of an upper-income Congolese young adult in the late '90s living in Goma, the capital of North Kivu province in eastern DRC. Though women who were and still are forced to flee the DRC come from all economic, social, and cultural milieus, many are from lower socioeconomic groups, lack resources to protect themselves if they stayed, and/or are from marginalized political, social, and/or cultural groups.

Yet, Engjy's life history perspective provides a unique positionality because, as her accounts reveal below, her upper-class childhood and young adulthood provided her exposure to Western academic, social, and political perspectives that most Congolese women did not have exposure to. This background would later provide a basis for navigating Western-run humanitarian agencies while displaced, as well as Western norms in resettlement. Thus, Engjy's accounts give a unique and enormously valuable perspective to not only the political-economic context of sexual and maternal health and healthcare in neocolonial and displacement settings, but also aid in understanding the nuanced power dynamics in different stages of refugee flight, displacement, and Western resettlement.

Advent to and Early Days of The First Congo War Life History Narratives

E: I had... like I can divide my childhood into two. Part one is before war and part two is after war. Or during the war. When I was born, and when I was still young they used to treat me like a princess and all. My dad was wealthy. Like every vacation we could choose where to go. Sometimes we could go in the village, sometimes we go like to Kinshasa, Belgium, you know, like to different countries. And when my father was traveling for business, sometimes he was taking me with him. I remember I traveled a lot when I was young....So, life was good. I went to a Belgian school. I even studied the language.

J: Did you live in the capital?

E: No, in Goma. Goma is a city which is near Gisenyi. So, life was good. I wish it stayed like that. But unfortunately, war came in.

In recounting her relatively privileged upbringing in Goma, she acknowledges the resources that were available to her mother before the First Congo War as she periodically experienced mental health issues. She later goes on to say that these issues were linked to traumas in her mother's childhood that were exacerbated by the stressors of pregnancy and raising five children.

E: The only thing that, in my childhood, that was kind of stressful was the breakdowns of my mom. Because she's bipolar. Sometimes she could have breakdowns and she could take out all her anger on me, you know?

And she could do things that she couldn't control. She could do things like, it's not that she wants to do them, they just happen. Because of her mental state. Before it was somehow OK because whenever she could have a crisis, she could go and get treatment in Belgium. She had a therapist and all those kinds ...yeah, medication. But then after, it became a disaster.

J: After the war started?

E: Yeah, because she didn't have access. And in Congo, when you talk about mental health, they make you, instead of helping you, they make things worse.

As Engjy acutely notes, focusing dedicated medical resources to mental health treatment was generally a Western practice at this time in the 1990s. Her mother would also travel to Europe for some treatments for these problems that plagued her largely in the postpartum periods of her life. Traditional Congolese treatments would not have employed therapy or other medical-based resources for postpartum mental health disorders, such as PPD or PPA, if even naming these as direct issues to maternal struggles postpartum.

In this example, the political economy of health framework can be applied to understand the contextual power structures at play that led to Engjy's mother's sudden loss of mental

healthcare support and subsequent, unsupported mental health struggles. This framework is used by scholars both within and outside of the Marxian legacy, as noted in Harvey's definition below. As I generally use the term, I am broadly referring to the intertwining and compounding of cultural, social, economic, historical, and political forces and their direct influences on individual and population-level health. In the case of this research, I am focusing on individual and population-level maternal health and the many ways that it is impacted at each stage of refugee flight by larger cultural, social, political, and economic forces.

Political economy of health scholar Michael Harvey (2021) first explains the general concept behind this framework and then the nuanced understandings of racial, gender-based, and class inequalities that are also understood within this lens.

... Marxian political economy of health is concerned with a set of issues that fall broadly in a leftist political imaginary inspired by the Marxian tradition. The role of economic inequalities and class stratification is prominent. Many of these definitions emphasize social structures, institutions, and public policy as well as their role in exacerbating or ameliorating economic and health inequalities-often along the social axis of class but also along axes of sex, gender, race, ethnicity, nationality, and citizenship status.

Additionally, the relationship between the capitalist class (i.e., the capital-owning class, the upper class, or-more colloquially following the Occupy Movement-"the 1%") and the working class is framed as central to understanding these inequalities and the political-economic systems from which they arise. An empowered working class that is committed to social justice can realize universal economic, social, political, and civil rights, while limiting the influence of the capitalist class and their corporations in society (Harvey, 2021, pp. 297).

In my macro definition of this lens - compounding cultural, social, historical, political, and economic factors affecting individual and population-level health, this can be understood by Engjy's family, though wealthy, still being citizens of a country with a history and economy still largely tied to Western neocapitalist power structures. When the First Congo War started due to Western-influenced, financially-driven grabs for natural resources in the Kivu region of eastern DRC, local residents, even those in the upper class and tightly attuned to Western cultural and

social norms, were impacted by the sudden halt in, what some may argue, more targeted healthcare resources among many other economic and social resources. Though Engjy's family's wealth and connections afforded her mother access to Western mental health resources, they rapidly disappeared once the war began, leaving her mother to face the hardships of war with four children and attempting to manage her mental health struggles without the external support she was familiar with. The reasons for these sudden changes were manifold.

First, Engjy's father was a wealthy businessman in the gasoline industry backed by Western fuel companies. When the First Congo War began, he found his company overthrown by insurgent government forces who strong armed him into using the fuel that he sold to support their war efforts. This removed his steady source of income but also made him an ongoing target by insurgent forces to exploit for more resources as the war progressed. Additionally, the support of his Western networks waned as they distanced themselves and their formal, public-facing business connections from the epicenter of an intercontinental war which had most African countries involved in one capacity or another.

As Engjy explained:

E: It [the war] started when I was eight. And then when it happened I was ten. My dad had to run away from Goma because, the people of the government, like the rebels from before, they became the liberators. They wanted him to support them. In exchange for them to keep his property, he was supposed to support them financially. They were taking his fuel, you know, he had like a gas, a gas station.

J: Oh, your father owned a gas station?

E: Yes. They took almost all of the gas. They took money. They took so many things. Then promised to pay back. But they never did. When my father was, he felt in danger, he ran away from Goma to Kinshasa.

J: By himself?

E: Yes, by himself. He left us behind. That's when they came to look for him and they found us, me, my mom, and my siblings. My mom was, it was after she delivered our last born.

Sexual Violence in the First and Second Congo Wars Life History Narratives

The arrival of key insurgent forces directly altered Engjy's family's economic livelihood, their social standing, and their personal safety and security indefinitely. While the insurgent forces posed a grave danger to all family members, Engjy and her mother experienced some of the worst of the violence in the form of sexual violence and assault by insurgent forces who were looking for her father to further exploit him of resources. Engjy was ten years old at the time. Below, she recounts the experience.

J: She [your mother] had just given birth?

E: Yes. And like really, it was horrible. They tortured me. I was also raped....

J: By the soldiers coming to look for your father?

E: Yes. And tortured.

J: And you were 10 years old?

E: Yes. You see, I have several scars here and here and here and on my leg here [gestures to several scars on body]. On my foot. I almost died. You know? Because I lost a lot of blood. And my mom, they also raped her in front of me....

So it was, very very difficult. Very. And they were like, tell us where your family is. We want to talk to him. We want to see him. And then we were like, we don't know where he is. He is not with us. But they couldn't understand that....

Sexual Violence and Rape as a Weapon of War in the DRC

Rape as a weapon of war is a militarized tactic of sexual violence used in the DRC. In 2008, the UN Security Council declared that civilian women and children are the most targeted by sexual violence in armed conflict. In linking it to intersectional oppression on the basis of sex and ethnic differences, with the goals of community degradation and forced migration, the UN

Security Council argued that rape is a “tactic of war to humiliate, dominate, instill fear in, disperse and/or forcibly relocate civilian members of a community or ethnic group” (UN Security Council, 2008).

Yet, this phrase has been criticized - seen as an oversimplification and “somehow self-explanatory through its implied universalized storyline of gender and warring” (Baaz and Stern, 2009, p. 496). Other studies report that, for the survivors of sexual assault in the DRC, rape in the DRC is “both endemic and indiscriminate”, where “sexual violence is not only part of the war, it *is* the war” (Maedyl, 2011, p. 147). Such perspectives have led many researchers and humanitarian workers (Buss, 2009; Maedyl, 2011; Baaz and Stern, 2013) to advocate for rape to be reframed as a strategy - a *modus operandi* - of war.

Despite these arguments on *how* rape in warscapes is framed, literature on the contexts of how and why rape is used in conflict remains sparse. Thus, analyzing this topic with the anthropological lens of the political economy of health can help to provide a more holistic understanding of the contextual nuances of this weapon (i.e. historical, cultural, social, and political factors). These perspectives supplement and/or integrate the more logistical, strategic, or statistical foci of rape as it is studied in the corresponding fields of international relations, humanitarian aid, public health, international human rights, and international development, among others. In a systemic review of the scientific literature on rape in the Eastern Kivu region of the DRC between 1996 and 2013, Mpinga et al. (2017) revealed key historical insights to rape as a weapon of war used in the DRC over time and for different, yet similar, purposes.

The review showed that kidnapping of women was sometimes used in precolonial African societies in crafting “social identities by the forced subjugation of weaker clans or ethnic groups”, in addition to being used in efforts to take over new lands, commandeer valuable

resources, and grow domains of power (Mpinga et al., 2017, pp. 582). During colonization, rapes were used to assert power and dominance over indigenous populations by the armies of Leopold II and afterward, by the Kingdom of Belgium.

Rapes were subsequently used in various African states in the wars for independence. Post-independence, leaders who manipulated election results or overthrew existing states would sometimes employ rape and other forms of violence within the population in an effort to maintain their newly obtained power. These instances of rape by militia and/or state forces to maintain illegitimate state control have taken place across the African continent during and after wars for independence.

Broader Context on Sexual Violence and Violence Against Women in Conflict

Mpinga et al. (2017) found that existing public health studies on rape in armed conflicts in the DRC primarily focus on epidemiological data regarding how these rapes are committed, how frequently, their strategic use by militant groups, and how they affect individuals to populations (Mpinga et al., 2017, pp. 582). Other social science fields also focus on similar or just as targeted methods or field-specific themes when studying rape in conflict zones.

However, as illustrated below by Engjy in her targeted life history responses, there are many intersectional cultural and social factors that allow this war crime to remain a viable weapon. These perspectives demonstrate the ongoing need to integrate the existing knowledge on logistical and strategic reasons of how sexual violence is used as a weapon against women in conflict with the *context* of the *how* to best address this complex, multivariate issue and to provide the best, evidenced-based support for survivors. Thus, the following lived experiences from Engjy's past encounters with unthinkable sexual violence and subsequent trauma provide often overlooked yet critical insights into the cultural and social contexts of sexual violence in

conflict zones. These insights provide invaluable information in the construction of a more holistic, political economy understanding of refugee women's maternal health experiences while living in conflict settings.

Lack of Personal Agency: Abusive Arranged Marriages

Engjy's targeted life history accounts explain that after she was raped at the age of 10 years old, alongside her mother, by militant forces looking for her father, she moved around with her family in an effort to seek safety. During this time, they mainly lived with Engjy's grandparents. However, she details her experience of turning 17 years old and the beginnings of an arranged marriage by her family to a man that they owed money to and could not repay. The man subjected Engjy to ongoing psychological and physically abusive behavior, culminating in her fiancé raping her after she refused to have sexual relations with him before marriage. After this, she fled to Kinshasa, the capital of the DRC, to, as a deliberate act to regain her personal agency, pursue a university degree in medical studies.

J: You were 18 or 19?

E: Yes. My family kind of sold me to my fiancé. The first fiancé that I had.

J: What?!

E: Yeah. Because he had a hardware shop. And my mom was using materials from his shop to finish our house. One of our houses. She accumulated money and she owed him a lot. And then, when he was coming to ask them to pay, it was like, they told him you have to marry [informant], and then we will pay you. It was like a contract.

J: It wasn't a dowry?

E: Yeah. He was supposed to pay the dowry.

J: But instead, your family got the free materials in exchange for you?

E: In a way. And then he was mistreating me. It was such a bad experience.

J: You were 19 when you were married?

E: Yes. I was 19. I was actually 17 when he paid the dowry. We almost got married. But the way he was treating me, you know, I was like, I can't get married to such a kind of person.

J: How was he treating you?

E: He could come with a whore. Like a prostitute. Have sex with her in my eyes.

J: Like in front of you?

E: Yes. In front of me.

J: And make you sit and watch them?

E: Yes! Like why? Because I refuse. I was like no, I will wait until the wedding. And he could beat me up. And I remember one time, he was sick, that's why I went to his place to take care of him. I really suffered during that time. He could vomit down. He could poop down and I have to come and clean everything.

J: Was he much older than you?

E: Yeah, kind of. He was 27 or 28.

J: Okay, about 10 years older?

E: Yeah. He was older than me. But he was such a jerk. Like really. And then I was like trapped, you know, in the relationship. The agreement was me, for the money. You know? I had to run away. And I went to Kinshasa....Yeah. But my fiance, he raped me. I wanted to wait until after. He did rape me, so. It was one thing after another after another.

Traditional Gender Norms & Community Influence on Upholding Norms

Socio-cultural norms for women in the DRC are traditionally gendered, with general expectations for women to marry at a younger age and produce many children (Muanda et al., 2017; Costenbader et al., 2019; Steven et al., 2019). As Uwiringiyimana, a Congolese author and activist, writes in her memoir:

My parents met for the first time on the day of their wedding—an arranged marriage. Whenever I ask them about it, they describe it very matter-of-factly. It's not as if they had a courtship or romance. At the time, my mom was just fourteen years old. She had completed five years of school, which was considered a lot of education for a girl in those days. Typically, after five or six years of school, girls simply dropped out, because there

seemed to be no point in continuing their education: Their fate was to marry young and produce children. My dad was eighteen years old, just finishing high school...For my young parents, it wasn't really up to them. It's just the way things were done. (Uwiringiyimana, 2017, p. 8).

The reason behind having many children is due to several, overlapping factors. The first and often largest reason is economic. It is common in rural settings to have many children where more children meant more physical labor for agrarian-based family income. This physical labor helps cultivate more crops, yield higher returns, helps feed more family members, and equally important - it acts as old-age insurance for parents with reciprocal expectations to be economically taken care of by their children in their older years.

In Congolese culture, another reason for having many children is to adhere to religious doctrine to multiply and prosper. The DRC is a predominantly Christian country and high fertility rates are seen as a sign of religious blessings - marking the family as wealthy and physically healthy. A recent study showed that even Congolese families that used contraceptives still expressed a desire to have large families, citing religious and economic value for high fertility rates. "Parents viewed children as a gift from God. They intended to have many in the hope that at least one would survive, be able to go to school, and help them financially in the future" (Muanda et al., 2017, p. 1014). Since children are seen as a sign of social capital in the DRC, it can be devastating if, for any number of reproductive-based reasons, women are not able to have children. They may therefore be seen as not fulfilling their familial and social obligation. As Uwiringiyimana explains in her memoir, her mother's reproductive challenges resulted in being socially outcast:

[Following the wedding,] it was my mom's job to get pregnant. That was a woman's duty: to marry and bear children. But her young body wasn't ready to carry a child. She had two miscarriages, and people began to whisper, saying that if she couldn't have children, it must be due to witchcraft. Her in-laws shunned her for not performing her job. My mother had a very difficult time in those early years of marriage; she was a

teenage girl, ostracized by the adults around her. But she was also very strong willed, determined to rise above the people who made her feel small. In time, she managed to give birth to my oldest brother, Heritage. After that, she began having a child every couple years or so. I was the sixth (Uwiringiyimana, 2017, p. 8).

Finally, fertility in the DRC is not celebrated in the same way. While all children are seen as social capital, there is more value in the patriarchal society to having male heirs to pass down family names and wealth. Female children are seen as domestic and physical labor until their families can collect a dowry for their hand in marriage. As Uwiringiyimana recounts, this Congolese cultural gender norm has always confused and angered her:

In my culture, having a lot of kids was a symbol of health and wealth, unless the children were all girls. Girls were basically seen as useless. This has always struck me as odd. The women in our culture are known for working incredibly hard, juggling so many things—raising the children, working on the farm, harvesting, fetching and chopping firewood, and then cooking dinner for the men. Traditionally, the women prepare the meals and the husbands eat alone, or with their male friends, not with their wives. It makes me cringe, but that is the culture (Uwiringiyimana, 2017, p. 8).

In the DRC, decisions regarding family health and finances are generally made by the husband, which is seen as a direct barrier to women accessing sexual and reproductive health (SRH) services (Steven et al., 2019). This is in addition to the stigma that husbands can impose on wives who have experienced sexual assault or rape, a stigma that can be reinforced by community members and community leaders, individuals who have social clout, especially in rural communities (Babalola et al., 2015). For example, a study in rural DRC on contraceptive use by community women “indicated that both husbands and community members played a significant role in reinforcing unequal gender norms and influencing women's individual SRH choices; results indicated that conservative attitudes expressed by community members and partners dissuaded women from utilizing contraception” (Steven et al., 2019, p. 2).

In recent years, humanitarian and aid agencies have recruited the assistance of faith leaders to leverage their social clout as “key entry point[s] into an entire community” to alter

social views on key sexual health and safety issues. For example, a study completed between 2015 and 2017 in the DRC used these partnerships with faith leaders to promote norms of gender equality and decrease social tolerance of intimate partner violence (IPV) as a form of strategic intervention strategy (Le Roux et al., 2020, p. 17).

Anti-Rwandan Ethnic Tensions/ Ethnic Territoriality

According to Engjy, certain characteristics of her physical appearance would sometimes cause others in the DRC to think that she was Rwandan, and specifically of the Tutsi minority ethnic group. This is because members of the Hutu-majority and Tutsi-minority ethnic groups in Rwanda would sometimes be identified by physical characteristics based on racist ideologies that date back to early colonial days when German and then Belgian colonialists claimed that the Tutsi were “racially superior”. The European colonialists believed them to have "Hamitic" origins from Caucasoid invaders from northern Africa and thus, they claimed that the Tutsi had more advanced intellectual capacities than the local Hutu, a largely agricultural people of sub-Saharan African origin (Baisley, 2014).

Being that Engjy grew up in Goma, the capital of the North Kivu province of the DRC that borders Rwanda, and that members of the Hutu-led government were largely the perpetrators of the 1994 genocide (aided by Hutu-led and other militias and neighboring Hutu groups), this false distinction led to several grave incidents in Engjy’s young adult life. This is compounded by the fact that many rebel forces directly involved in both Congo Wars and the protracted Kivu conflict are Rwandan and were in the DRC over their claims to indigenous, pre-colonial lands and corresponding natural resources that are now geographically (per Western, colonial-drawn state lines) located in the DRC, among other claims and reasons for involvement. As such, anti-Rwandan-fueled ethnic tensions and ethnic territoriality are charged in certain regions and

communities in the DRC. Specifically, among some members of the Congolese government and insurgent forces and among local, rural Congolese populations who have been pillaged by Rwandan forces in the past and/or continue to be.

Engjy recounts being mistaken as Rwandan growing up...

E: What's going on now is crazy, you can't really understand why they keep killing each other, killing people, you know? They claim that they want to help the nation but they are not. Because they are killing civilians.

J: Right, in the towns where these natural resources are?

E: Yes.

J: And raping them as a weapon of war?

E: Yeah, especially that. And in Kinshasa, as I was trying to say, when he decided to chase away the Rwandans, it was really scary because for us, we look like Rwandans. But we are not, you know?

J: Why do you think that you look like Rwandans?

E: Because of my nose. That is what they always tell me. I look like Tutsi.

J: Really?

E: That is what they always tell me.

J: Who tells you that?

E: In Congo. So many people were seeing that and thinking that. I was like, I'm not.

Several years later, this common mistaken identity would lead to events that would indefinitely alter the trajectory of Engjy's life.

Patriarchal Power Structures & Sexual Harassment

*Sexual violence is an act of gendered violence and must be understood as an expression of power and domination based on configurations of gender ideas that justify or naturalize it (Bourke, 2007; Carpenter, 2006). **It refers to the form of violence inherent in behaviours, norms and attitudes based upon gendered power relations (Lang, 2002:2).** Hence, the violence and the inequalities that women face in conflict are part of a*

continuum of violence, discrimination and marginalization that they face in peacetime (emphasis added; Sahin, 2021, p. 6).

Engjy's early-adult life in the DRC, during and between the First and Second Congo Wars, was riddled with instances of patriarchal, gender-based sexual harassment and assault where men in her life with power over her leveraged this dynamic with attempts at sexual exploitation. Yet, as Sahin mentions above, Engjy's sexual assault is a continuation of gendered social norms that have always existed in peace times and war times in patriarchal societies. Sexual assault during war is an amplified form of the standard patriarchal power over women that has always been there - a fundamental component of social female subjugation. As Brownmiller argued in her groundbreaking 1975 opus, *Against Our Will*, rape is a means of exerting patriarchal power over women. Rape is "nothing more or less than a conscious process of intimidation by which all men keep all women in a state of fear" (Brownmiller, 1975, p. 12).

Anthropologists have problematized this issue in the past - this disconnect between the idea that rape in war is seen as inevitable. Brownmiller addresses this falsehood by arguing that rape in war is different from other acts and outcomes of war - it is a byproduct of a *pre-existing* war on women: "But rape in war is qualitatively different from a bomb that misses its military target, different from impersonal looting... different from deliberate ambush, mass murder or torture during interrogation, although it contains elements of all of the above. Rape is more than a symptom of war or evidence of its violent excess. **Rape in war is a familiar act with a familiar excuse**" (Brownmiller, 1975, p. 24). She goes on to explain that war is instead a type of conduit with the "perfect psychologic backdrop" to allow men to "give vent to their contempt for women". She elaborates that the overly masculine nature of the military structure and culture normalizes this notion of women being inferior and thus rightful subjects to such dominance. Therefore, rape in war is a form of control of women that upholds the norms in a patriarchal

society that says that women are peripheral almost non-humans to be conquered just as with new territories, ideologies, and peoples (see more on the Anthropology of Rape in the Introduction).

After she fled her abusive fiancé, Enjgy enrolled herself in University courses in Kinshasa, the capital of the DRC. There, while making progress in her coursework in medical studies, she soon realized that good grades were expected to be exchanged not for her merit but in exchange for sexual favors to her professors. Further, this sexual harassment took the form of sexual advances and expectations from both her university teachers *and* a male family friend, a friend of her father's, that was paying her school fees.

E: And I went to Kinshasa [post-fleeing fiancé]. I stayed with a friend of my dad. There was a family friend. By then I was studying, I was doing medical studies. But I couldn't finish. Why? Because I was pretty.

J: Because you were pretty?

E: Yes. Like the teachers would want sex to give me my marks.

J: Oh my god.

E: I went to enroll myself to school. And then I started school. But the other problem was, I can see being pretty, because teachers like professors, they were like asking for sex so they can give me my good marks. And when I say no, they just give me whatever they wanted. That's why you'll see for example, I had an 8 out of 20 in mathematics, I had any 10 out of 20 and, was it biology I think? Yet, those are things that I am really strong in.

And then the first year, I escaped. In a way, I finished the year, and I was promoted to the second year. But the second year, it was like really difficult. Because almost four professors were after me. And all of them would invite you to their office, you know? It's like a consultation room period and they'll tell you, you go there, I want to consult you. And that means, I want to have sex with you....And then I was like, I can't continue like this. So I quit. I was like, I will not do that anymore.

This harassment also came from a male family friend who paid her school fees as, what was assumed at the time, a favor to her due to his closeness to her father. It was soon revealed thereafter, however, that in the sponsor's eyes, this was a deed for which he expected reciprocity.

E: He also wanted sex. For him to continue paying for my studies.

J: How did he tell you that he was interested in that?

E: One day, he invited me over. There was another girl who was there. And he said, you see her, she will go to France because she accepted to do everything that I told her. Along with sleeping with me.

J: And he said it outright like that?

E: In front of her! I think his wife was staying in the US. I think.

J: H was wealthy?

E: Yeah, he was wealthy.

J: He [was an ambassador of sorts]?

E: Uh-hm. Or work [...] with other ambassadors. Things like that.

J: Your father was very well connected.

E: Yes, he was. Because he had a lot of money before. Before the war.

J: How did you react in the moment? Like what did you say?

E: I was like, is this a joke? [Laughs]

J: Right?

E: He said no, I'm serious. He showed me a bag, full of money, of dollars. A briefcase – big like this [gestures at large size]. Full of money. Like bricks of money.

J: He had it for you?

E: He told me, go downstairs and check in that drawer, you will find a bag. And he said, it will be yours if you decide to sleep with me.

J: You decided to go down and look at it?

E: Of course I went down because I didn't know what it was. I just went. And when I came back, he told me, if you accept to sleep with me, that bag is yours. And I was like, you can't buy me.

J: Good. Good.

E: No matter how much it is. I'd rather be poor than take this money. You are like my grandfather, like really, seriously.

J: How old was he?

E: I was like 20. 19 or 20, yes. I was the same age as one of his granddaughters, imagine?

J: He was like 70s?

E: Or 60s.

J: And this other woman also lives with him?

E: No, she just came. Had fun. And then she went to the university with money.

J: OK. And he wanted to do that with you too?

E: Yes. With me too. And then I said enough is enough, if one day I will go back to school, I will do it with my brain, not giving my body for good grades. No, I refuse to go back. Other people were saying that I was stupid.

J: That you should have done it? Because you would have been paid?

E: Yes. Then I was like, I can't. It's against what I believe in.... I could not live with myself knowing that...that is like being a prostitute.

J: A paid girlfriend.

E: Yeah.

J: How much school had you done up until he asked you about this?

E: I had finished the first year and I was in the middle of the second year.

J: Why do you think he waited that long to ask you after paying for a year and a half already?

E: I don't know. I really don't know.

J: What was the reason he originally gave for offering to pay? For you to go to school.

E: No, he was like, I'm really pretty. He really liked me to have some kind of relationship that was different from the one that we had. And I was like, really?

J: At the beginning, right before you started school, and he was like, I'll pay for your school. For that year and a half, what was his reasoning for paying? Because he hadn't proposed that yet, right?

E: No. He was grateful of what my dad did for him. And he wanted to help out. But then, I think he wanted more. Then he was offering. And for other women, they can accept, but for me, no.

J: You said I have morals and ethics?

E: Yeah. I did refuse so many things....So I'm glad I made them because it defined who I am. I'm not corruptible. I'm not someone without morals.

After being forced to drop out of university due to ongoing sexual harassment from multiple men in her life, Engjy moved back to Goma, where her family lived, and found a job at a local restaurant.

Intersectional Gender-Based Violence

Gender-based violence (GBV) in conflicts in the DRC derives from systemic patriarchal violence in the DRC (Heise et al, 2002; Baaz and Stern, 2009; Beyene, 2014; Glass et al., 2019; Krause, 2021; Sahin, 2021). In her book, *Sexual Violence Crimes and Gendered Power Relations* (2021), Bilge Sahin explains that “the attention given to sexual violence crimes in the DRC has led to the country being labeled ‘the rape capital of the world’ (UN News, 2010), and both international organizations and international NGOs have documented these acts of violence in a number of reports [such as Amnesty International, 2004; Dolan, 2010; HRW, 2002; Women for Women International, 2007]” (Sahin, 2021, pp. 3).

In the Kivu region specifically, armed Congolese government forces and armed militant groups trying to state a claim over regions, resources, and peoples in the Kivu region employ gender-based violence to humiliate, show dominance, and promote superiority of sex, ethnicity, class, politics, etc. over others. One study by Baaz and Stern (2009) looked at the rationale given by Congolese military soldiers as to why they believe rape occurs. Dominant discourses in the

soldiers' responses distinguished the difference between "lust rapes" and "evil rapes", with an emphasis on the ties between rape and masculinities, which the researchers link to "the increasing globalized context of soldiering" where "rape becomes possible, and even 'normalized' in particular warscapes" (Baaz and Stern, 2009, p. 495). Specifically, the researchers found frequent mentions of justifying, even normalizing, sexual violence in an effort to attain a level of unattainable masculinity.

...the soldiers explicitly linked their rationale for rape with their inabilities (or 'failures') to inhabit certain idealized notions of heterosexual manhood. The soldiers posited the discord between their embodied experiences and their expectations of themselves as soldiers (men) in the armed forces as a site of frustration, anxiety, negotiation and an underlying incitement to sexual violence (Baaz and Stern, 2009, p. 497).

In addition, while existing research confirms this link between GBV in conflict zones and structural patriarchal violence, recent research on the topic has gone beyond this link to intersectionally explore the colonial and racial histories that influence GBV in conflicts in East Africa (Baaz and Stern, 2009; Beyene, 2014). For example, in her research of colonial genealogy of violence against Tutsi women during the 1994 Rwandan genocide, Helina Asmelash Beyene found that

...highly sexualized colonial ideologies such as the Hamitic Hypothesis, not only marked the Tutsi population as non-indigenous, non-black invaders, but also codified Tutsi female sexuality and fertility as a beguiling, non-indigenous threat to the natural population of the land.

The colonial era provided the lexicon that staged Tutsi sexuality within the blueprint of African indigeneity, which the post-independence Rwandan state reassembled in its discourses surrounding overpopulation, refugees and national security. Such discursive consolidation positioned Tutsi women's sexuality as biopolitical threats to the national security of the indigenous population, making them high stakes targets in state crises (Beyene, 2014, iii).

Thus, similar to the false narrative-weaponizing that has happened in recent years in the nearby Kivu region largely over the social, political, and economic issues of refugees, national

identity, and indigenous rights to land, female members of the minority Tutsi ethnic group were given a false narrative as wielding their dangerous sexuality and fertility that is framed as jeopardizing the safety and sovereignty of a majority ethnic population. This sexist and racist propaganda has and continues to be used to fuel acts of sexual violence by numerous government, militant, and other groups and individuals operating in the DRC as they pillage local towns, rape and sexually violate local populations and leave in their wake devastating trauma, mental health disorders, sexually transmitted diseases, children of rape, and forced displacement.

Sahin (2021) also notes that we must examine GBV in the DRC in the cultural and social contexts of patriarchal power relations/masculinities and in the context of ongoing national/ethnic tensions. For example, she states that while local Congolese populations “prefer to believe that crimes of sexual violence are committed, not by Congolese armed men, but by foreign armed groups who came from Rwanda, mainly *Les Forces Démocratiques de Libération du Rwanda* (FDLR) (Bosmans, 2007:4; Kelly et al., 2011:288)...”, statistically, most armed groups are guilty of perpetrating these crimes (Sahin, 2021, pp. 4-5). Most survivors of sexual violence describe their attackers as “armed men” as there are well over a hundred armed groups and individuals, both foreign and Congolese, who are currently in the DRC (Sahin, 2021, p. 5).

Engjy’s targeted life history interview responses show us that her experiences with GBV in the DRC are entangled with anti-Rwandan sentiment, rooted in nationalist and racist ideologies by armed government forces, patriarchal violence, and masculinity norms (Waiganjo, 2018). Below, she recounts a salient memory and profound moment in her life that illustrates this intersectional violence.

E: But unfortunately for me, one day, it was some Rwandans, like M23, like the rebel group, they came into Goma. And the soldiers were looking for them in the houses. That

day I was going to work, because I was working at a restaurant just to, you know, make money and also have something to do, you know? That day, I was supposed to cook for a wedding. I went very early, it was around 5 am that I left home. And I was going to take the bus, from where we were staying to the bus it's like [1/2 a mile]. and on the way, I saw those soldiers. They made me stop...

J: In the bus? You were on the bus?

E: No, I was on foot. They made me stop. They were asking me, they were saying like, hey you, do you know where the M 23 people are? And then I was like, no I don't. And they were like, 'you should know because you look like a Rwandan and we know that they are staying in Rwandan houses'. Then I was like, I don't know and I'm not a Rwandan. I'm Congolese. And then they were like, no, you only say that. And I was like no, sincerely, I'm not. My grandfather is Indian. And then they started laughing. When I tried to go, they were like now, come here. Then they threatened me with a knife and a gun, you know? It was one by one, I screamed. And no one came to my rescue. No one. It is very difficult for me. Very. And at some point, I was like why am I even living, you know? Because it was too much. And it's never stopped, you know? It's like, sometimes I was like, am I cursed or what, you know? And I got pregnant.

J: And it was three soldiers?

E: Four.

J: And it was in public where this was happening?

E: Outside. Like on the street.

J: Because they thought you were hiding soldiers?

E: Yes. Yet I didn't know. I had no idea.

Military Gang Rape

Rape by armed forces, specifically military gang rape, in the DRC is a common practice, rooted in a culture of patriarchal violence, sexism, masculinity, and nationalism. The Congolese government forces, the *Forces Armées de la République Démocratique du Congo* (FARDC), are the largest perpetrators of sexual violence in the DRC due to their vast size and disbursement across the DRC. Both FARDC soldiers and commanders are guilty of committing these crimes. The systemic sexual violence committed by these forces include “gang rapes, rapes leading to

injury and death, and abductions of girls and women. Their crimes are serious violations of international humanitarian law. Commanders have frequently failed to stop sexual violence and may themselves be guilty of war crimes or crimes against humanity as a consequence” (HRW.org, 2009).

Bartels et al. (2012) completed a review of patient records from 4,311 sexual violence survivors between 2004 and 2008 to study patterns of sexual assault in South Kivu. The results showed that the majority of the assaults were committed by both national and foreign-armed military members and that the methods of sexual assault differed from the sexual assaults by civilians. They found that of those surveyed, 60% of the reported rapes were gang rapes, almost all by armed combatants, with a methodological pattern being frequently reported of being “encircled by a group of men and then attacked” (Bartels, 2012, pp. 349).

Further, the implications of gang rape in particular on a woman’s mental, sexual, and reproductive health are manifold. Showing salient similarities to Engjy’s experience, Bartels’ ethnographic research in the DRC among survivors of gang rapes reported:

Some narratives provide detail about women being restrained by a group of men who each take turns assaulting the victim. More often, however, narratives simply state, “. . . then they took turns raping me.” This high prevalence of gang rape is significant since the odds of contracting sexually transmitted infections (STIs) or HIV naturally increase as the number of assailants increases, as does the chance of becoming pregnant.

Similarly, we believe that the risk of serious physical injury likely increases with multiple assailants and that women are probably at higher risk for genital trauma, fistulas and bodily injury as a result. Such a high proportion of gang rape speaks to the widespread acceptability of sexual violence among armed combatants in South Kivu (Bartels, 2012, pp. 350).

Compounding Barriers to Women’s Healthcare Access in DRC Conflict Zones: Lack of Reproductive Healthcare Options for Rape Survivors, Ongoing Epidemics, & Natural Disasters

J: And what did you do after that?

E: So, when they left me there, there was some women who were going to church who came, like they were passing and they saw me and I was like crying. I was like destroyed, like I was in very bad shape. They took me to a clinic, to the hospital. But they forgot to give me, you know, it is a pill?

J: The morning after pill?

E: Yes. They forgot to give it to me.

J: And you didn't know you had to have it?

E: No. I didn't know...

As Engjy's account above exemplifies, access to timely and complete healthcare needs of survivors of sexual assault and rape in the DRC is complex. With the protracted insecurity in the Kivu region of the Eastern DRC, compounded by restrictive abortion laws and sociocultural stigmas, public health providers are extremely limited in their capacities and resources to provide essential maternal and sexual healthcare (Babalola et al., 2015). Further, many international and humanitarian health organizations have had to evacuate healthcare workers as the security situation in the DRC is too dangerous (Hogg, 2019; Rohan and McKay, 2020). This issue is compounded regarding access to specialized and time-sensitive healthcare for victims of sexual assault and rape in this region (Tran et al., 2021).

A pressing issue resulting from the high prevalence of militarized rapes and gang rapes in the DRC is that abortion access is extremely restricted, "permissible only to save the life of a woman". For this reason, "women may seek services through unskilled providers and/or use unsafe methods of termination" (Scott et al., 2018, p. 7). Another layer of the human rights injustices from rape as a strategy of war in the eastern DRC is the lack of emergency reproductive and/or sexual health care, including access to timely and complete rape kits, emergency contraception, prenatal care, mental and physical trauma emergency care, and management and treatment of sexually transmitted diseases spread from rape, among other.

This lack of access to quality, comprehensive care has been compounded by existing healthcare resources focused on the ongoing public health crises of Ebola and cholera epidemics in the Kivu regions in recent years (Muisyo, 2021). (Details on the ongoing Ebola epidemic in the Kivu region above in Section 1).

Cultural Stigma of Rape & Social Repercussions for Victims and their Families

In the DRC, girls, women, and elderly women can be blamed for being raped, accused of encouraging the sexual act, by direct family members and/or by members of their communities (Kelly et al., 2017). This is a major factor that leads many rapes to go unreported (Mpinga et al., 2017, pp. 582), especially in more rural communities with stronger cultural stigmas against sexual assault and/or with less access to support agencies and medical care facilities (Ussher et al., 2017). In reaction to this social ostracization and to avoid future prejudice, families can feel the need to marry off these female family members.

In other cases, women are personally compelled to and/or are forced to leave their families and/or communities as a means to avoid stigma for their families and/or communities, but also as a means to find a safer environment, though fleeing alone is also accompanied with complex complications and issues with safety and security. As Engjy recounts, her mother's reaction to Engjy disclosing being gang raped by four soldiers and impregnated was a combination of disbelief, shame, and rejection, leaving Engjy no choice but to vacate her mother's house and temporarily stay with her employer and friend while she figured out what to do in the meantime.

J: You didn't flee immediately?

E: No. I was still in Goma.

J: You went home and told your parents what happened?

E: I didn't tell my parents. Because my mom if she knew, she would chase me out of the house. And that's what she did when she found out.

J: How did she find out?

E: Because I was having morning sickness. And then I don't know who told her period like I never understood who told her period so she was like, I suspect you, you must be pregnant, you know? And then when I admitted that I was pregnant, it was like...

J: But you were like mom, you don't understand how it happened ...

E: And then she was like, I'm lying, she didn't believe that it happened to me. I was like, you know, the only thing that I could do was to go and live in another place. I went, my boss took me in. I was staying with her.

The rape of a female family member can bring shame and dishonor to the woman and to their entire families, with the overarching goal of cutting off the family from its community, thus deteriorating communal bonds and support structures between victims, their families, and their respective communities (Bartels et al. 2012, p. 350). A 2011 mixed methods study of 255 female survivors of sexual violence in eastern DRC by Kelly et al. revealed that 28.5% of women were rejected from their families and 6.2% by their communities (Table 1). As Kelly et al. explain, “Family rejection means that a woman is told she can no longer stay in the home of her husband or parents. In the case of community rejection, women are ostracized by peers to such a degree they feel forced to leave the community” (Kelly et al, 2011, p. 4).

In terms of the community rejection, the stigmatization was characterized by

... ‘gossip or finger pointing’ (*kushota kidole* in Kiswahili), which intensified survivors’ feelings of shame and humiliation. Women described how often local mores created an environment conducive to the stigmatization of survivors: customs that had previously been directed towards female adulterers were now applied to victims of rape. Women who have sex outside of marriage, whether voluntarily or by force, were perceived to bring misfortune to the household (Kelly et al., 2011, p. 4).

Lack of Justice for Sexual Violence Survivors in Patriarchal DRC Society

E: No. I didn't know. I called my boss. I told her what happened. And she comforted me and she told me in case of any problems, don't forget that I'm here for you, you know?

She is like a big sister that I never had. She was really nice. It was very difficult. And when I found out that I was pregnant, it was, like I almost died with pressure. Like my blood pressure...

J: And she, your boss was like a caterer?

E: Yes, like a catering service. Because it was a restaurant, one of these days, one of those soldiers came there to the restaurant.

J: The same one?

E: Yes! And my tummy was already showing up, you know? And they were like, we remember you. Like one of them was like, I remember you. And, is that our baby? You know? And after that, he started saying that I should go and live with him because I am pregnant and they don't want me to go and say that what they did to me. I have to go and live with them.

J: With one of the four?

E: Yes. And be their wife. Then I was like, never. I would rather die than do that. Then he started threatening me.

J: This was at work, at the restaurant?

E: Yes! Then he started sending street kids to throw rocks at me. One day, he was following me and I had to go to Gisenyi, just to hide. Because I knew he was a policeman, a soldier, and he cannot just cross the border. So I crossed the border.

J: Okay. Gisenyi in Rwanda?

E: Yes! Because I didn't want him to know where I was staying.

J: Wow. You originally fled to Rwanda?

E: Not really. It was just a one day thing.

J: Oh, one day? And then you came back?

E: Yes. And then I came back. But then when it was too much, I said I just need to get away from this. And my boss was like, I don't know how I can protect you anymore. Because I went to, it was a police force. It was a new police force. Which was dealing with women who have been abused and raped. I went there, they issued a warrant to arrest him, but they arrested him but he was released because he was a best friend of the higher ranked officer there. They released him.

J: Pointless.

E: Very pointless.

J: And putting you in further danger.

E: Yes. And that is why I had to run for my life.

In addition to the lack of reproductive health justice for survivors of sexual violence in the DRC, there is a distinct lack of social justice for sexual violence survivors. While sexual violence crimes in the conflict areas have, more so in recent years, had the valuable though limited attention and support of international agencies, severe structural issues in the Congolese justice system, heavily influenced by the patriarchal Congolese culture, remain. “Survivors of sexual violence crimes are often disappointed with the decisions of the courts and express that their needs are not addressed through these legal processes” (Sahin, 2021, pp. 2.)”.

Furthermore, the Congolese military justice system specifically operates by a system of patriarchal social norms. Similar to what Baaz and Stern (2009) argue in their analysis of masculinity ideologies driving militarized rape, in addition to male officer-condoned and perpetrated military rape, the Congolese justice system is similarly built on this patriarchal social structure where, while not outright condoning rape, it creates an environment where it is essentially acceptable, though publicly frowned-upon, social behavior.

As exemplified in Engjy’s experience above, this patriarchal system is further supported by a type of “good old boys club”, where when rapists, generally by members of the Congolese FARDC military forces (HRW.org, 2009), *are* arrested for rape, there is limited, if any, punitive action and thus, justice is rare. For example, “during 2008, 27 soldiers were convicted of crimes of sexual violence in North and South Kivu provinces. During the same year, the UN registered 7,703 new cases of sexual violence (by army soldiers and other perpetrators) in North and South Kivu” (HRW.org, 2009).

This patriarchal structure underlying the Congolese social justice system is further highlighted by the fact that there is a direct correlation between reported FARDC rapists who do receive punitive action and increasing hierarchical military rank. More explicitly,

... almost all military prosecutions of sexual violence to date have focused on lower-ranking soldiers. No senior military figure has been prosecuted for sexual crimes; the criminal responsibility of senior officials, including their command responsibility, is rarely the subject of investigations by military prosecutors.

The most senior officer convicted of crimes of sexual violence in the Kivus has been a captain-no major, lieutenant colonel, colonel, or general has been prosecuted. Military commanders continue to be powerful figures who are treated as untouchable by political and military leaders; brigade commanders in particular are often given free reign. Commanders also continue to protect their soldiers in many instances, obstructing the course of justice. This undermines ongoing efforts to render justice even for crimes committed by lower-ranking soldiers (HRW.org, 2009).

Finally, the ongoing systemic sexual violence in the “rape capital of the world” has undoubtedly captured the attention of international organizations, foreign donors, and international nongovernmental organizations (INGOs) around the world. Efforts to support survivors, though well-intentioned, can do more harm than good as their definition of justice is influenced by Western ideologies and social justice norms and standards. The focus of these groups is often on policy regulation, exploiting one-dimensional survivor narratives at will, to achieve these goals. Thus, support efforts often do not include pivotal, evidence-based stakeholder input from the Congolese women they are meant to serve. As one of the survivors interviewed on this topic recounted:

We [Congolese women] do not only want justice, but we also want to be heard. All they [international actors] know is Congolese women are raped, all they mention is how unsafe we are, but they don't mention how we fight, how every day we still have to go to the markets and sell. I got tired of being a victim, I wasn't a victim because I had to wake up every day, there was no one holding my hand, or telling me things would get better, why would I want to be a victim? (Name removed for anonymity; Sahin and Kula, 2018, pp. 309-310)

Therefore, this quest for justice must first begin by decolonizing the Western power structures at play that can do more harm than good when survivor narratives are reframed and dominated with a Western lens. Unfortunately, GBV continues in contexts of displacement during refugee flight, including in refugee camps in neighboring East African countries (Krause, 2021).

Conclusion

This chapter sets out to accomplish two things. First, it presented a comprehensive overview of the political, economic, and historic factors that either directly or indirectly affect the sexual, reproductive, and maternal health of Congolese women in the DRC in recent years. Secondly, it has provided vitally informative, qualitative targeted life history account from a woman who experienced multiple forms of rape and sexual harassment. Engjy's firsthand account is analyzed through the lens of the political economy of health and supplemented with data from studies, reports, and literature reviews to draw a more comprehensive picture of the intersectional forces that impact Congolese women's experiences with sexual and maternal health and healthcare in protracted conflict zones in the DRC.

The DRC has been traumatized by colonial and neocolonial predicaments that have made the lives of its citizens highly vulnerable. Congolese women, and especially survivors of sexual violence, face compounding social and cultural barriers and pressures in their experiences with sexual, reproductive, and maternal health and in accessing quality, comprehensive healthcare. These barriers come from likely sources, such as a lack of access to healthcare or justice in the Congolese patriarchal society, conservative religious mandates, traditional gender norms, and the militarization of rape by armed government forces, but also from lesser-known or unlikely sources such as by colonial-bred sexism and racism of regional ethnic groups (Waiganjo, 2018),

a Congolese civilian population that blames gang rape on other militant groups when their own military forces are by far the largest perpetrators of such war crimes - some trained by the US military (Whitlock, 2013), and Western aid agencies unilaterally seeking a Western-defined justice for Congolese women without stakeholder input.

Thus, as mentioned throughout this chapter, and inevitably throughout this dissertation, if we are to comprehensively understand and support Congolese and any refugee women who are living in Western contexts, we need to examine, to the best of our limited capabilities, the full, complex, and nuanced picture of where they come from and where they have been before and after arriving in their present locations. The lens of the political economy of health is, in my opinion, the best tool for that task, in conjunction with key theories that will be introduced in subsequent chapters.

In Chapter II, I will trace Engiy's targeted reproductive and maternal health and healthcare experiences, like many other Congolese women fleeing the DRC, in displacement contexts. This chapter will roughly follow the same template by first examining the broader economic, political, and key historical factors and contexts of life in displacement for Congolese and East African refugees, and then focus on life-history-led experiences and broader studies that reveal the lesser-studied social and cultural factors that equally impact these experiences. Additionally, Chapter II will also layer in additional theories and qualitative data from other resettled Congolese refugee women that I interviewed, adding new perspectives to consider in the ultimate goal of informed, comprehensive support for displaced and Western-resettled Congolese and other refugee women.

Chapter II: Experiences in Contexts of Displacement Outside of the DRC

Overview

Chapter II focuses on the sexual, reproductive, and maternal health and healthcare of Congolese women in displacement contexts. This chapter largely continues to employ the perspective of the political economy of health for data analysis and follows the same format as Chapter I. Section I begins with a brief, broader history of the anthropology of refugees. Then, it will present select broader political and economic factors around displacement contexts in East Africa - on life in refugee camps and general displacement conditions as experienced by East African and Congolese women.

In Section II, I share the experiences of Engjy from her targeted life history as she flees the DRC and resettles in neighboring Uganda, not as a registered refugee, but as a temporary Ugandan citizen for various reasons which I discuss. This chapter will also include the addition of displacement experiences of resettled Congolese women from my semi-structured ethnographic interviews with them. These women were forced to flee the DRC to neighboring countries, and, unlike Engjy, did register as refugees with the UN and other agencies. Therefore, these perspectives will provide additional, critical health and healthcare perspectives from their time, sometimes as long as decades, living in refugee camps.

Collectively, the qualitative data presented in Section II from Engjy's targeted life history and from the semi-structured interviews will add invaluable, intersectional historical, social, and cultural perspectives and context, with the information from Section I, to enable a holistic political economy of health analysis. This analysis is supported by additional information on this topic from reports, studies, and literature reviews to provide a population-level perspective. Where applicable, I also utilize the theories of structural violence and cultural hegemony to

analyze aspects of the women's lived experiences with sexual, reproductive, and maternal health and healthcare in displacement contexts.

Please note: As I hope my research has shown thus far, refugee flight and migration is a vast, nuanced, and ever-changing topic that requires close, intersectional analysis. Given the already broad scope of my research in this chapter on refugee displacement, focusing on the experiences of displacement outside of the DRC from the perspectives of registered refugees and of someone who was externally displaced, I only cover a brief background and history on a third common type of displacement in this chapter: internal displacement.

Internally Displaced Persons (IDPs) account for the largest population of displaced Congolese individuals from the ongoing conflict in the DRC, with approximately 5.5 million IDPs living in the DRC in 2022 (UNHCR DRC Data Portal, 2023). For these reasons and others, there is still a great deal of vital, intersectional research that needs to be done to better support these Congolese populations, and especially female IDPs. These women are still living in conflict zones in the DRC after being ripped from their homes, families, and communities to avoid various forms of violence.

I: Overview of Refugee Studies and Displacement in East Africa

History of the Study of Refugees

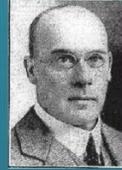
There are two tracks in the study of refugees. The first is the analysis of what has been happening with mass migration and refugee movements over time. The second is the anthropological/social science analysis, with respective theories, of refugee movements. The second track largely came later in the 1980s (details below). In between these two tracks are the fieldwork,

PIONEERING SCHOLARS* IN THE FIELD OF REFUGEE STUDIES

1938

SIR JOHN HOPE SIMPSON

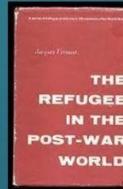
Simpson's *The Refugee Problem* was a robust survey which sought to examine the geographic parameters of refugee study. Focused on refugee groups being assisted by League of Nations or under consideration for assistance. Omits Chinese and South American refugees.



1953

JACQUES VERNANT

Argued that the legal definition of a refugee as one who lacks diplomatic protection does not include crucial displacement contexts. Said the political context of the country of origin must include *persecution* or the treat of it against oneself or ones community.



1980s

EARLY REFUGEE ETHNOGRAPHIES

Early ethnographic work on displacement and resettlement contexts include Loizos' *The Heart Grown Bitter* (1981) and Harrell-Bond's *Imposing Aid* (1986). Late '80s refugee-focused ethnographies began to cover multiple decades: Habarad (1987) and Hirshon (1989).



1992

DAVIS & ANTHRO. OF SUFFERING

Davis called for a subfield of anthro. to focus on the contexts of violence. Others agreed that there is violence in any social science issue which requires tailored methodologies and theories to analyze. Topics from this decade include circumstances of violence, how it is justified, and who are key actors.



1995

MALKKI & LIMINALITY

Malkki situates refugees in a protracted liminal state of statelessness in what she calls the Western world order of nation states. Leveraging Douglas' pollution, she argues that refugees are seen as pollution to a Western hegemonic orderliness of clear national borders. This leads to dehumanization and dehistoricization of displaced peoples.



2010

CARTER & AFRICAN DIASPORA

Carter studies the political economy of African diasporic movements. He cultivates the notion of the anthropology of invisibility, including social rejection and segregation. He studies Senegalese Muslims in Italy and the US.



2016

BESTEMAN & WESTERN RESETTLEMENT

Besteman's work with Somali refugees in Kenyan refugee camps and in Lewiston, Maine examines the complexities of secondary migration and Somali-Bantu experiences with discrimination by locals and within resettlement groups. She also critically examines aid agency promotion of narrative enhancement in exchange for resettlement.



*This list is by no means exhaustive. Many anthropologists and social scientists have and continue to add to and challenge topics in the study of refugees.

Figure 9: Infographic by Julia McDaniel (2022)

surveys, and development work that social scientists put out on refugee studies, such as in smaller journal publications (Eastmond, 2015). By the 1980s, with the advent of dedicated centers and departments for refugee studies, these data moved into the larger Anthropological and mainline publications (Pankhurst and Dessalegn, 2013). One of the historical catalysts in the 1980s for moving refugee studies into Anthropological literature was the 1983-1985 Ethiopian famine and hunger crisis which resulted in mass forced displacement. Further, Valerie Mueller's work (Pankhurst and Dessalegn, 2013; Mueller and Thurlow, 2019) based on the anthropological portrayal of Ethiopian refugees in the 1980s is an example of how dedicated research on refugees during the 1980's continues to contribute to contemporary refugee studies (Eastmond, 2015).

In an effort to situate my research on refugees in the context of the wider anthropological and social science literature, the following is a brief historical overview of the development of the formal study of refugees. Furthermore, the adjacent infographic timeline highlights just some of the many scholars and their respective work in the subfield of refugee studies within the social science fields.

The twentieth century has been referred to as the “century of the refugee” (Colson, 2003, p. 1). Scholars began to study refugees and displacement contexts in the 1920s following World War I which saw mass refugee movements. Subsequently, World War II resulted in roughly 60 million displaced persons, ten times as many as in World War I. This caused scholars to broaden their scope of study of refugees though they still largely focused on European refugees. Refugee studies became an established field in academia in the 1980s with dedicated centers, degrees, and publications. Of note, in 1982, Oxford University launched the Refugee Studies Programme and in the same year, *Refugee Abstracts*, what would eventually become *Refugee Survey Quarterly*,

began to aggregate published scholarly and academic literature on refugee studies (Skran and Daughtry, 2007, p. 15).

Once generally studied in the context of international migration, refugee studies were now conducted with a dedicated focus. Furthermore, the field could also be studied by or in conjunction with several disciplinary approaches as components to the field spanned the fields of anthropology, psychology, law, international relations, political science, geography, economics, and various others. Moreover, refugee studies also became a subdiscipline within various fields. In Anthropology, refugees and their contexts are examined by the subfields of policy and law, among others (Eastmond, 2015, p. 105). Historically, the establishment of the field of refugee studies was a product of its time with the 1980s seeing several global refugee crises. From 1979 to 1981, the number of global refugees doubled in size due to ongoing global conflicts.

By the early 1990s, the aftermath of the Cold War on Communist federations and the results of colonial political and economic degradation in former colonies resulted in still larger numbers of refugees fleeing from oppression and/or violence. Following the September 11th attacks in 2001, the wars on terror in the Middle East led to staggering civilian displacement and asylum applications to the Global North despite systemic discrimination faced by those of Middle Eastern descent (Eastmond, 2015, p. 105). In 2015, ongoing conflicts in Syria led to mass migrations to various European countries. Most recently, in 2022, the Russian invasion of Ukraine saw mass forced migration to neighboring Poland and into other Eastern European states.

East African Displacement Contexts

East African states have seen decades of post-colonial, geopolitical conflict which especially affects vulnerable populations, including poverty-stricken, systemically and

historically marginalized communities⁸. In 2016, the UN Refugee Agency reported that there were over 20 million displaced people in Africa (Owain and Maslin, 2018, p. 1, UNHCR, 2018). This statistic includes both refugees, individuals who have crossed national borders to flee violence, and internally displaced persons (IDPs), those who move within national borders to seek safety. In 2022, UN research found that there are more than twice as many IDPs than the already staggering number of refugees in the world - 26.7 million refugees and 53.1 million internally displaced people worldwide (UNHCR, 2022). Additionally, in 2019, roughly 5.2 million people in the DRC were long-term IDPs, mostly in the eastern provinces, including the Kivu region where there is ongoing conflict (Jacobs & Kyamusugulwa, 2018, p. 180; UNHCR, 2019, p. 30).

The protracted conflict in the Democratic Republic of Congo (DRC) is one of the most severe and longest global humanitarian and human rights crises of modern times. As of December 2022, there were 1,026,077 refugees and asylum seekers who were forced to flee the DRC (UNHCR DRC Data Portal, 2023). The ongoing violence has also led to a significantly high rate of internally displaced persons (IDP) of more than 5.2 million people. Of this internally displaced population, 2.9 million people were displaced in the eastern provinces in the DRC, the region of the ongoing Kivu Conflict, mainly Ituri, North and South Kivu and Tanganyika. This is the largest IDP crisis in Africa and one of the longest humanitarian crises in known global history. The crisis has been further compounded by the COVID-19 pandemic, ongoing Ebola

⁸ Which comes first - civil war or marginalization? Civil wars generally emphasize pre-existing social marginalization in a given society. In the case of the DRC and Somalia, it is a combination of factors that have led to political and economic instability that emphasize, perpetuate, and widen the disparity gap for already marginalized populations, especially for women. Before the civil unrest, these groups already lacked equal power in these societies, usually due to traditional gender norms and/or norms that promote patriarchal institutions. Once civil unrest grows to nation-wide conflicts, these marginalized groups are that much more vulnerable because they lack decision making power, access to resources/finances, and still live in societies where men have more clout in decisions regarding finances, housing, health (use on contraceptives, baby spacing, family planning, accessing routine gynecological care, etc.), which camps and/or countries to flee to, etc..

outbreaks, and grave food insecurity in 2020, affecting 15.6 million Congolese and leaving 4.7 million suffering from severe malnutrition.

Congolese individuals forced into flight, mainly from the eastern Kivu provinces, generally flee to neighboring Uganda (UNHCR RRRP, 2023). By November 2022, there were 473,529 Congolese refugees and asylum-seekers, or 46.8% of the Congolese population, living in Uganda. Other countries that Congolese individuals frequently flee to include Burundi, Tanzania, Rwanda, and Zambia. The percent of the Congolese population living in those countries as of November 2022 is, respectfully, Burundi (8.6%), Tanzania (7.9%), Rwanda (7.1%), and Zambia (5.6%) (UNHCR DRC Data Portal, 2023). Record numbers of Congolese local populations continue to be forced to flee from the protracted conflict and violence in the DRC, largely caused by political and economic instability and ethnic tensions linked to the effects of European colonial and Western neocolonial exploitation and degradation.

Brief Background: UN Refugee Camps & Politics of Refugee Camp Operation

In the context of my research and interviews conducted on refugee women's experiences with maternal health and healthcare while displaced in refugee camps in East Africa (this chapter, Section II), it is important to first understand some of the nuances of how this organization supports the operation of refugee camps in a given country. While the United Nation is, by and large, the most wide-reaching intergovernmental organization on the ground in many of the world's most precarious and high-risk conflict zones, the UN operates differently in each country - there is not a standardized approach. In most cases, UN officials work with national and local governments to understand the needed support for local displaced and/or refugee populations, as well as the policies and regulations that each country requires around the presence and operation of UN staff and materials.

This leads to various scenarios of UN involvement in refugee camp operations, from refugee camps fully run, funded, and staffed by the UN, including UN staff requirements to abide by UN mandates and procedures, to host government state-run refugee camps that only use materials and supplies donated by the UN, with that being the extent of UN involvement, and various other scenarios in between. While the UN will provide guidelines for services for refugees, in accordance with national and international laws and standards, in all cases, the host governments will make the final call on all aspects of refugee displacement care and services (Bulley, 2017). Thus, while a refugee camp may aesthetically look like it is fully run by the UN - iconic UN-blue tents stamped with the UN logo, staff members adorned with UN vests and jackets, educational supplies following a UN curriculum, and so on - the camp may be state-run and its policies and procedures may not at all align with those of the UN camps which supposedly follow UN-based mandates (Bulley, 2017).

In addition to the UN and its various funds, programs, and specialized agencies (i.e. UNHCR, UN Women, UNICEF, UNFPA, etc.), there are many other NGOs and INGOs working with the host governments and the UN to provide services for displaced populations and refugees on the request and guidance of the host country. This collaboration and specialized response care are especially necessary for hosting and caring for refugees from conflict situations as complex as the DRC with ongoing, compounding humanitarian, public health, and natural disaster concerns.

However, with more agencies (UN, NGO, INGO) and host government resources and regulations involved, as is the case for DRC refugees, this can raise the risks of security issues in both access to quality care and how it is delivered to female refugees while they are displaced in refugee camps. Understanding these nuances and power dynamics in refugee camp operations is

imperative when examining women's sexual, reproductive, and maternal health and healthcare in refugee camps. Policies and regulations of policies in all camps are very much informed by customs, traditions, cultural norms, systemic and/or historical ethnic discriminations, and any number and formula of other cultural and social factors.

Therefore, just because a camp is run by the UN, with the staff required to abide by UN policies or mandates, does not mean that that is the reality. For example, a study (Ngo and Hanson, 2018) of the ways in which UNHCR officers attempted to (1) understand refugee culture and (2) UNHCR staff's particular focus on gender equity programming showed clear discrimination and cultural biases from UNHCR staff members. This is in addition to the multitude of reports and studies over the years (Baz and Stern, 2013; Mudgway, 2018; Westendorf, 2020; Sahin, 2021) of the egregious sexual misconduct and violence by UN and NGO/INGO staff members in humanitarian settings where the most vulnerable are preyed on in despicable abuses of power from those meant to serve and protect.

Thus, there is allegedly more oversight at UN-run camps given the scale and power of the organization (UNHCR CCCM, 2021), in spite of a dark history of exploitation of power and systemic sexual abuse by UN staff members in countries of operation. Despite this heightened regulation, these cultural and social nuances can and do affect all aspects of women's sexual, reproductive, and maternal health and healthcare during their time, often the duration of their reproductive years, living in the camps whether the camp is run by the UN or not. This topic is mainly explored in Section II below. Furthermore, larger issues concerning UN narrative shifting (Besteman, 2016), Western nationalistic power dynamics (Appadurai, 1996; 2006), and the vulnerability of refugees in their liminal, state-less position in the Western world order of nation states (Malkki, 1995; Bulley, 2017) are explored in other chapters.

Who Defines Who and Why: Informal Settlement Dwellers (ISDs) versus Camp Dwellers

Another crucial nuance in refugee displacement migration that is often overlooked and which specifically relates to my research is the fact that many of those fleeing violence and crossing international borders do not, for various reasons, choose to be registered as refugees/go to refugee camps in displacement. In a portion of her targeted life history below, Engjy explains her own reasons for choosing not to be immediately registered as a refugee when she arrived in Uganda after fleeing the DRC, choosing instead to be registered as a Ugandan citizen upon arrival. While this is not always a personal option, in Engjy's case, her choice was influenced by personal experiences with Rwandan refugees in the DRC when she was younger in conjunction with her faith in her skills and personal resources to survive outside of the refugee camps.

It is therefore imperative that I, at least briefly, explain the generally acknowledged differences between informal settlements versus camps in displacement in regions of East Africa. Before that is embarked on, it must first be clarified that every host country has its own policies and regulations for each of these types of community and humanitarian residential structures, as well as respective policies and procedures as to the civil rights afforded to displaced peoples living within a host country's national borders. I will specifically focus on Uganda in this context as that is where Engjy was displaced and it also has unique refugee resettlement policies.

Neighboring the DRC, Uganda is largely considered the "best place in Africa to be a refugee" and is now the largest refugee-hosting country in Africa. This is due in part to its refugee policies that provide free social services, such as education and healthcare, and endorse "self-sufficiency" and "local integration" (Nara et al., 2019, p. 112). Furthermore, Uganda has an open border policy. The 2006 Refugee Act and 2010 Refugee regulations grant refugees

access to “land and public services; the right to work, establish a business, and own property; and freedom of movement...”.

In addition, South Sudanese and Congolese refugees are given protection on a “*prima facie* basis” which grants refugees the right to decide where to settle if they have family already in country (Khasalamwa-Mwandha, 2021, p. 4). Most displaced Congolese in Uganda either live in the Nakivale Refugee Resettlement, if they register as refugees. Displaced Congolese individuals not registered as refugees live in communities in the Makindye district in the capital of Kampala. These communities might then be referred to as formal settlements though again, this can be very nuanced depending on the respective governmental, policy, social, and geographical contexts.

Next, I examine the general distinction made between informal settlements and camps, as well as the characteristics they share. Informal settlements are areas and/or structures where residents do not have any legal rights and camps are interim, informal residences for displaced individuals with the funding and political and logistical oversight of aid agencies, governmental organizations, and/or the host country (Khasalamwa-Mwandha, 2021). In the case of Uganda, displaced individuals who live in informal settlements generally have more rights than those who live in refugee camps. They have more autonomy to work, earn an income, own land and property. These same rights are largely not afforded in refugee camps, where residents reside off food rations and assigned dwellings. While the two are technically not the same, the complexities of transnational migration and nuances of humanitarian support lead geographical borders and government influence to become intertwined and/or obscured. This obscurity can then impact the status and rights of the residents therein

This gray area in governance between informal settlements and camps leads to vast complexity in citizenship status. This is because, for example, individuals who are registered refugees and live in refugee camps may choose to not follow exact regulations and live in and outside of the camps for a number of reasons, including the ability to earn money outside of the camps. Alternatively, those who are not registered as refugees may benefit from rations or other resources from friends or family living in the camps. In these instances, the extended family kinship structure does not fit into a Western model of one “family” being registered as refugees in camps. In many East African cultures, a family is traditionally aunts, uncles, cousins, grandparents, great grandparents, all living under one roof. **Thus, despite the promoted clean-cut order of stateless peoples which the national order of nation states promotes, transnational migration can never and will never be that compartmentalized, nor should it be.**

In addition, the sharing and intertwining of cultures, histories, social structures, norms, traditions, and values between residents of informal settlements and camps, which traditionally takes place in settings of transnational refugee migration, cannot be put into neat boxes under the title of “informal settlement A” or “refugee camp B”, despite the best efforts of Western world powers. Thus, we must always question who is differentiating between and placing titles on displaced populations and what the motives are. This matters because refugee populations have historically been seen as “matter, out of place”, as Mary Douglas would say. They are seen as a scorn to the Western world order and something to be dealt with versus a result of Western colonial era degradation and subjugation who should be cared for by the world community by all means necessary.

To get more granular, Huq and Miraftab's (2020) ethnographic research in the city of Dhaka, Bangladesh showed that informal settlement dwellers (ISDs) and refugees, though both displaced populations, were framed through humanitarian government lenses as either "deserving" or "undeserving" individuals. Specifically, refugee camp dwellers were seen as worthy of humanitarian aid and protection... with a "purity of claim and innocence", and informal camp dwellers are undeserving due to their informal housing status and thus are persecuted for this informal status (Huq and Miraftab, 2020). Again, what fits in a box and follows Western regulations (and is therefore easy to manipulate and control) is "right" and worthy of protection and what does not - what has nuances and gray areas and doesn't follow a set structure, is not only ignored by Western resources but condemned.

As I continue to argue, to combat such abuse of Western and/or state power and exploitation via narrative shifting, in the case above between ISDs and camp dwellers and for stateless people in general, the ethical response is to dismantle the current displacement and resettlement process and hand over control of displacement infrastructure, policies, and regulations to the populations directly affected. In the case of this example, how informal settlements or camps or any other spatial practices and governance are structured should be rooted in ethnographic, first-hand accounts, community engagement, and/or in indigenous practices or needs. As seen in most case studies included in this dissertation, a Western-centric, top-down, one-size-fits-all approach is not only ineffective but in many cases, including in healthcare settings, can be fatal (Tappis et al., 2021). In recent years, academics and aid workers have started to promote such an approach but are truly only scratching the surface of what needs to be done.

For example, in an extensive literature review of refugee community participation in humanitarian logistics (HL) and operations (HO), including in camp design, Jahre et al. (2018) found that recent literature reviews do not mention refugees. As one source argued, “the refugees’ perspective of what they want and need has often been overlooked” (Jahre et al., 2018, p. 324). Furthermore, refugee perspectives on these crucial structural and social infrastructure designs would be able to include the critical cultural perspectives that equally affect camp development. Along the same lines, these refugee perspectives would build into a comprehensive political economy framework of the study of camp development that also considers other imperative contextual details needed for sustainable, community-driven design in host countries.

Such refugee cultural perspectives can, for example, help prevent potential ethnic clashes regarding where certain ethnic communities are placed in the camps. In “Making refuge: Somali Bantu refugees and Lewiston, Maine” (2016), Catherine Besteman discusses how an ethnic minority group, the Somali Bantu, and an ethnic majority group, the Somali Somali, lived alongside each other, with deep histories of discrimination and violence, in both refugee camp settings *and* in their shared resettlement town of Lewiston, Maine, USA. Yet another instance where cultural perspectives from community input in camp design and resettlement policy decisions would have been immensely impactful by taking into account generations of ethnic violence and discrimination between the two ethnic groups when resettling them.

Next, I move to Section II and examine Engjy’s targeted life history experiences from living in displacement in Gulu, Uganda (another relatively large city) after fleeing violence in the DRC, and the experiences of other Congolese refugee women who lived in East African refugee camps. Most of the recounted experiences from displacement included receiving women’s and maternal healthcare services that were delivered in an inhumane manner, whether in public

hospitals or in refugee camp settings. Therefore, in this section, I will explore the compounding issues of availability and accessibility to various female and maternal health and healthcare services, focusing on a comprehensive understanding of contextual cultural and social issues that are often overlooked or ignored in humanitarian women's health aid and research. Shining a light on these contextual social and cultural issues is vital to providing sustainable, patient-centered, humane healthcare in displacement and beyond.

II: Sexual, Reproductive, and Maternal Health and Healthcare Narrative Accounts & Supplementary Data Using the Lenses of the Political Economy of Health, Structural Violence, and Cultural Hegemony

I have now reviewed, at a high level, the literature on the historical, economic, political, and some social contexts of the sexual, reproductive, and maternal health and healthcare of displaced East African, mainly Congolese, women. In continuing to employ the perspective of the political economy of health to gain a more holistic understanding of this topic, putting the voices and experiences of Congolese refugee women at the center of that understanding, this next section continues on to study more of the cultural and social contexts of displacement for this population. These will be organized by the most common intersectional themes, mainly rooted in cultural and social factors, that I found in the interview responses. I will also employ the theoretical lenses of structural violence and cultural hegemony, when applicable.

Children from Rape & Compounding Factors in Abortion Decisionmaking

J: And so when he got out, did he threaten you?

E: Yes! Yes! And then I just ran away. I went to Uganda.

J: And you don't really know which of them is the father?

E: No.

J: And so, you have your son from that?

E: Yeah.

J: And do you look at him and does he remind you of that?

E: I look at him and don't remember all of that. I look at him like a blessing, you know? Because, yes, it was a bad event. But still, God gave him to me so I can be a mother. So yeah.

J: So out of something terrible something good.

E: Yes.

J: I am so sorry.

E: Very difficult.

As we can discern from Engjy's response above concerning her pregnancy from gang rape, survivors of rape who become pregnant can find themselves in a very complex circumstance. In *A qualitative analysis of decision-making among women with sexual violence-related pregnancies in conflict-affected eastern Democratic Republic of the Congo* (2018), Scott et al. cite several intersectional factors that complicate decision-making when considering an abortion by survivors of rape in the DRC who become pregnant from the rape. One of the largest factors that complicate decision-making around reproductive and maternal health decisions for pregnant survivors of rape is the fact that the decision-making options are limited in the DRC. In addition to the social and cultural (including conservative religious) stigmas and pressures, and economic challenges, faced by women who become pregnant from rape, there is the crucial reproductive justice issue in the DRC. Specifically, the fact that women cannot legally terminate a pregnancy in the DRC unless it is threatening the life of a mother (Scott et al., 2018, p. 7).

This leaves survivors with the less safe options of seeking unregulated abortion services if that is how she decides to proceed with the pregnancy. Furthermore, as exemplified in the

responses below of pregnant rape survivors in Scott et al.'s study, responding to a pregnancy of this nature considers many personal and family emotions, social pressures, cultural norms, and countless other factors:

25 year-old woman, separated from her husband, who terminated a sexual violence-related pregnancy (SVRP):

I didn't want to mix children (Hutu children and Congolese children) and I didn't want to have a child from an unknown father (or five fathers).

40 year-old woman, married, who terminated an SVRP:

I didn't terminate the pregnancy but my concern was to have a child from a foreign ethnic group, a child fathered by a member of an armed group. I have no spouse any more. I live with my children...I was scared by the attitude of the community about such pregnancy. I didn't will to carry that pregnancy to term.

25 year-old woman, separated from her husband, raising a child from an SVRP.

I felt my life became hopeless. I felt very upset; my heart ached as I was rejected by my spouse when pregnant. I thought of performing termination but I changed my decision because I was not rejected by the family.

20 year-old woman, unmarried, raising a child from an SVRP.

I carried the pregnancy to term because I was afraid of death and Christians are prohibited from performing termination. God could punish me if I killed his creature.

(Scott et al., 2018, pp. 4-5)

As discussed in the section titled *Compounding Barriers to Women's Healthcare Access in DRC Conflict Zones* in Chapter 1, this topic is yet another area where a political-economic perspective is essential to fully understand the context of such a complex issue, where many factors compound, interfere with, and/or limit a survivor's options in how to respond to pregnancy from rape. Or, as Scott et al. similarly argue, the findings from their study "highlight

the importance of considering the contexts and frameworks within which women with SVRPs process their circumstances...” (Scott et al., 2018, p. 7).

It should also be noted that in recent years, cultural views in the DRC (note: NOT political/ policy-backed views) on abortion access and the promotion of agentive, informed, and empowered abortion decision-making have emerged in Congolese society, despite the various barriers to abortion access in the protracted conflict and conservative sociocultural views on abortions in general. For example, in 2019, Tran et al. studied three training workshops that piloted an abortion-related reproductive healthcare module in the humanitarian contexts of Uganda, Nigeria, and the DRC. Workshop results showed participant “confidence building and positive attitudinal changes promoting a rights-based, fearless, non-judgmental, and non-discriminatory approach toward clients. Participants valued the hands-on, humanistic, and competency-based training methodology...” (Tran et al., 2021, p. 1).

Similar to the restrictive legal regulations in the DRC, abortion is also illegal in neighboring Uganda, the largest refugee-receiving nation in Africa. Despite its largely welcoming and hospitable refugee policies, this restriction to legal and safe abortions significantly affects the roughly 216,000 displaced Congolese women currently living in Uganda. In addition, many Congolese women have or continue to experience sexual violence which can result in unwanted pregnancy. In such cases, safe abortion access is vital.

The legal restrictions around abortion access in Uganda are vague and confusing but generally restrictive, even in cases of pregnancy resulting from sexual violence. There are several pieces of legislation regarding abortion, all from different time periods, that generally conflict.

... the Ugandan Constitution states: ‘No person has the right to terminate the life of an unborn child except as may be authorized by law’. ...the Penal Code Act 1950 [states

that] attempting to abort a pregnancy is subject to 14 years in prison, attempting to induce a miscarriage is subject to seven years in prison, and providing a medication that induces an abortion is subject to three years of prison.

However, the National Policy Guideline and Service Standard for Sexual and Reproductive Health and Rights issued in 2006 allows for exceptions under which abortion can be provided. This policy stipulates that termination of a pregnancy is permissible in cases in which the pregnancy threatens the life of the woman, involves a fetal anomaly, was the result of rape or incest, or is that of an HIV positive Woman. The Ugandan Ministry of Health indicates that these exceptions are subject to interpretation (Nara et al., 2019, p. 263).

Given the ambiguity between these various abortion laws, according to Nara et al.'s research, most women and healthcare providers are left unclear as to when an abortion is permissible by law or not. This adds yet another barrier to safe and accessible reproductive healthcare for displaced Congolese women in Uganda.

In 2017, Nara et al. (2019) conducted an intersectional study with displaced Congolese women living in both urban settlements and refugee camps on this topic. Specifically, the study focused on “maternal health and delivery care, contraception, and abortion/post-abortion services and the intersection of these issues with sexual and gender-based violence”, leveraging focus group discussions and interviews with Congolese women of reproductive age to better understand knowledge, practices, and attitudes on these issues. Given the restrictive context provided above with the ambiguous Ugandan abortion laws, it is not a surprise that the study findings suggested that “Congolese refugees in Uganda are unable to navigate the legal restrictions on abortion and are [therefore] engaging in unsafe abortion practices. This appears to be the case for those living in both camps and urban areas. The legal restrictions on induced abortion pose a barrier to the provision of post-abortion care” (Nara et al., 2019, p. 268).

Compounding Sexual, Reproductive, and Maternal Mental Health Trauma in Displacement

J: Maybe you can just kind of recap how these experiences have affected your mental health, if you feel comfortable talking about that? Or maybe how they early on did?

E: The fact that I was considering early on, kind of, letting it to ignore about it, like about the things that I went through, that is what caused me to have some breakdowns along the road. Both the trauma of the rape, of the torture, everything. You know?

J: And losing the babies.

E: Yeah. Losing the baby was the hardest. Why? Because I had a neighbor and we were both pregnant in Uganda. So I was supposed to deliver like a week early, like, we were just two weeks apart. And then I lost the baby.

...

E: ...it was really tough. Like I almost reached a point where I wanted to say, let us look for a house somewhere else. Because whenever the baby was crying, you could hear the baby crying, you know? And sometimes she could be out with the baby, bathing him...

J: And it was a boy too?

E: Yeah, a boy too.

J: And did you... did you start lactating? Did your body start producing milk afterwards?

E: A lot.

J: And then you heard the baby screaming, and then your milk probably kept coming in?

E: [Shakes head yes]. And then I have, like too much, I can breastfeed even four babies!

In Chapter 1, I began speaking about the topic of maternal mental health in traditional Congolese society and postcolonial contexts. I reference Engjy's recollections of her mother's pre-Congo War mental health struggles as she straddled between two worlds of views on mental health disorders living in the DRC but having more mental health resources available to her through her social connections in her husband's work with a European company. As I discussed,

her mother's access to these European mental health resources was abruptly cut off at the onset of the First Congo War in 1996.

She then found herself struggling to manage her deteriorating mental health while also living through a continent-wide war with herself and her family, including her young children, being the direct targets of insurgent forces. These attacks included sexual violence and in her daughter, Engjy's case was the beginning of ongoing sexual violence and trauma into the Second Congo War and beyond. While Engjy's mother is a statistical outlier in terms of Congolese women who had access to specific mental health care for preexisting mental health issues before or after the Congo wars, Congolese women in rural and/or more traditional sociocultural communities also had ways of combating mental health issues before the war.

As this research has shown, the protracted conflict in the DRC in the last 25 years and into present-day has seen sexual violence by armed forces on local Congolese populations at the highest rates in known global history. Trauma from sexual violence experienced by Congolese women often compounds with pre-existing conflict-related trauma and other sexual and reproductive health issues. When women become pregnant in these contexts, the lack of quality maternal healthcare, unprocessed trauma, and lack of mental health resources further compounds the mental struggles and toll on the mother which then further affects their pregnancy and postpartum health.

Studies conducted in the DRC have shown that trauma from sexual violence can be compounded by reproductive health issues such as fistula⁹ or chronic pelvic pain (CPP), where

⁹ An obstetric fistula occurs when a mother has a prolonged, obstructed labor, but doesn't have access to emergency medical care, such as a C-section. She often labors in excruciating pain for days [and]... her baby usually dies. During her prolonged labor, the mother's contractions continually push the baby's head against her pelvis. Soft tissues caught between the baby's head and her pelvic bone become compressed, restricting the normal flow of blood.

women who experienced conflict-related sexual violence (CRSV) have high rates of PTSD symptoms, psychological distress symptoms (PDS), and high PTSD and PDS rates. CRSV and fistula led to community isolation by being rejected by family, husbands, and friends, massively contributing to mental health issues (Dossa et al., 2014, p. 2212). In studies of types of sexual violence (rape, non-consensual sexual violence, no sexual violence), Verelst et al. found that social stigma varied by how sexual violence was labeled by the survivor. Girls who labeled sexual violence as rape had the highest levels of daily stressors, stigmatization, and stressful war-related events (Verelst et al., 2014, p. 6).

Though record numbers of Congolese women are now living and struggling with intersectional, compounding conflict-related mental health disorders in displacement in East Africa, these regions and communities still largely have sociocultural norms that either do not acknowledge the health crisis of conflict-related mental health disorders and/or do not have the resources to treat these issues in humanitarian contexts (Greene et al., 2017; Mutiso et al., 2018; CDC, 2021). This is in addition to the fact that GBV remains a persistent issue in refugee camps for Congolese and other refugee women (Krause, 2021).

Barriers to mental health services span from structural challenges in healthcare, cultural factors, and lack of services. Consistent with these findings, a targeted 2012 study on psychosocial outcomes among women with sexual violence-related pregnancies (SVRPs) in eastern DRC (Scott et al., 2017) showed that sociocultural factors led to the most severe psychosocial issues for women who experienced CRSV. Experiences negatively impacting

Without adequate blood supply, sections of tissue soon die, leaving holes—known as “fistulae”—between the mother’s vagina and her bladder or rectum. It is these holes that cause incontinence. If untreated, the woman will uncontrollably leak urine, stool, or sometimes both, for the rest of her life (fistulafoundation.org, 2021).

psychological health included “social stigmatization and/or rejection” toward children born from SVRPs.

Agency After Sexual Violence

Scott et al. also include mention of a phenomenon that is rarely discussed or studied within the field of sexual violence in the DRC. They note that several women showed “resilience, or what could be termed post-traumatic growth, identifying avenues of agency to advance the social conditions for women” (Scott et al., 2017, p. 8). The Congolese women interviewed who experienced SVRPs displayed varying levels of “trauma-informed desire from agency and advocacy” to help other Congolese women:

My worry is to stop sexual violence and Congolese women should be protected...Provide constantly women with medical care especially gynecological assistance and let women take the liberty of making termination in case they don't need to have children delivered.

- a 24-year-old married woman who had terminated an SVRP

Women are abandoned, ill-treated. They are used as shields of enemies during wars...The first assistance is to stop wars, to restore dignity and respect of women in their communities, to provide advice and training to men whose wives were raped to prevent rejection.

- a 28-year old unmarried woman who had experienced two SVRPs in her lifetime (raising a child from the first SVRP and terminated the most recent SVRP) strongly advocated for women’s agency and education of men

My main concern about Congolese women is that they are abandoned, not considered and not respected. Also they suffer a lot over the war. Some are killed and others are victims of sexual violence. The first aid is to rebuild peace and to stop the war. Also to take care of children by providing them with education, medical care, and chiefly orphans and so on.

- a 40-year-old married respondent in the termination group

(Scott et al., 2017, p. 6)

The agency and determination of these Congolese women to change the trajectory of not only high rates of SVRPs in the DRC but also to build out more protection and choice for Congolese women living in the protracted conflict setting are made clear. As the excerpts from

Engjy and the other Congolese refugee women interviewed will show below and in Chapter III, *Resettlement*, this sense of agency and advocacy is expressed in many of their interview responses.

Finally, it should also be mentioned that while Western-run aid agencies and refugee camps have mental health resource offerings in both the DRC and in the humanitarian settings in displacement, they are often limited for a variety of reasons (Greene et al., 2017) and the organization of the camps and refugee policies can cause structural environments that exacerbate mental health issues (Chiumento et al., 2020). The systemic inequalities in many of these environments and their general lack of capacity to offer adequate and equitable care to refugee women are discussed in studies and the interview response data from my interviews with displaced Congolese refugees below.

Compounding Barriers to Care: In East African Refugee Camps for Congolese Women.

Dissociative Thoughts to Manage and Process Past Compounding Traumas

E: So I think, you know, you see like now, how whenever I tell my story, I'm always like, come on I'm telling someone else's story. So it doesn't hurt me, you know? It's a mechanism that just came, you know, because sometimes, for example, in Uganda, they were all the time asking you, what happened to you? Why this, why that, you know? So as time was going, I was like, instead of being emotional, why don't I just think about someone else.

J: So it's easy for you to tell someone else's story?

E: Yeah. That's why sometimes, I just don't break into tears. But sometimes, like when I sit and I try to think, and I'm like, it really happened, you know? You're like someone who's waking up. And I'm like, oh, this really happened. Sometimes it's difficult, like really difficult. But I'm trying my best, you know, I'm trying to fight it, you know? Especially because of my mental health.

A single traumatic incident can ignite lifelong mental health issues in most individuals. When we examine the context of Engjy's past, she has experienced several compounding traumatic incidents that intersect different components of her identity. She is the survivor of

several gender-based sexual violence attacks. As we will explore more below, she has lost two almost full-term babies, despite agentic action to prevent the losses at the hands of medical institutions. Each time, her various pleas for help were ignored for multiple reasons, from her low socioeconomic status to her perceived marginal status as a refugee in the midst of a resettlement protocol.

Further, as I explore more in Chapter III, she has experienced domestic and sexual abuse on multiple occasions. These are all in addition to habitual discrimination for being a woman, refugee, single mother, and working mother, structural abuse by Western aid agencies and medical institutions, and past experiences living most of her life either in the midst of civil wars in the DRC or in the precarious liminal state of displacement in Uganda.

Thus, as the excerpt from her targeted life history above illustrates, a common method used to cope with these compounding traumas is to either consciously or subconsciously adopt dissociative behaviors. This dissociative response in the aftermath of trauma has been seen in various studies of survivors of sexual assault (Marx et al., 2008; Schalinski et al., 2011). In their study titled “Female dissociative responding to extreme sexual violence in a chronic crisis setting: The case of Eastern Congo”, Schalinski et al. (2011) found that in cases where individuals displayed shutdown dissociation, this could denote possible PTSD.

Dissociative types of PTSD include symptoms of “depersonalization and derealization” and are associated with reduced cognitive functioning (Boyd et al., 2018, p. 1). Furthermore, van der Hart et al. (2005) found that dissociative parts of the personality respond differently to events or triggers following the traumatic event(s). For example, one or more dissociative personality parts can block past trauma and enable one to conduct daily activities, while others can continue to live in their trauma and have it negatively impact their lives.

Academic and clinical research on dissociation, trauma, and PTSD is included here to give more background and insight into the limited research that has been done to date with this demographic. It is also included to show how compounding traumas have been seen to lead to ongoing mental health problems later in life for survivors of sexual violence, which will be discussed further in Chapter III. Please note, this is by no means an attempt at a psychological analysis of the details provided by my informant in her targeted life history.

Compounding Barriers to Care in Displacement: In Urban Settlements for Congolese Women

Avoidable Miscarriage due to Compounding Barriers to Care in Urban Displacement Settlements: Structural Hospital Barriers (due to socioeconomic barriers & systemic barriers from discrimination on gender, class, and refugee status)

She had agency. She spoke up when something was wrong. She still lost her baby from an otherwise healthy pregnancy. The following excerpt from Engjy's lived experience of her first miscarriage living in urban displacement in Gulu, Uganda reveals socioeconomic barriers to quality care due to lack of insurance. It also reveals layers of structural barriers including corruption by healthcare providers and discrimination based on refugee status, gender, and class. These compounding barriers collectively led to an avoidable loss of her second child at eight months gestational age.

E: Yeah. Losing the baby was the hardest. Why? Because I had a neighbor and we were both pregnant in Uganda. So I was supposed to deliver like a week early, like, we were just two weeks apart. And then I lost the baby. And it was very difficult because not only the way, like the way it happened, you know? But also, it was not supposed to happen.

J: No. In this was the second baby that you lost?

E: No, this was the first baby that I lost.

J: But it was your second pregnancy?

E: Yes. Why? Because what happened is, I lost my insurance that I was having.

J: Because of your age?

E: Yes. Because of my age. So I went to just a normal hospital. I didn't think about going to a fancy hospital because they told me, like, local hospitals are also good. Like Catholic hospitals. But the problem in Africa, the hospital can be a good hospital but the people who work there, are the ones who are not good sometimes, you know? So what happened is, I was having the warning signs, you know, like having some blood come out, pain, cramping, fever, because I was having preeclampsia. No...

J: High blood pressure during pregnancy?

E: Yeah. Preeclampsia. So I went to the hospital when I saw those warning signs, you know? And the doctors, they didn't make a decision whether I should stay to the hospital or should go back home. You know? It's like they toyed with me. How? Because one was saying, no, let her stay. The other was saying no, let her go. And they were not showing interest. Why? because they knew I had a doctor and assumed I would pay him or give corruption.

J: At the public hospital?

E: Yes. It's not really a public hospital. It's more like, for example a hospital for Catholic Charities. As an example. Then I was like, OK, then what will I do? Then they said OK, because it was a Friday, they said come back Monday.

J: Because they were like, you're not in labor so...

E: I was not in labor but the warning signs were there.

J: Right, absolutely!

E: It's not that it was not there, they were there.

J: And so they took your blood pressure, you saw them see that it was high?

E: Yes, it was high, they said go and rest. Take your medication, you will be fine. But the baby died on Sunday. You know? And if I stayed at the hospital, I could have had my baby. You know?

J: Right.

E: In the way that I find out that the baby died was really rushed. Let me just explain to you. Like I was not feeling the movement because he was very active. Like, he could kick and you could see on my clothes, he's doing like this [movement gestures]. You know? But after some time, I was like, I am not feeling him. I could move, try to move him around, but nothing. So I said OK, let me go to a nearest clinic so they do an ultrasound to check if the baby is OK. And imagine the technician telling me just out of the blue, 'how did you come with a dead baby in your belly?' Like, 'Why did you come with a dead baby?' And then I was like 'what?' I passed out first. Like really, I lost consciousness. I fainted. And then, my husband, because he was there, he was like come out why did you tell her like that? And he was like, no, it's the truth, the baby is dead. And I was like, Oh my God. You know?

J: I am so sorry.

E: It was really difficult. Then I went to the hospital, I spent there, two days. I went and told them, you are the one that killed my baby. You know? Because I was here, but you didn't want to care about me. Like you didn't do your job well, you know? So you know, it was like very difficult. And then when I went back home, I was just in my room for some time....

...
E: Not seven months, eight months. Eight months and two weeks. I was remaining with two weeks.

J: Oh my God. Oh my God. And you had to deliver the baby, after the baby died?

E: Yeah.

J: They didn't do a C-section on you?

E: No. They didn't. And then without pain management.

J: Why?

E: Just because they don't want to do that.

J: They don't want to give pain medicine to someone who's having a baby?

E: Yeah. They don't give pain management unless you have a C-section.

J: How was that experience? Other than terrible.

E: Compared to a baby who is alive?

J: Yeah.

E: It's very, very painful. Like extremely painful.

J: So not just emotionally painful but physically?

E: Physically. Like you feel your stomach is burning inside.

J: While you're in labor before?

E: While you're in labor.

J: Did your body just start going into labor naturally after the baby died?

E: No, they put Pitocin and another drip, I don't remember how they call it, but there is the injection and then there is a drip.

Most intersectional topics covered in Section II of this chapter focus on the social and cultural factors from my informant's experiences that compound with the political and economic context provided in Section I to affect various health and healthcare experiences in displacement. However, the excerpt from Engjy's experience above intersects all factors that make up a comprehensive political economy of health analysis, where political and historical factors more directly overlap with social and cultural factors. From this experience above, I will focus on two main intersectional factors.

First, the socioeconomic barrier that displaced women face when they are not registered refugees living in a refugee camp and instead, choose to live in urban settlements largely inhabited by other displaced refugees and use public insurance. I examine this topic specifically in Uganda as there is the most readily available information for displaced persons living in urban settlements in this East African hosting country. It is also the only one that offers free public health insurance for displaced populations. Second, I explore some of the structural barriers that exist in the public Ugandan hospitals available to displaced persons with free public healthcare. I will focus here on barriers that Engjy either directly mentions or refers to in her targeted life history, such as corruption and systemic biases by healthcare providers, directly affecting the quality and access to care.

Socioeconomic - Using Public Insurance as a Displaced Person in Uganda

As Engjy mentions, when she was displaced and living in Gulu in an urban settlement, she and her new husband were eight months pregnant. During that time and before she gave birth, she lost the health insurance she had when she was previously pregnant and gave birth in Uganda. She explains below how she had her previous health insurance from her mother's employment with UNICEF but aged out of coverage:

Then after some years, I got married but then when I was pregnant, I had preeclampsia. So I was coming by the time come up because I reconnected with my mom, she gave me, I had insurance from her work because she was working for UNICEF so the insurance was international so I could use it in Uganda. But unfortunately for me when I had the 2nd baby, I was over 25 years old. And my coverage was no longer there. so I had to go to this local hospital...

Now, she did not have the financial means to go to a private, expensive hospital where her previous insurance would likely have been accepted. Therefore, like the majority of displaced women in Uganda not living in refugee camps, Engjy used the free Ugandan health insurance available to her when issues arose at the end of her second pregnancy. This is coverage that most displaced women in urban settlements in Uganda have no choice but to use, generally never having external coverage from family members employed by Western aid agencies. This is a significant motivation to flee to Uganda specifically when there is a choice.

As Engjy notes, using this insurance at the affiliated public hospital did not seem like a big difference at the time. She was told that there was not a big difference between public and private hospitals to deliver babies. As she explains,

So I went to just a normal hospital. I didn't think about going to a fancy hospital because they told me, like, local hospitals are also good. Like Catholic hospitals.

Uganda is significantly ahead of other East African countries in providing free public health insurance to displaced persons within its borders. In comparison, due in part to ongoing

violence and the resulting collapse of public service infrastructure, the DRC does not offer free public health services, including basic obstetric care, to its citizens let alone to displaced individuals (Gerstl et al., 2013; Ntambue et al., 2018; Zhang et al., 2021). However, offering free public health services exacerbates pre-existing disparities in the quality of healthcare offered by the public versus the private sector. Since the public health systems are funded by very limited government tax revenue, healthcare service is directly impacted in both quantity and quality (Twikirize and O'Brien, 2012, p. 67). In fact, nine years after Uganda reintroduced free healthcare in 2001, “less than 30 percent of the population [were] using these services”, opting instead for the more expensive private community insurance (Twikirize and O'Brien, 2012, p. 66).

General documented issues in Ugandan public hospitals include absenteeism, physical resource management (infrastructure, transport, drugs), education and communication issues with patients, and a lack of established tools to enforce accountability (Ahmed et al., 2017, p. 19). In their mixed methods study examining why rural Ugandan households opted to pay for community health insurance versus using free healthcare services, Twikirize and O'Brien (2012) discovered the following.

Issues of opting for private versus public health services in Uganda included “poor quality services, including frequent drug stock-outs, unmotivated and insufficiently trained health personnel, and overcrowding”. Further, specific factors cited for choosing private community insurance included “easier access to healthcare, financial protection against the cost of care, better quality care and benefits related to mutual assistance” (Twikirize and O'Brien, 2012, p. 66). However, most displaced individuals living in Uganda, especially pregnant women and mothers, do not have this option to pay more even if the premium fee is a relatively low cost.

Still, the poor state of the public health services in Uganda runs deeper than logistical deficiencies like drug stock-outs, insufficiently trained healthcare workers, or overcrowding (Heslehurst et al., 2018). Briefly alluded to in study findings dealing with issues to access to care and quality of care, I next examine aspects of the structural violence that exists in public Ugandan hospitals as cited in Engjy's targeted life history.

Structural Violence in Public Hospitals in Uganda

Displaced individuals often chose to flee to Uganda, in part, because of its generally hospitable refugee policies (Khasalamwa-Mwandha, 2021), including free public healthcare (Nara et al., 2019). However, like Engjy, until they arrive they do not realize that there is such a disparity between the quality of care at the free, public hospitals versus at the expensive, private hospitals. Let us now look closer at a few of the aspects of the structural violence that Engjy experienced in a public Ugandan hospital in the time leading up to and following the avoidable loss of her near-term child.

First, I will provide a brief overview of the theoretical lens of structural violence, conceptualized by Norwegian sociologist Johan Galtung, the principal founder of the field of peace and conflict studies. Structural violence is indirect violence as opposed to direct, physical violence. Structural drivers include the distribution of power and resources and built-in inequalities in basic processes or procedures. These drivers are systemic and embedded into social and political environments (Kriesberg and Dayton, 2016).

Johan Galtung describes structural violence as “violence without [a clear subject-object relation], [which] is built into the structure...when one husband beats his wife there is a clear case of personal violence, but when one million husbands keep one million wives in ignorance there is structural violence” (Galtung, 1969, p. 171). Generally speaking, violence refers to any efforts

made to impair human livelihood, sovereignty, and/or ideologies of personal purpose. Four types of violence have been conceptualized: physical (direct human contact to wound or kill), economic (exploiting and/or withholding financial/general resources to those in the most need), political (withholding human rights), and cultural (isolation/ostracization that negatively impacts one's life/standing in their community) (Kent, 2010, p. 132).

Economic and Political Structural Violence in Urban Maternal Healthcare

Engjy cites many examples of structural violence throughout her targeted life history. Regarding the circumstances surrounding the loss of her second pregnancy at the public hospital in Gulu, Uganda, she experienced a clear case of intersectional economic and political violence dealing with corruption in the expectations of bribery for quality maternal healthcare. She recounts:

But the problem in Africa, the hospital can be a good hospital but the people who work there, are the ones who are not good sometimes, you know? So what happened is, I was having the warning signs, you know, like having some blood come out, pain, cramping, fever, because I was having preeclampsia. No...

J: High blood pressure during pregnancy?

*E: Yeah. Preeclampsia. So I went to the hospital when I saw those warning signs, you know? And the doctors, they didn't make a decision whether I should stay to the hospital or should go back home. You know? It's like they toyed with me. How? **Because one was saying, no, let her stay. The other was saying no, let her go. And they were not showing interest. Why? because they knew I had a doctor and assumed I would pay him or give corruption.***

As we can see from this excerpt, economic violence took place when Engjy was expected to exchange monetary funds for more attention for the dire maternal health issue that she was experiencing, putting both her life and her unborn child's life at risk. Secondly, political violence took place when she was deprived of her basic human right to receive quality healthcare for a pressing maternal health issue. Working in the capacity of duty-bearers of basic human rights,

the healthcare workers at the hospital had an ethical obligation to treat Engjy's preeclampsia in a timely manner. However, as she could not provide them or her doctor supplementary compensation in the form of a bribe to expedite medical attention to meet the standard of basic human rights, she lost her child.

Mixed-methods studies on maternity care in public hospitals in Uganda have yielded similar findings such as staff without proper education, hospitals lacking basic medical resources, and refugee patients reporting discrimination, corruption, and other systemic barriers to equitable healthcare (Nara et al., 2020b, p. 1073). According to the United Nations Human Rights Office of the High Commissioner (OHCHR), under international human rights law, governments are legally required to provide quality and equitable healthcare to women and children. Unfortunately, a perpetual issue of UN mandates is a lack of capacity for regulation and oversight. Corruption is rampant in all sectors around the world, especially in those that lack funding in developing contexts.

Cultural Structural Violence in Urban Maternal Healthcare

In addition to the economic and political violence that Engjy experienced while displaced in an urban, public hospital with the deprivation of her basic human right to quality and timely maternal healthcare because of bribery expectations, it can be argued that she also experienced compounding cultural violence. This cultural violence was based on her status as an impoverished uninsured person (class), her status as a female (gender), and/or being a displaced Congolese person (nationality). This discriminatory behavior from Ugandan hospital staff on the likely basis of class, gender, and/or nationality can be seen as cultural violence as it was built into the cultural beliefs of Ugandan healthcare workers (from a broader societal ideology) and used to legitimize discrimination (Galtung, 1990).

I have already spoken at length about the violent patriarchal culture that leads to gender-based violence (directly or indirectly) in the DRC. Sadly, this gender-based discriminatory culture is historically, and globally systemic, and not bound by state borders. The same can be said for discrimination of the displaced or refugee “other” (Appadurai, 1996; 2006). Healthcare access and quality care are basic needs for self-sustainability in displacement. However, accessing healthcare in displacement as a poor female requires careful navigation of “rules, norms, and values that govern access to economic and social spaces” (Khasalamwa-Mwandha, 2021, p. 20). Yet even the most diligent navigation does not guarantee access to quality healthcare.

Studies have shown a direct correlation between refugee or displacement settlements (not camps specifically) and discriminatory behavior from local Ugandan communities. The belief is that promoting residential settlements of a group by ethnicity facilitates an “us versus them” mentality - especially among native locals. “The systematic concentration of refugees in settlements leads to ethnic clustering that promotes residential and social segregation. [This clustering] ...affords refugees vital networks from within but fails to bridge networks with the local communities.... significantly reinforce[ing] discrimination, marginalisation, and poverty” (Khasalamwa-Mwandha, 2021, p. 19). The situation is further aggravated in certain rural regions of Uganda where natural and public social resources are limited, putting a strain on the education and healthcare systems, for example. In addition, the current Ugandan land allocation policy has led to a shortage of land resources “leading to land degradation due to over-harvesting of wood resources and vegetation for firewood and construction” (Khasalamwa-Mwandha, 2021, p. 19). This further complicates local displaced/refugee integration as a durable solution.

There is not a clear answer regarding sustainable policy or humanitarian solutions to mitigating such intersectional socioeconomic disparities for and discriminatory behavior against displaced women and mothers from urban settlements, in Ugandan public healthcare contexts or in general. However, preliminary studies in recent years concerning East African displaced/refugee maternal healthcare in urban settlements (Nara et al. 2019; 2020a; 2020b) begin to enable conversations by global relief agencies and government policymakers. (Though, as I argue, these conversations on policies and provisions should ultimately be led by the refugee women themselves.)

These conversations are beginning to focus on the nuanced micro-issues that prevent displaced/refugee women outside of refugee camps from accessing their basic human rights to quality health and healthcare (Amodu et al., 2021; Logie et al., 2021). As such, key intersectional socioeconomic issues like poor healthcare quality at public hospitals and structural issues such as bribery, cultural discrimination, and sustainable refugee/host community integration are complex topics that require urgent attention if these basic human rights are to be realized.

Compounding Barriers to Care: in Tanzanian Refugee Camps for Congolese Women

After reviewing Engjy's experiences with compounding barriers to care while living as a displaced Congolese woman in an urban settlement in Gulu, Uganda, I will now step back from Uganda specifically to look at select social and cultural barriers to care in East African refugee camps. To do this, I review and analyze the responses provided in semi-structured interviews conducted by myself and a SUNY Upstate Medical University medical student working with me on this portion of the research. These interviews took place in early 2020 with Congolese refugee women resettled in Syracuse, New York.

A section of the interview questions asked the study participants to reflect on their experiences with sexual, reproductive, and maternal health and healthcare after flight while living in refugee camps in East Africa - most in Tanzania¹⁰. These responses were examined for themes and only the three most recurring themes are included here. I briefly note instances of cultural hegemony in the responses. However, this section is meant to provide additional examples of social and cultural context for life in refugee camps for Congolese refugee mothers during prenatal, labor/delivery, and postpartum periods under the broader analysis of the political economy of health. Additional data and research are added to build out context.

The information on UN refugee camps in Section I illustrates the broader political, economic, and historical challenges that exist with health and healthcare in UN camps. The responses below focus more narrowly on key social and cultural barriers to health and healthcare access and quality. Collectively with Engjy's experiences in displacement in an urban settlement, this information provides a more comprehensive political economy of health analysis on Congolese women's health and healthcare in displacement.

Nuances of UN Refugee Camp Staffing & Malpractice

These interviews were conducted with women who were registered refugees at Tanzanian UN refugee camps. However, as a quick reminder, "UN" camp could mean any number or combination of stakeholder groups running each specific camp. Additionally, administration and/or staff could be made up of host-country natives, UN expatriate workers from around the world, international agency workers, or a combination. Therefore, the largely negative experiences of these Congolese women in the UN camps with various policies and healthcare workers could be the result of poor camp management or systemic discriminatory behavior by

¹⁰ The majority of data from this fieldwork can be found in Chapter III as it largely focuses on Congolese refugee women's experiences with sexual, reproductive, and maternal health and healthcare in resettlement.

any number of different UN or host country agencies. More importantly, in our interviews with them, we never asked which specific camps that they lived in to maintain a certain level of confidentiality.

Theory of Cultural Hegemony

In reviewing the top three themes from my interviews with resettled Congolese women on their experiences with pregnancy, delivery, and postpartum in East African refugee camps, I discovered examples of cultural hegemony. Therefore, I wanted to briefly speak on this and review the theory before presenting the interview responses that will otherwise be analyzed through the perspective of the political economy of health. The theory of cultural hegemony was developed by Antonio Gramsci to explain power and class dynamics. In this theoretical lens, the oppressed internally accept a system where they are convinced that their position is what it should be. This allows the “ruling” social class to maintain control and dominance over the “ruled” class (Bates, 1975).

This setting of “ruling class” and “ruled class” becomes slightly clearer when considering some of the women’s responses to our questions on whether they felt safe in the refugee camps. I include two of the responses below:

So there was not peace in the camp. ...because most of the time the soldiers were coming, putting in the curfew, like from 5:00 PM everybody should be in their house or today, no one is getting out. So they didn't really have peace in the camp.

In the camp, to feel safe was a little bit hard because since they are in the camp, they felt like prisoners because they...there is no contact with the outside. They just stay in the camp. And then you are treated as a refugee... as a foreigner so there's no way you could feel safe in those conditions.

From these reflections, it makes one question if the respective groups running the camp act less as protectors and more as prison guards controlling refugees. This power dynamic is further complicated when considering recent community policing programs by refugees in East

African refugee camps as a technology of Western-influenced or led government (Brankamp, 2020). This is a clear example of neocolonialism where Western “security” standards are being enforced instead of community-based traditional standards by the various displaced communities that live in the camps. Further, while the women technically have the right to leave the camps, where are they going to go in lacking security, shelter, finances, community, etc. outside of the camp?

Because the circumstances described above were the expectations for the refugee women of their situation as being stateless... as being refugees without external resources or security, one can conclude that they accepted a system that convinced them that their position in this prison-like environment was what it should be. This also applies to the responses below in camp circumstances regarding diminished prenatal food security, lack of pain management and abuse in labor/delivery, and limited resources in postpartum breastfeeding. In recounting these experiences, not one woman said that these situations should have been better... that they deserved better as a basic human right.

In the explanation of his theory, Gramsci posits that phrases like “common sense” are tools to maintain the status quo of the majority. Yet, what is common to one is not to another - making “common sense” very subjective and anything but common (K. Crehan, 2011; K. Crehan, 2016). Therefore, cultural hegemony can also be applied to issues of healthcare access and quality for refugee populations. Hypothetically, if a refugee woman receives subpar care with her prenatal care or with the labor and delivery of her child, and accepts this level of care because she is a woman or refugee or both and as such, believes that she is less important in the given healthcare system (UN camp, Western hospital setting, etc.), this is cultural hegemony.

In these interviews with resettled Congolese refugees, the realization that subpar care was experienced in the camps came only afterward when “better” care was provided, in this case, with subsequent births that took place in Western healthcare settings. Therefore, it is important to remember that these experiences of pregnancy, labor/ delivery, and birth are given in the context of the women also being asked how their experience with birth was in the US.

Finally, I want to note that though it is easy to read these experiences and classify pregnancy, labor/ delivery, and birth in refugee camps as “bad” when compared to pregnancy, labor/ delivery, and birth experiences in the US in Chapter III, it is also important to notice the nuanced positives and negatives in each context. For example, in traditional Congolese culture, it is customary to have more female family and friends attend the birth and help the mother during labor. In some cases, this was more feasible in camps before family and friends were separated in resettlement to different countries and/or regions. Additionally, local indigenous foods, though severely limited due to scarce food rations in camps, were grown locally and could then be used for pregnancy and postpartum diets. When accessible, this was a way to continue traditional maternal care practices. However, overall, circumstances in the camps for women, and especially for mothers, were in no way considered a comfortable, or generally even a safe place to grow, deliver, and nourish new life.

Findings from My Research, Contextualized by Existing Literature

1. Social, Political, & Economic Barriers: Insufficient Food during Pregnancy & Postpartum Breastfeeding in Camps

Social determinants of health are the “‘conditions in which people are born, grow, live, work and age’, [which] continuously influence both a person's and a group's health status at macro, meso and micro levels and are largely responsible for health inequities” (Gewalt et al., 2019, p. 287). Social determinants of health are determined by various social, economic, and

political factors, which often intersect and compound, leading to layers of health marginalization and deprivation.

One example of a social determinant of refugee health in refugee camps is their low socioeconomic status affecting access to adequate food quantity and quality. Most refugees living in refugee camps do not have the right to work and earn income in the formal economy of host countries. They also often arrive at the camps with little to no preexisting financial capital. This directly affects their ability to access necessary foods for their families while living in the camps, with most refugees living off food rations provided by the camps. Humanitarian budgets are notoriously low and continue to decrease, leading to fewer food rations for refugees (Brankamp, 2020, p. 273). This low socioeconomic status then affects their ability to supplement the quantity and variety of food to the provided rations while living in camps. This status also impairs the ability of certain individuals to maintain dietary standards, such as pregnant women who require larger quantities of food and select nutrient profiles during gestation.

Further, as we have seen in Engjy's account and similar studies, a lack of economic capital, even in the camps, can prevent access to certain basic healthcare standards when bribery is a common practice. "...socioeconomic status indirectly affects one's health via the purchasing power (or lack of) to access health services....Social determinants of health...are [therefore] factors associated with economic and social conditions and may dispose of a strengthening or deteriorating effect on an individual's health status" (Gewalt et al., 2019, p. 287). Thus, refugees' marginal social status in refugee camps and their corresponding inability to work and earn a formal income to help supplement meager food rations in camps can lead to inadequate food quantity and/or quality. This can then lead to poor health outcomes, especially for pregnant women.

Despite this grave social determinant of health for refugee women, refugee camps maintain that they abide by the Universal Declaration of Human Rights, which declares that the camps provide safe living environments and basic human needs. However, we know this is not the reality, with this policy infraction being a persistent issue in many East African refugee camps and beyond (Gagnon et al., 2013) - especially the right to adequate food and medical care for female refugees (Pinehas et al, 2016; Napier et al., 2018; Logie et al., 2022). Therefore, the low socioeconomic status of refugee women, a social determinant of poor health, is also a political factor that impacts refugee maternal health. Declarations are useless without regulation and oversight.

In addition to the inability of camps to uphold basic human rights, an additional sociopolitical barrier that prevents refugee women from accessing adequate diets in the camps is their inability to self-govern. They do not have any say in policies that regulate how much food they get, what types of food, or access to special dietary needs. Instead, they are at the mercy of the camp policies that provide standardized food ration amounts, often considered to be insufficient (Pinehas et al, 2016; Napier et al., 2018; Logie et al., 2022). When they get pregnant, they do not have the right to inform policy or enact legislation to ensure that they have enough to eat during the gestational period. When they give birth and for any number of reasons, their breastmilk does not come in, they do not have the right to push for policies that allow them access to formula or tools like bottles to bottle-feed their children. This inability to access adequate food for their newborns is yet another infraction on their human rights per the standards set in the Universal Declaration of Human Rights.

Reflected in the above contextual information, the first recurrent theme that we found in our interviews with the resettled Congolese refugee women was that there were instances of

compounding social, economic, and/or political barriers to food access. These barriers inhibited their ability to maintain proper health during pregnancy and during the postpartum period when they were breastfeeding their children, which then directly impacted infant health. Specifically, all but one woman interviewed reported having an insufficient amount and/or variety of food to eat while pregnant and/or while breastfeeding in the camps. As one woman stated (via translator), a lack of external income was a direct barrier to sufficient food during her pregnancy: “In the camp, since there were no income, she was eating even the thing that she doesn't want to eat.... like... there is this type of small fish. Very tiny. And then beans.... She was just eating them because that's what's there”. Another woman reported eating “anything that she could get...but mostly veggies” while she was pregnant.

One woman spoke about an inability to afford meat to eat while she was pregnant. Further, to stretch her budget until the next disbursement of food rations and add some variety, she would exchange certain rations for others at the market:

I: And what kind of foods did she eat when she was pregnant in Tanzania?

W: She was only eating beans and peas. And because that's the only thing that was available. If you don't have money, you cannot buy meat, you cannot buy chicken.

I: Did she feel like she had enough food while she was pregnant in Tanzania?

W: So sometimes they could give them food for two weeks. And they make, and they want them to make it last for months. So it was like not enough. They could eat just little.

I: And what were some of the things... or possibly that they did, or other pregnant women in the camps did, to get more food?

W: So what they were doing, for example if they give you two bowls of beans, she will eat one, and keep one. Because after some time, when she will have like five bowls, she will sell it so she is able to buy tomatoes, oil, and other things. That's how things were happening in the camp.

I: When she was pregnant and when she was not pregnant or all the time?

W: All the time.... So in Tanzania it was only beans and ugali. And that was every day, every year, all the time. Either beans or peas. One of the two.

This same woman also spoke about how the lack of food in the camps impacted her fertility decision-making abilities:

... Like if she was asked to have another baby in Africa, she couldn't....Because of the condition of life....because in Africa, you really suffered to get food on your table. And here, you have food stamps, or if you work, you have money to buy food. It's not like in Africa. She has to look for everything, every single day.

Finally, this same woman mentioned that when her milk supply did not come in after the birth of each of her children in the camps, she was forced to feed her infants a type of soy-based porridge. This was because infant formula was not provided in the camp, even in circumstances like this where the mother was not producing any breast milk. She also briefly mentioned a lack of supplemental lactation support once her milk did not come in.

W: All of her children, she didn't have milk.

I: And so she got bottles and formula at the refugee camp for her other children?

T: No. [Surprised tone at the question.]

W: All of her children, she was feeding them with porridge of soya.

I: In replacement of breastfeeding?

W: Yeah.

I: Because that's what was available at the refugee camp?

W: Uh-huh.

I: And did she get any postpartum help with her baby or breastfeeding if she needed it in the refugee camp?

W: No. When you give birth and that is it.

Another woman said that she did not have money to buy enough food while she was pregnant, as well as to support her body's ability to breastfeed postpartum. She also cited an additional

geographical barrier that prevented her from accessing enough food. When her milk did not fully come in, she did not have money to buy bottles or formula to supplement and had to rely on her insufficient milk supply to keep her newborn alive.

W: Because like sometimes she could breastfeed and the breastmilk is not enough. She could need to bottle-feed the baby but who will give her the bottles or even the milk? No one. So that's why it was difficult.

I: It was a question of money? Amafaranga?

W: Yeah. The baby could have bad health because of that so yeah, it was not pleasant.

I: How did she get the money to buy the bottles?

W: No, she didn't get any money.

I: Did you strictly breastfeed then even if you felt like sometimes it wasn't enough?

W: Yeah. So the breastmilk was not enough. The baby could cry a lot so, you know, no choice. No alternative.

I: So did she feel like she had enough food after she gave birth to make enough milk for the baby? Was that an issue?

W: There were no food in the camps so they were starving.

I: The whole family?

W: Yeah.

I: Did she have to do anything to get more food while she was pregnant? Was she hungrier when she was pregnant?

W: So it was very difficult because if you want something and the market was far, you could reach there and not get it. But also a problem of money.

I: Ah. And they didn't have any money. Like the camps didn't give them any money to go buy...

W: No, no money.

2. Cultural, Political, Economic, and Social Considerations: Lack of Pain Management during Labor in Refugee Camps

The second recurrent theme from our interviews was that of the women asked, all reported not having access to pain management support during labor and delivery in the refugee camps. There was not any additional detail added each time the question was answered, just a clear statement that there was not any such support. This is perhaps cultural on the part of the refugee women as, outside of large urban hospitals, the traditional birth practices in the DRC do not generally involve pain management such as an epidural, nitrous oxide, oral medication, or other versions. The traditional cultural view in most of Sub-Saharan Africa is that labor and delivery are natural events that do not require outside intervention. Some also see such pain management measures as potential threats to their health and/or to their baby's health (Brown et al., 2010; Higginbottom et al., 2013). This general belief greatly impacts perinatal healthcare approaches for resettled refugee women in Western healthcare contexts. Even in cases of emergency cesarean deliveries in East Africa, which are generally very rare in most settings and only used in life-threatening cases, pain management is often limited or fully unavailable.

Furthermore, Western agencies could also not be offering pain management to refugee women on the basis of their own limiting racist cultural beliefs that African women can withstand labor pain more than others. There is extensive research and data on these racial-ethnic biases (Trawalter et al., 2012; Hoffman et al., 2016; Anekwe, 2020; Mathur et al., 2020; Saluja and Bryant, 2021). I explore the topic further in the context of refugee maternal healthcare in Western contexts in Chapters III and IV. If these beliefs are guiding such policies, these would be considered both sociocultural and sociopolitical barriers to health and healthcare for refugee women living in refugee camps.

3. Sociocultural Factors: Discrimination and Abuse in Pregnancy and Labor/Delivery

The third theme and most frequently cited experience across all women interviewed was an experience of abuse in the camps by healthcare staff, mainly during labor/delivery, but also during pregnancy. The abuse varied from verbal, physical, emotional, and/or psychological. This treatment is in stark contrast to indigenous and/or traditional birthing practices in the DRC in both urban and rural settings. Traditional practices are generally marked by women being surrounded by extended female support systems throughout pregnancy, during labor and delivery (whether in a hospital or at home), and during the postpartum period. Support provided can be emotional, physical, medical, and/or support with a newborn.

While some refugee women retain a small portion of immediate family and/or friends in their perinatal period in the camp, guests at birth in camp maternity wards are usually limited to a few individuals including the husband or father, a mainly Western practice. This experience of maternal abuse in refugee camps is an intersectional phenomenon that compounds cultural, social, political, and other factors. These intersectional factors, partially described below, add to the historical, political, and economic issues that collectively form the context for Congolese refugee sexual, reproductive, and maternal health and healthcare experiences in displacement.

The Respectful Maternity Care (RMC) Charter, published in 2011 and updated in 2019, states that maternal health rights are a part of universal human rights. The RMC Charter was established by the RMC Global Council, composed of more than 150 organizations and 350 members from 45 countries (Jolivet et al., 2020). It states that in obtaining maternity care before, during, and after childbirth, every woman has the right to:

1. Be free from harm and ill treatment
2. Information, informed consent and refusal, and respect for her choices and preferences, including the right to companionship of choice wherever possible
3. Confidentiality & privacy
4. Dignity & respect
5. Equality, freedom from discrimination, equitable care

6. Timely health care and to the highest attainable level of health
7. Liberty, autonomy, self-determination, and freedom from coercion (Al-Makaleh et al., 2017, p. 1).

Furthermore, Al-Makaleh et al. (2017) add that these guidelines and mandates are especially necessary in humanitarian contexts:

Respectful maternity care is not a luxury, and it is not more expensive. Respectful maternity care is **a universal human right that is due to every childbearing woman in every health system and setting—especially in humanitarian crises**. It's important that the community doesn't refuse life-saving humanitarian assistance because of disrespect and abuse (emphasis added; Al-Makaleh et al., 2017, p. 1-2).

Despite these charters and mandates, recent studies in East African refugee camps show ongoing cultural and social discrimination of perinatal Congolese refugee women:

International standards prioritize the provision of respectful maternity care (RMC)... RMC extends beyond simply preventing maternal morbidity or mortality; rather RMC **incorporates basic human rights for the woman, including her autonomy, dignity, and feelings** (Reis et al. 2012). [This inhumane treatment continues]... despite these international discussions, and the number of tools and frameworks that define, measure, and aim to prevent disrespectful treatment of women seeking maternal and delivery care (Bohren et al. 2015; Shakibazadeh et al. 2018) (emphasis added; Nara et al., 2020b, p. 1079-1080).

In their multi-methods study of the delivery care experiences of Congolese refugees in an East African refugee camp, Nara et al. (2020b) found systemic discrimination specifically against Congolese pregnant and birthing women. "... our study suggests that RMC is not actively practiced... for Congolese refugee women. The experiences reported by women in our study suggest that mistreatment and discrimination are common". For example, one Congolese woman interviewed in the study noted:

Sometimes when you arrive at the hospital, the first person you meet asks you 'Where do you come from?' When you say you are Congolese...it's something. There is no warm welcome. They say 'ah this Congolese.' But they also want your money, so they do their job and that's why they receive you. But it's not to say that they receive you like in a good way. Other nationalities are fine, but [for] Congolese and Sudanese, it's much worse (Nara et al., 2020b, p. 1078).

Besteman (2016) reported similar findings in her fieldwork in the Dadaab Refugee Camp in Kenya. Notably, discriminatory behavior from individuals of the ethnic majority, the Somali Somali, who held management roles in the camp, toward the ethnic minority, the Somali Bantu.

The responses that we received from the resettled Congolese women interviewed echoed similar discriminatory abuse. However, the women interviewed did not specify whether they felt that the discriminatory abuse was because they were Congolese, refugees, specific ethnic groups, women, or a combination of factors. Yet, compared to Nara et al.'s findings, the responses from our interviews illustrated much deeper and more direct levels of physical, emotional, and/or psychological abuse towards Congolese women in the refugee camps. In the interviews, accounts of this inhumane treatment spanned from healthcare workers ignoring complaints of ongoing pain in prenatal appointments to refugee women physically being beaten while in labor.

One woman spoke about a concerning ongoing pain that she felt while pregnant and what happened when she voiced this pain to the healthcare practitioner. Among other unhelpful and abusive comments, she was accused of “faking” the symptoms:

Because the nurse in charge would come and yell at her and insult her. She was saying that she was not making any effort because her husband is there. That she is faking it, you know? That she can sit and she is in pain and she is like, 'I can't sit, I am unable to sit, I am in pain' she was like 'Stop pretending!' you know? So it doesn't really help when you are in such kind of situations, you know?

Another woman mentioned that the mistreatment she experienced came specifically from the nurses, not the doctors. When then asked if they were UN nursing staff members, she confirmed this to be the case:

W: ...in Africa they give you names....They can tell you – when you were sleeping with your husband you were not crying, why are you shouting [while in labor]. Things like that.

I: That is common?

W: Oh yeah. Some people are mean.

I: The nurses or the doctors or both?

W: The nurses.

...

I: So what she was saying about the experience of the nurses yelling at her, that was at the refugee camp?

W: Yes.

I: And does she know why they were so mean? Were they mean to everybody? Or was it specifically her?

W: It's the habit of people over there. Not all of them, no. But most of them, yes.

I: Were they UN employees? Was it a UN camp?

W: Oh yes, they were in the camp... It was [a] maternity [ward] but the doctors and nurses were something else. They were not good.

Another woman mentioned being physically abused while in labor, where nurses would slap her because she cried out in pain.

W: ...But in Africa it is very different. First of all, they don't care about you. Like, they don't even ask you if it's the first pregnancy or if it's the number of pregnancy. They don't ask you, you know, basic things. They just come up like come out you are just there. And the nurses are group. They can even slap you, saying that, why are you showing up? Or, 'why are you behaving this way like someone who is not a woman?' ... when you cry in pain so that they are like, you should not cry in pain. ... it's just a way of treating people which is not right. You know?

...

I: Did they slap her?

T: Uh-huh.

Yet another woman cited incidents of physical abuse during labor. This woman had lived in a refugee camp in Tanzania for over twenty years, and thus, this abusive treatment was her expectation for all healthcare settings even when she later arrived in the US. In her experiences with abuse in labor in the refugee camp, she waited until the last possible moment to go to the

maternity unit to deliver, putting herself and her baby at risk. She also gave an anecdotal example of another woman who waited for these same reasons and ended up losing her twins due to complications from trying to labor at home for too long. Despite this devastating loss, the woman was *still* beaten by the nursing staff for losing the babies.

So she said that in the camp, it was not a pleasant situation to be at the hospital because the nurses, they were beating them up. Like really beating you up. If you start like crying or shouting because of pain, they will come in and say, 'Hey, shut up!'. You know? Most women go in to deliver when she feels like she is ready, like very ready. And some of them could deliver on the door or even at home just because they had fear to be tortured at the hospital because the beating is like torture, like torture.

... she gave...an example of a lady, she had twins, but the second one died. Why? Because she delivered the first one on the road, on the street. And then the second baby, because she was not in a good position, he took the water which is inside, what is it called... the amniotic, he took a lot of it and he suffocated and died. So she saw it there and when the baby came out like that, they beat her up again, saying that it's her fault, you know?

Further, two women mention the compounding difficulty of experiencing this abuse in labor in conjunction with a lack of traditional Congolese social support in the perinatal period and in labor and delivery. While some did have few family members present in the camps, the abuse continued nonetheless while they still had to contend with the lack of an extended traditional support community. For example, one woman speaks about the difficulty of abruptly losing her family during the Congo War and starting her own family in the camp without this support system:

W: When the war started, she was at the river washing the dishes. Then when she went back home, she found that everyone was not home. So she decided to just run. For her life. And on her way, she met a group of people, said she was alone, she entered into that group so they can just go together. And her husband was in the group. So in the road as they were going, they were talking together and then when they reached their camp, they just fell in love and that's how it started.

I: And did she find out where her family went?

W: She said that her mom, she never knew about her mom, but her father was , they were in touch twice before he passed away. But her mom, she believes she is still alive but she doesn't know where she is or who she is.

I: And her siblings?

W: So she has one sister only, they were staying in different camps.

...

I: What was her experience like giving birth in Tanzania?

W: So since she was an orphan and she didn't have anybody to be there for her, it was very difficult because they could give her names, you know, they could be mean to her. But she was just quiet and calm because there is nothing else she could have done.

As another woman adds, though she had the support of her mother and husband in labor, the lack of a large support system in labor combined with the lack of adequate healthcare support in labor and delivery was hard. She did not have a choice but to exert all of the mental fortitude she could manage to keep herself and her unborn child alive through the process.

Yeah. It was very difficult to deliver in Tanzania. Most women could even die while giving birth. So when you are giving birth, you had to have courage by yourself. Because otherwise, if you could just, you know, leave yourself without pushing, or without trying to do more, you could lose your baby or you can die in the process. So so many were losing their kids. You could see the baby was tired, and things like that.

Conclusion

This chapter presented a comprehensive overview of the intersectional political, economic, historic, cultural, and social factors that either directly or indirectly affect the sexual, reproductive, and maternal health of Congolese women living in displacement in East Africa. Dictated by the circumstances and resources at hand, some women flee to refugee camps in neighboring countries and some flee to urban refugee settlements in neighboring countries, like my informant Engjy did. For Engjy, a combination of past experiences of seeing how Rwandan refugees lived in the DRC, in conjunction with the economic freedom and free public healthcare

afforded to displaced peoples in Uganda were all contributing factors to her choice to register as a temporary citizen in Uganda instead of as a refugee.

Unfortunately, Engjy encountered various grave compounding issues with the quality and accessibility of the Ugandan public healthcare system - issues that cost her son's life and very narrowly her own. With the lens of structural violence, I highlighted just some instances of intersectional economic, political, and cultural structural violence that she experienced. Her inability to pay bribes for standard care led to standard maternal healthcare being withheld - a violation of basic human rights. This discrimination that Engjy experienced was based on her class, gender, and nationality - representing cultural structural violence also experienced while receiving maternal healthcare at an urban public hospital in Gulu. I include reference to additional research that attempts to mitigate such discriminatory behavior toward displaced women in healthcare and beyond. Approaches that could be further built out include improving oversight of existing UN mandates meant to protect vulnerable women's human rights to healthcare in humanitarian contexts and rethinking the systematic concentration of refugees in settlements to reduce ethnic segregation.

Section II also provided crucial social and cultural perspectives from displaced Congolese women's experiences in pregnancy, labor/delivery, and postpartum in displacement in refugee camps. Following a brief overview of the nuances to East African UN refugee camp administration by various combinations of stakeholder entities, I provided a brief background of UN refugee camps in Tanzania - where most of the Congolese women I interviewed lived in displacement. Employing the theoretical lens of cultural hegemony, I review instances of the interviewed Congolese women's experiences in the camps where they were forced to accept a system where their inferior, prison-like circumstances were ostensibly what they should be

because they were refugees. Instances from their maternal health experience accounts in the camps highlight this perceived inferior status from being a refugee.

Specifically, experiences of diminished prenatal food security, limited resources in postpartum breastfeeding, a lack of pain management in labor, and various forms of abuse during prenatal and postnatal periods. These compounding social, cultural, political, and economic barriers to adequate and respectful health and healthcare care for displaced women continue to prevent them from accessing their universal basic human rights as mandated by the UN. These shared accounts of the systemic inhumane treatment of displaced mothers collectively highlight the complexities of being pregnant and giving birth in flight. Trying to simultaneously process past traumas that forced them into flight, navigate providing nourishment for their unborn child, existing children, and usually extended families, and create a semblance of stability in a new and substandard living environment far from all that is familiar to them is already an unimaginable task.

Add to that, countless situations of feeling powerless in navigating corrupt healthcare systems, systemic discrimination on various aspects of their identity, and withstanding verbal and physical abuse through the excruciating pain of labor and delivery - all for women and their children to come out on the other end alive. International agencies need far more than broad, unenforceable mandates to protect these women. Effective, sustainable policies begin at the grassroots with a close examination of systemic, complex, and often intersecting and invisible layers of oppression. This chapter attempts to highlight just a few of these sources of oppression and marginalization. In Chapter III, I examine refugee women's maternal health experiences after resettlement in Western contexts.

In Chapter III, I employ the political economy of health perspective and the theories of structural violence and cultural hegemony to examine and analyze the lived experiences of sexual, reproductive, and maternal health and healthcare in resettlement from Engjy's life history and from interviews with resettled Congolese women. In addition, this chapter introduces the perspectives and experiences of Western healthcare workers who work with resettled refugees from interviews that I conducted with them. I present testimonies from labor and delivery nurses, postpartum care nurses, and OBGYN doctors and the cultural, linguistic, and social barriers to care that they experience while working with resettled refugee women. These new perspectives are imperative to build out a comprehensive health and healthcare approach for displaced and Western-resettled Congolese and other refugee women.

Chapter III: Experiences in Contexts of Western Resettlement (Part 1)

Overview

This chapter begins with a review of the maternal health and healthcare of resettled African female refugees in Western contexts. This data focuses on refugees from Africa more broadly as there is limited data on resettled East African or Congolese refugee women in Western contexts. Additionally, there is a particular focus on this population in the United States, specifically Syracuse, NY and the Upstate New York area, as this is where I collected my qualitative data for this research. However, I also include data, studies, and literature on resettled African populations in other Western refugee-receiving countries and on resettled East African or Congolese women in the United States when possible.

Unlike in past chapters, I begin examining this third period of refugee migration by exploring the broader political, economic, historic *and* cultural and social contexts of health and healthcare for African refugee populations. This is because cultural and social considerations have, in recent years, become a burgeoning focus of researchers in studies of health and healthcare of resettled refugees in the West. Thus, I include various relevant intersectional information that adds cultural and social context which facilitates my political-economic analysis.

Specifically, I look at various components of East African refugee women's health upon resettlement, including female refugee maternal healthcare access and disparities in care, family planning during resettlement and the cultural drivers behind contraception decisions, multilevel issues in pregnancy during resettlement, and new fields of research on refugee maternal health and healthcare in the West. This section also reviews how social networks influence decisions on issues of maternal health and reproduction among refugee women. Topics covered include

network influence on giving information, processing trauma, developing identity, and reframing traditional roles.

In Section II, I examine Engjy's targeted life history with maternal health and healthcare in transition to and while in resettlement. I focus on her role as an intermediary in this and other points of her targeted life history. The next chapter, Chapter IV, will further examine additional qualitative data from interview responses from resettled Congolese women in Syracuse, NY, and interview responses from maternal healthcare providers in Syracuse, NY who have worked with refugee patients. Collectively, data and analysis from Chapters III and IV provide unique and crucial social and cultural context for a comprehensive political economy of health analysis. I also employ the theories of structural violence and cultural hegemony to analyze sections of the life history and interview responses between the two chapters.

I. Overview of African Refugee Women's Health and Healthcare in Western Resettlement Contexts

In recent years, as record numbers of individuals with refugee status are resettled in Western countries (Betts and Collier, 2017), academics, aid agencies, and local and federal governments in Western countries have conducted various studies on newly resettled refugee populations. Refugee healthcare access, quality, and efficacy have been key topics of interest, given obvious and not-so-obvious cultural, linguistic, and logistical obstacles. The subfield of resettled women's sexual, reproductive, and maternal health and healthcare in Western contexts has been of particular interest given the added obstacles that refugee mothers face in resettlement contexts in conjunction with rising numbers of incoming African refugees to Western countries (Agbemenu et al., 2018; Fair et al., 2020; Gibson-Helm et al., 2014; Lane and Cole, 2013; Miller et al., 2016; Young, 2020; Zhang et al., 2020; UNHCR, 2021). Refugee resettlement already presents a wealth of challenges for resettled populations. Layering in cultural, socioeconomic,

physical, and psychological components of transitioning to life in the West and giving birth to first generations in new cultural contexts makes it all the more complex.

Refugee Maternal Healthcare Access & Disparities During Western Resettlement

Between 2014 and 2019, the United States resettled an estimated 50,000 refugees from the Democratic Republic of Congo (DRC). What is known of the health of these large refugee groups is that they likely have either been exposed to or suffered from disorders such as “anaemia, malaria, human immunodeficiency virus/acquired immuno deficiency syndrome (HIV/AIDS) and infectious diseases such as tuberculosis (TB)” (Carolan, 2010, p. 408). Despite this information, the risks for female African refugees giving birth in Western countries remain “unclear” since, as Carolan (2010) argues “these women constitute a relatively new maternity client group, and currently there is little literature available that explores their prior health status or pregnancy complications following resettlement” (Carolan, 2010, p. 407).

Female Refugee Maternal Healthcare Access & Care Disparities during Resettlement

However, certain targeted studies have taken place in the past few years that attempt to glean more information on this new maternity demographic, such as looking at both technical access to maternal healthcare (scheduling appointments online, language barriers, childcare, transportation, etc.) for refugees and structural disparities that exist in the maternal healthcare received by refugees (racism, socioeconomic barriers, etc.), as well as certain fundamental cultural beliefs of the refugee women. Intersectional research on refugee women’s health and healthcare in resettlement and displacement is still sparse today in 2023 despite an influx of refugees being resettled in the West in recent years (for example, research that goes beyond just an academic or medical lens to include social and cultural considerations). A literature review conducted in 2010 of the limited intersectional refugee maternal healthcare research found that

there are various barriers to access to care for this refugee population including financial, systemic, and language barriers (Carolan, 2010, p. 408).

Moreover, J. Lane and G. Cole (2013) examined the hesitations that might influence the lack of use of available, free prenatal care services among African refugee women resettled to Utah. The study found that most women did not seek prenatal care until the second or third trimester, with reasons for this delay in seeking care being transportation access and cultural and language barriers. Some women also cited concern for being judged if they had experienced female circumcision or if their preferred method of childbirth did not align with the recommendations of the Western healthcare professionals. Similar to the systemic racial discrimination experienced by African American women in the United States, Correa-Velez and Ryan (2012) report that access to reproductive healthcare among refugee women living in Western countries can be influenced by “the degree to which intrinsic racial discrimination occurs within the institution” (Correa-Velez and Ryan, 2012, p. 14). Other cited factors that affect access to care included access to childcare service during planned appointments, interpretation services available, and whether there is a concern or past experience of a healthcare provider being warm and kind to the patient (bed-side manner).

Finally, Agbemenu et al. (2018) examined female Somali Bantu reproductive health decision-making given various influences in resettlement. Their findings revealed that nurses and other healthcare providers lacked a culturally and historically-informed approach to speaking to Somali-Bantu women about reproductive decision-making. Specifically, the authors note the importance of how certain subjects are approached: “it is important to recognise the dominant culture’s assumptions about reproductive health. ...History should include questions not only

about birth control, but about desire for child spacing and family members, religious and cultural beliefs and other factors that influence these decisions” (Agbemenu et al., 2018, p. 3361).

Conversely, specifically regarding this concept of cultural competence in clinical patient care when working with culturally diverse patients, Kleinman and Benson (2006) argue that we have yet to properly define the term “cultural competency” to the point that we can operationalize it in clinical settings. They assert that while culture is, of course, a crucial component to patient care, there hasn’t been enough substantial research connecting attention to culture to improved care. They believe that in order to secure enough research to make this connection, the concept of culture needs to be better understood in medicine and not used as a tool to generalize. In a clinical setting, they note, cultural competence “becomes a series of ‘do’s and don’ts’ that define how to treat a patient of a given ethnic background. The idea of isolated societies with shared cultural meanings would be rejected by anthropologists, today, since it leads to dangerous stereotyping” (Kleinman and Benson, 2006, p. 294). Since the term “cultural competence” is present in many clinical studies of resettled refugees, this argument and frame of reference by Kleinman and Benson is especially relevant in the context of this research.

Additionally, regarding approaching the topic of contraception with female refugees, researchers, social scientists, and medical practitioners have emphasized the dual importance of agency of the woman to make these decisions as well as the importance of cultural contextualization where these decisions can be made based on each individual woman’s preferences (Agbemenu et al., 2018; Ganle et al., 2019; Gele et al., 2020; Royer et al., 2020; Zhang et al., 2020). For example, Agbemenu et al. suggest the following regarding healthcare providers discussing contraception with female refugees in reproductive healthcare appointments:

It may be detrimental to frame birth controlling as a permanent decisions, as this [may be] a cultural taboo. It may be helpful in terms of equating strategies with how they spaced children traditionally. The patient should be asked whether she would like any other family members to join the discussion for birth control. Of course, this should be approached delicately and when the woman is alone in the room.

Group visits with community gatekeepers may be helpful for providing a more comprehensive discussion about options. Cultural peers may assist women in their decision-making that is culturally congruent and acceptable. A community health liaison may be very helpful in this situation (Agbemenu et al., 2018, p. 3361).

Therefore, as we talk about offering female refugee patients the option to include community gatekeepers, cultural peers, and/or community health liaisons in these discussions around their reproductive decisions, I must emphasize again that the decision to include these individuals should only come from the patient herself. Other factors that healthcare providers should be aware of that play into women's decision-making around reproductive healthcare decisions are various religious regulations around contraceptive use, child spacing, and/or number of children.

A Cultural Relativist Lens in Refugee Reproductive Healthcare: Contraception

Thus, cultural influences (new and old) and religious norms can have varying influences on refugee women's reproductive health decisions during resettlement. Again, this topic should be approached with a cultural relativist lens and a clear understanding that refugee women are trying to navigate many traditional and novel ideas of family structures during resettlement, as well as new, intersecting capitalist notions like *productivity* and *formal education* which may not have been concerns to consider in the past. Therefore, we should approach this topic from their perspectives instead of, as some of these studies imply, encouraging these women and their families, communities, and religious leaders to simply see the "value" of certain healthcare decisions in pursuing purely Western ideals. It needs to be emphasized that they may not have the same goals for themselves or their families during resettlement as Western governments, academics, and/or public health professionals do.

Let us examine the topic of female refugee contraception in this context of Western healthcare influence. While there are studies on this topic that emphasize “cultural awareness” by healthcare providers in an inclusive and progressive means of understanding perspectives of female patients from non-Western cultures, most available literature on this topic approach discussions of contraception with the goal of persuading refugee women to use contraception because that is what is perceived as “best” for them. Royer et al. (2020) includes recommendations for family planning discussions with an ostensibly well-intentioned yet clearly patronizing list of suggestions on how to essentially persuade Somali and Congolese women to use contraception.

For instance, recommending providers to encourage the “empowerment” of “modern methods of contraception” implies, as Abu-Lughod (2013) argues, an assumption that these women are helpless, weak, and come from a place stuck in time where “modern methods of contraception” have yet to make their debut. It is important to note that most East African refugees *do* have access to contraceptives in refugee camps, and some prior to that in healthcare settings pre-flight. However, there are limited options, such as condoms or the Depo-Provera shot, which are both not favorable and therefore, seldom used. Further, contrary to Royer et al.’s findings, Western healthcare professionals that I have spoken with argue that models of care used in the West with refugee populations are not meant to persuade women to take contraceptives. Instead, they take a more nuanced approach. As a healthcare provider who works with refugee patients in Syracuse, NY noted,

Recommendations for shared decision making rather than [Western] traditional autonomous models for newly resettled refugees takes into account that they don’t come from a model of medicine where patients ask questions... or where they get to drive their care. Providers often make their best suggestion, more paternalistic than US model of medicine. This simply asks people to meet somewhere in between.

Therefore, these hybrid models are meant to bridge the gap between traditional models used in natal countries and Western models for Western patients.

Multilevel Pregnancy Complications: Compounding Past Physical & Psychological Trauma on Birth in Western Countries

Another aspect of resettled refugees' maternal healthcare to consider is the trauma that they may have experienced at any point prior to, or during, resettlement. This trauma affects their physical and/or emotional wellbeing and can also compromise future pregnancies. Roughly 10,000 of the 50,000 DRC refugees resettled in the US between 2014 and 2019 were registered under the "women-at-risk" category, defined as "women who have protection problems particular to their gender and the category is widely operationalized in practice by UNHCR as refugees who are 'single women and single mothers'" (Wachter et al., 2016, p. 876). Of particular concern for the women at-risk group in the US was past experiences with "significant trauma", which includes "sexual violence, abduction by armed groups, witnessing the death and torture of loved ones, contracting HIV, and giving birth to children conceived through rape" (Busch-Armendariz et al., 2014, p. 5). Coping with complex past traumas such as these and others adds a unique layer to refugee maternal healthcare needs.

Regarding past trauma, Carolan (2010) notes that refugee women's mental health has been found to impact maternal health during resettlement. Most refugee women experience "political unrest, displacement, famine, [and] torture" before they are resettled which put them at risk of psychological distress, including PTSD and depression. Additional layers of psychological pressure include the stress that comes with resettling in a country where basic navigation and communication are hindered by language barriers, finances are scarce, and there is often no longer a community support system. Further, religious and cultural norms can lead women to "conceal [psychological] distress" which makes it harder for them to seek help.

Therefore, psychological stress from these and other sources negatively affect refugee women's maternal health.

African refugee women are already “particularly vulnerable” to weakened overall health from “suboptimal preconceptual health and frequent pregnancy [where] many are malnourished which contributes to iron-deficiency, anaemia and poor immunity [and] pregnancy adds to this burden” (Carolan, 2010, p. 408). Other factors that can affect pregnancy and postpartum health during resettlement are the lack of general and prenatal healthcare women experienced previously during displacement. War and destabilized public health services in countries of origin and displacement contexts lead to limited access to healthcare which leads to inadequate pre-migration health. Services such as mental, maternal, and reproductive healthcare are often unavailable or extremely limited.

New Studies & Topics in Refugee Maternal Health in Western Contexts

Western Models of Refugee Maternity Care

In recent years, innovative approaches have been applied to Western models of maternal healthcare to tailor care for refugee populations and their unique set of needs. Fair et al. (2020) have shown that models of maternity care need to be structured in a way that meets the needs of *all* women in society to guarantee equitable and accessible healthcare, as well as healthcare that treats the specific needs of refugee women. Correa-Velez and Ryan's (2012) research looked at the existing models of care available to women from refugee and immigrant backgrounds settled in Western countries to extract best practices from the most successful models. Their research discovered that successful models of refugee maternal care had the following characteristics: (1) caregiver continuity: having the same caregiver made women feel happier, facilitated communication, and allowed women to feel more agentive and informed in their

decision-making, (2) forums for education and communication improved contextual medical understanding for the female refugee patients and bolstered the hospital staff's knowledge of the historical/cultural context around what their refugee patients had been through prior to resettlement, and (3) a particular emphasis of understanding the user experience of the hospital system from a refugee mother's perspective, including factors like transportations, childcare availability during appointments, language barriers, etc..

Power Dynamics of Western Healthcare Systems - Authoritative Knowledge

In the last three decades, anthropological research has been conducted on new forms of power in the Western medical fields of pregnancy and labor/delivery. Specifically, the phenomenon of authoritative knowledge being taken from Western healthcare providers and other powerful groups by different actors such as traditional healers, doulas, family members, and/or activists from health-based social movements (HSMs). Brigitte Jordan, called the “midwife of the Anthropology of Birth” by Robbie Davis-Floyd and Carolyn Fishel (2017), explains the complex concept of authoritative knowledge, and its inherent power (also tied to hegemonic power): “The central observation is that for any particular domain several knowledge systems exist, some of which... come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both”. She adds that, “equally legitimate parallel knowledge systems exist and people move easily between them, using them sequentially or in parallel fashion for particular purposes” (Jordan, 1997, pg. 56). It is important to include mention of the field of authoritative knowledge here as it is seen to frequently act as a dominant force in many fields of society and suppress, marginalize, and/or outrightly ignore alternative knowledge systems, as was reflected in my research findings.

Dissonance in Existing Refugee Sexual, Reproductive, and Maternal Health Policy in Resettlement

When examining refugee women's health and healthcare in Western resettlement, a crucial component to include is policy dissonance. Specifically, what the policies portend to do for resettled refugee women, particularly given their unique health and healthcare needs, and what is actually done. This includes formal or informal and intentional or unintentional attempts to shape, interfere, and/or influence in any way traditional Congolese social or cultural practices as they regard sexual, reproductive, and/or maternal health. Instances of any such intentional interference are, among many other things, unethical and go against legal regulations meant to protect refugee populations' rights to maintain their own cultural and social identity and autonomy. I discuss this topic further in Chapter IV, as well as the related topics of how refugees are manipulated and exploited in host-country nationalist policies and in power struggles of the Western world order of nation states.

The Guttmacher Institute, a leading research and policy organization committed to advancing sexual and reproductive health and rights in the United States and globally, conducted extensive research in post-conflict refugee camp settings and during resettlement and have found various barriers, both formal and informal, that prevent women from receiving state-backed health benefits and adequate healthcare for sexual and reproductive needs. Specifically, a 2017 policy review report revealed that common policy dissonance factors were cultural obstacles, issues with data, financial barriers, and broader structural issues (Barot, 2017). In both humanitarian and resettlement policy, aside from these factors that contribute to policy dissonance, another substantial barrier concerns logistics: the policy focus is on temporary responses instead of durable, sustainable systemic solutions to address refugee crises holistically.

Most Western policy makers do not consider sexual and reproductive health a main part of a primary healthcare system.

Yet, in the instances where sexual and reproductive health concerns are integrated into a primary care system with facilitated healthcare access upon resettlement, it is often done with a strong Western influence on this already vulnerable population. An example of a formal barrier during resettlement that prevents women from receiving culturally sensitive healthcare for sexual and reproductive needs is when rigid Western cultural norms compound with Western healthcare policy to push Western maternal healthcare methods on vulnerable resettled refugee populations. Forced Cesarean delivery is an example of this, aside from extreme medical emergencies. This forced practice can lead to many forms of trauma during resettlement. In 2010, Brown et al. of the University of Rochester published “‘They Get a C-Section . . . They Gonna Die’: Somali Women’s Fears of Obstetrical Interventions in the United States”, which studied opposition to Western prenatal and obstetrical interventions among Somali refugee women in Rochester, New York.

A key finding from the study was that refugee women thought that having a Cesarean birth would inevitably lead to death of the mother and possibly the child as well where the healthcare providers wrongly assumed that the fear of Cesarean births came from a lack of knowledge of the practice. False. This is where cultural relativism is such a crucial component of resettled refugee healthcare. Somali women’s fear of Cesarean births, in fact, comes from an intimate knowledge of the practice. This is because, in Somalia or in the displacement contexts where the Somali women have lived and given birth, Cesarean births are rare and only happen in extreme cases of obstructed labor, possibly in unsafe and/or under-resourced medical environments, and can lead to death of the mother and/or child.

Therefore, if healthcare providers are educated on the reasons *why* most Somali women are afraid of Cesarean births, this enables them to have more sympathy and patience in approaching and explaining the topic. While these women might have a cesarean section in the US for the same reasons as they would in Somalia, such as obstructed labor or maybe even breech delivery - the experience in a Western hospital is likely to be very different and the statistical odds of a safe delivery for baby and mother are much greater. This cultural and historical lens *must* be incorporated into refugee policy and literature.

II: Sexual, Reproductive, and Maternal Health and Healthcare Narrative Accounts & Supplementary Data Using the Lenses of Political Economy of Health and Structural Violence

This section will examine the narrative accounts that I collected focusing on refugee sexual, reproductive, and mainly maternal health of Congolese refugee women in Syracuse, New York. Additional external data from related studies on African refugee populations who were resettled in Western contexts will be added to build out a broader context on the unique backgrounds and needs of this population in Western healthcare, cultural, and social systems. The first set of data is from my informant, Engjy, from her targeted life history account. I will analyze the responses after I introduce each narrative account. I will do this broadly using the lens of the political economy of health, as well as the lens of structural violence where relevant. Subsequent, related data and analysis are included in the next chapter, Chapter IV: Resettlement Pt. 2 - a continuation of this chapter.

Brief Contextual Background on Complexities of Refugee Resettlement

Prior to exploring and analyzing the narrative accounts in this chapter, it is important to give a general overview of the intricate and often tedious process that refugees must face before, during, and immediately after the resettlement process. Before refugees arrive in the US,

independent and/or larger international aid agencies require lengthy application processes for approval for refugee status and then for refugee placement for resettlement. Each receiving country has their own policies, requirements, and criteria regarding who is admitted for resettlement with the general long term plan of those admitted gaining citizenship to the receiving country after a set number of years and naturalization requirements being met. Other factors also influence the expediency of applications such as already having family resettled in a certain country and/or region which is seen as a natural pre-existing support system that will ease the often complex and at times tumultuous process of resettling to a new country and culture. This is especially true when refugees from developing regions are resettled in Western, wealthier contexts.

What might seem commonplace to individuals in the West, such as refrigerators, grocery stores, snow plows, bus routes, or technology interfaces, for example, are among the many new, different, and often overwhelming material and/or cultural aspects that refugees are abruptly faced with learning upon arrival. Having even a small support system can help to ease this overwhelm. Furthermore, navigating these various aspects of Western societies is fundamentally important to refugee mothers and pregnant refugees. Successfully arriving at a prenatal appointment requires a refugee woman to face various back-to-back logistical obstacles such as, and this is not an exhaustive list - knowing how to buy a bus ticket with limited to no English, how to get on the correct bus, line up an interpreter for the appointment, figure out how to bring her other children along if she has older children, etc..

Below I review the refugee resettlement application process. The process has many barriers. It is often mired in red tape, questionable practices, sometimes blatant corruption, multiple logistical barriers, timing in terms of receiving country caps on incoming refugees, and

so on. Again, this is a crucial and necessary process required before a refugee woman can resettle to the US. If she has a spouse and children, or is single with children, all immediate family members must complete the application together. This does not include parents, siblings, aunts, uncles, cousins, etc. This is just one of the many examples where, for Western receiving countries at least, the refugee application process does not take into account the different sociocultural ways families are composed and structured outside of the Western nuclear structure. Still, in just this example alone, refugees are already being forced to reimagine and reconfigure systems and structures that are ingrained in their cultural traditions of how the notion of “family” is conceptualized.

In many African cultures, in-laws and grandmothers are considered just as close family members as children and everyone lives under one roof, in compounds, or down the road. This family dynamic conceptualization is very hard to break from, especially when considering that the applicants, in this process, must rapidly come to terms with the fact that they are leaving these close family members behind in refugee camps and/or in urban displacement communities without knowing when or if they will see them again.

Oftentimes, those who are left behind, whether they choose to stay behind in the natal countries, in the camps, or in displacement, if they are able to flee their natal countries to begin with, are the elder family members. These individuals generally either cannot fathom starting over again so far from where home is at the time or who are unable to pass the various medical exams required for resettlement. The absence of these elder family members is especially felt with African refugee populations when granddaughters and/or younger family members are giving birth in the US without the traditional presence, guidance, and support of the maternal elders. More on this later in this chapter.

Throughout the application process, there are a series of health exams that refugees must undergo. Once approved, there are more health exams and inoculations required for all wishing to continue the process to resettlement. Again, each receiving country has their own protocols and requirements in place of those wishing to resettle within their borders. Western countries generally have more requirements and health protocols. This process is further complicated for refugee women who are pregnant at the time of the application and pre-departure procedures because they do not get exceptions for the required pre-departure inoculation protocol. Yet, what does this mean when there is a long list of medications that pregnant women cannot safely take?

Engjy's Targeted Life History Accounts

In Section II of this chapter, I pick up on Engjy's targeted life history with maternal health as a refugee woman in the process of resettling in the US and once in the US. After introducing each excerpt from her life history interviews, I use a political economy lens to examine how Engjy navigates different experiences in resettlement. In the first section below, Engjy is in Gulu, Uganda, at the end of her fourth pregnancy, and in the process of completing the application for herself and her family to resettle in the US. Though this is her fourth pregnancy, she is expecting her third child as she lost the child from her second pregnancy due to medical malfeasance in displacement in Uganda as detailed in Chapter II. In this section, we can see a clear example of structural violence in the pre-resettlement protocols by the refugee organization, IOM, that was available to her. This may be and likely is a representation of a larger, common issue faced by pregnant refugees in the process of resettlement. In the second section below, I demonstrate several instances of how her conceptualization of kinship - of who is "family" - is influenced by various elements of her past political, economic, cultural, and social experiences in flight.

In the third section, she talks about how she sees her national identity given her past experiences in the DRC. Given these contextual thoughts on her own nationality while in the process of resettlement, she also discusses considerations she had when she unexpectedly found herself pregnant again knowing that her family had begun the application process for resettlement to the US and that this may impact the application status. Furthermore, she also mentioned thoughts on the fact that this baby would be born in the US and what that means for the cultural and national identity of this baby versus those of the rest of the members of her immediate family all born outside of the US. I close this section by focusing on how Engjy finds belonging in resettlement through her agentive involvement in local community and resources in Syracuse, NY. I also explore the intersectional approach that Engjy used in resettlement to manage her struggles and personal gains with her mental health due to compounding past traumas and ongoing stressors that she faced in displacement and resettlement.

Structural Violence in International Pre-Resettlement Protocols for Pregnant Refugees

The first topic that I will review from Engjy's life history responses takes place between displacement and resettlement. It illustrates various systemic barriers that Engjy experienced with IOM, the International Organization of Migration, which was one of the various organizations that she worked with to be resettled into the US. As you will see below, this a prime example of the use of a "one-size-fits-all", top-down Western approach to refugee families and individuals who have drastically different healthcare and general needs. The results of using this approach proved fatal.

E: Because we are waiting for a traveling. But the baby came, the pregnancy came. I had to do an MRI, and then they removed the IUD, and then when I was waiting to have another contraceptive method, the pregnancy kicked in.

J: And this is when you were applying to come to Syracuse?

E: Yeah, that's when we were waiting. And it's also the IOM people that told me that I was pregnant. I didn't know that I was pregnant.

J: It's when you were doing testing, like medical testing to come here that you found out?

E: Yeah.

J: And ironically the same medical testing that killed the baby.

E: The same people, the same agency are the ones who gave me that contraindicated medicine.

...
E: ... Yeah so, the baby was OK, it was fine. Just sometimes weak or sick but that's normal you know, when you're pregnant.

J: So nothing in your head saying something is wrong?

E: No. And then they gave me - when we were about to travel - they forced me to have a medication.

J: A de-wormer?

E: Yeah. A de-wormer.

J: What other medications did they give you?

E: It's a de-wormer, and it's a strong one, because it was big like this [gestures to one inch length]. Like the same day, when they gave me the medication, they told me, if I don't take it I cannot travel. And you have to drink it in front of them. You drink and you open your mouth in front of them like this [gestures wide open mouth].

J: Which agency was it?

E: IOM. International Organization of Migration.

...

J: And nothing else happened to you that would have caused that. And at that point, the chances of miscarrying or having a still birth are very low.

E: Yeah. And I was already seven months pregnant. Half an hour after I took that medication, it was not even half an hour, I felt really bad. I even fainted. The stomach was cramping. And then I was like, maybe it is this medication. And then we went back there, and I told them the medication you gave me made me feel really bad. And they were like, well, it will pass, it will go. But since then, she was not really moving, you know? And she died. Shortly after I took that medication.

J: And you knew it because...

E: I didn't know. I didn't know because she was not [normally] very active.

J: Oh, I see!

E: You could even try to disturb - try to make her move, but she was not really active.

J: So with your first one you knew because he was so active, and then with the second you were like, maybe she's just resting?

E: And there was another thing that now I tell myself. I'm like, God wanted it to be that way. Because if they knew from the start that my baby was dead, I could not come to the United States. Because I would have to wait until the baby comes out. And then they could postpone everything.

J: Yeah, but you could almost have died.

E: Yeah, that's the other thing. The baby died, I think a week plus, and she was already dead. And I was feeling, like really my body was feeling unwell. Like I was feeling pain all the time, I was feeling tired all the time. Sometimes some fevers, some chills.

J: Wow. And then you were traveling on top of that.

E: The day I traveled, I couldn't even move this leg. Like really, I was screaming because it was so painful period like you could feel the bone is touching itself. You can feel the pain all over the leg. And I was like, Oh my God, am I going to die or what?

J: And at that point, were you questioning the baby's safety or did you think she was just not being active?

E: I was thinking she was not being active but also, you know, before you travel they do the physical. Imagine the doctor wants a heartbeat in the files, yet the baby was dead.

J: So do you think they just wrote it to write it or do you think they knew and they wanted you to have a chance to go? Or maybe they were just rushed, and they just ...

E: ...they just don't care.

J: Do you think that there was a greater force behind it?

E: Yeah. That's what I think because if they knew that the baby wasn't alive, they could say that you could not travel. And also, they did say that I would not travel at some point because someone just decided that I would not go to the United States because I did not receive a shot. Yet, they did not give me the shot because I was pregnant, you know? That

happens one day before you traveled. It was so freaking scary. But when we traveled, they also gave me a nurse to come with. Because of PTSD.

J: The irony. They'll give you a nurse but they'll still force you to take the medicine that's not safe.

E: Uh-huh. No, they'll give you a nurse to travel with but she was really there because of another woman who was almost nine months pregnant.

J: OK, so it was for both of you technically?

E: I think she was there for the other woman because for me, I was only seven months pregnant.

J: Oh, it was a nurse for in case she gave birth on the plane?

E: On the plane. But it was because of corruption because usually when you are over 34 weeks, you cannot travel.

J: Right. Right.

E: But she was over 36 weeks.

J: So you think that this very pregnant woman paid the nurse herself to come with her?

E: She paid them so she can travel.

J: So it's not a liability to the organization for letting her go? She could say, 'I have a nurse in case something happens'.

E: Yeah.

J: I see.

E: And then when we reached, even on the way, I was really not feeling well. I even asked her, can you have some Tylenol because I'm really in pain. She was like no, you don't have to drink any medication. And I'm like, OK. So I just bared the pain. And when we reached here, the next day, like they didn't even tell them that I was pregnant, until I boarded the plane. And then they were like really, seven months pregnant, and they don't tell us? So what happened when I reached here, I was like, I'm not feeling well. I called the caseworker. I told her I'm really not feeling well. And I went to the hospital and they told me that the baby was dead.

J: And you said the nurse was...

E: ...the doctor ...the doctor was very rough. She was like, Oh my gosh, why did you come here with a baby who was already dead? She said that to me. She was like, there's

no movement, didn't you know? Then I was like, really? And then after whereas, she was like, I'm sorry. Maybe I was rash with you. But still, she still...she still did it.

J: And this is the second time that this happened to you.

E: I was like, devastated. Even my husband, he cried. And it was, I was like, this is too much. It was like God, why am I starting my journey in America on the wrong foot? So it's really affected me. And then I was like, I don't have any purpose in life, you know? Why am I keeping losing my children? I'm not supposed to bury my children. I'm supposed to see them grow, you know? So it was, it was really really difficult.

J: I can't imagine. You buried the baby here?

E: Yes.

J: In a cemetery?

E: Uh huh.

J: Did [your refugee relocation organization] help you organize it?

E: Yeah, they organized everything.

J: And there was a funeral?

E: Yeah. So, it is what it is.

J: And you had just gotten here. Who came for it?

E: Just people from [the refugee relocation organization], relatives, and some colleagues.

J: Oh my gosh. So community that you didn't know that maybe quickly became family because of that?

E: Yeah. It was really difficult.

J: Do you visit the baby?

E: Yeah, I do. I was there last year during winter. No... in the fall. That's when we went there because the stone with her name on it and a little angel. Yeah, so we went there to look at it.

Structural drivers include the distribution of power and resources and built-in inequalities. These drivers are systemic and embedded into social and political environments

(Kriesberg and Dayton, 2016). Anthropologist Paul Farmer writes about structural barriers in the global community by using the lens of political economy. Farmer uses this lens' postcolonial analysis to examine how structures are embedded in former colonies - structures that are rooted in "the enduring effects of European expansion in the New World and in the slavery and racism with which it was associated" (Farmer, 2004, p. 305). Farmer researches modern epidemics in the postcolonial context, linking them to current social inequalities (Farmer, 2004, p. 305).

This associated link to epidemics in the postcolonial context also extends to the largely neocolonial structures of the refugee resettlement process managed by various Western agencies, large and small, that decide who is granted refuge - who is "deserving" and who is not. For example, anthropologist Catherine Besteman writes extensively of the phenomenon of refugee narrative enhancement to try to subvert the structural violence of refugee aid agencies looking for the most "needy" candidates. Specifically, Besteman studies narratives of Somali Bantu refugees who were forced to embellish their experiences fleeing Somalia to artificially enhance their trauma and make themselves more "worthy" candidates for resettlement in the eyes of large aid organizations.

Besteman writes on how humanitarian and government agencies working in Dadaab encouraged narrative-manipulation by Somali Bantus by way of playing up hardships, inventing new ones, and/or emphasizing victimhood in order for them to be "victim enough; helpless enough" to be granted relocation to the West. Because Somali Bantus were the subjugated ethnic minority, international aid workers presumed that to be Somali Bantu meant that you had to have seen warfare and bloodshed in very specific contexts. One could not be seen as Somali Bantu without having been oppressed to a set degree or without having witnessed and experienced a set

amount of violence. Their unique histories of oppression, whether or not they had directly been exposed to violence, was irrelevant (Besteman, 2016).

Therefore, Somali Bantus, showing the same adaptability and perseverance they later would during resettlement, and understanding that this might be their only chance for resettlement and a better life, began to change their own narratives to play up victimization. Aside from a long list of “tribal, linguistic, and geographic markers”, jareer Somalis (Somali Bantus) accepted the fact that they would have to use a narrative of victimhood to “prove” their identities as Somali Bantu. In a conversation that Besteman had with a Somali Bantu friend regarding their experience in the resettlement process, she was shocked by the degree to which the narrative deviated from the truth. “He said, ‘My mother was killed. My father died. I was left alone.’ ‘Really?’ I asked, upset to hear this news. ‘No!’ he responded, realizing I had missed his point. ‘That’s what I had to tell the interviewers. That’s not what really happened’” (Besteman, 2016, p. 91).

This encouraged refugee narrative-manipulation by aid agencies is an example of how the refugee resettlement process is deeply embedded with structural forms of violence. The Western or International agencies use structural barriers to leverage power and resources in the relocation process. In Engjy’s experience detailed above, structural violence came in the form of applying a one-size-fits all approach to relocation inoculation protocol to a pregnant woman who had a unique set of inoculation precautions and prohibitions per general obstetric protocol. Despite this one-size approach, she knew that something was not right and spoke up against taking the “standard” dewormer pill. They still made her take it. Days later, her near-term baby tragically and avoidably died in her womb.

The structural violence continued when, as she puts it, another pregnant refugee woman was able to, in a sense, cheat the refugee relocation system and hire a private nurse to be able to travel to her country of resettlement. As Engjy states, this was a clear form of bribery, where the woman was too far along and should not have been able to travel per the same set of refugee relocation protocols from IOM that had detrimental, terminal effects on the baby that she was carrying. Thus, the protocols that were forced on Engjy seem to be penetrable by bribery attempts. In yet another instance of structural violence barriers in the healthcare system, perhaps Engjy lost her second near-term child due to her not partaking in corrupt behavior.

On this point of corruption in the refugee relocation process, the work of Besteman (2016), Malkki (1995), Mignolo (2012), Lindley (2013), and Turner's "structural invisibility" framework (2002) describe how refugee policies are often not objectively followed which results in an uneven distribution of support to various individuals and communities. It is hard to say what would have happened either time in Engjy's experiences of losing her unborn children from avoidable causes had she tried to subvert the structural barriers and play into corruption to receive better and tailored maternal healthcare.

However, the point is that we should not be here wondering what *might have* happened as those barriers for these extremely vulnerable populations of women who have already been through so much should not exist to begin with or by now, should be rooted out, abolished, and remain that way with careful oversight and regulation. At the very least, refugee women being resettled should have access to equitable, tailored, and unbiased maternal healthcare at all stages of displacement and resettlement. That is the bare minimum according to countless international treaties meant to protect these women and we are so far from that minimum standard in what is currently the reality. Such structural violence via power imbalances is unfortunately not isolated

to the refugee resettlement process and pollute all stages of refugee support, including well into resettlement as Chapter IV will illustrate.

Global Political Kinship: Conceptualizing Family in Conflict, Flight, and Motherhood

As mentioned, refugee flight and migration can significantly alter kinship structures and how a family is conceptualized. Social support networks like strong kinship support structures have a significant impact on maternal health and wellbeing, especially considering the sexual trauma that many Congolese refugee women experience. However, in flight, kinship is restructured to extend beyond bloodline, reflecting a more Western interpretation of who constitutes as family. Below, Engji discusses how she uniquely defines family - a criterion that reflects different periods and experiences from her past.

J: Do you now and when you were coming here with your family, your husband and your children, do you think of yourself as an individual family when you think of your family or when you say family, do you consider your sister-in-law or your mom back in the DRC? Like who do you consider your family?

E: I consider my family people who are near me. Not only blood family. It's a concept that I learned to have while I was in Uganda. Because you can be blood-related, but maybe you don't love me the way you should. And someone else love me more than you do, or show it to me more than you do, because for me, I consider someone family if you really are, you know, precious.

J: Who you can trust?

E: But of course. Of course my family is also my biological family so ...

J: Are they just as important to you? As the non-related family who shows up for you? Or the same level of importance?

E: It can be at almost the same level.

...

E: Yeah. You know, when you go through a lot, of different things, you have a selective character sometimes. Because you will always remember the person who was there when everything was wrong. Like really. When everything was wrong and there is that one person who stuck by you. You always have that person in your heart.

J: You are super loyal to them.

E: Yeah. So that's how I see family.

J: I see. So what about your mother who didn't have your back when you needed her?

E: For my mom, this is how I kind of understand it or try to explain it. Yes, she suffers from mental health. Like really mental health. And herself, she has been through a lot....

In employing a political economy lens, we can see how Engjy's past political, historical, cultural, and social experiences influence her personal definition of kinship structures and who is considered "family". One influencing factor to how Engjy defines family is her cultural and regional background of traditional Congolese/ East African notions of family that is focused on bloodline and incorporates extended family members. However, her definition also reflects Western notions of considering close friends as family and considering loyalty and support of non-blood related individuals when defining who is "family".

This perspective could come both from her early Western primary education and exposure through her father's work, but also from her time spent living in the US. Further, her response evokes notions of distrust at times, possibly from her background coming of age in a conflict zone, from multiple incidents of sexual assault, from having members of her own family who were not supportive when she was sexually assaulted and/or from family friends being the assaulters. At the same time, she saves grace for unsupportive blood family members like her mother in taking into account the mental health struggles that she faced when she was raising Engjy.

Finally, her definition also reflects the migratory nature of most of her life. Strangers become family when you are ripped from your homeland and blood family members. This is more so out of necessity and survival than who is loyal or kind to you outside of your blood

family. For example, the good Samaritan woman who found her crying on the street when she had just fled to Uganda and was robbed. Engjy was pregnant, did not have any money, and did not have anywhere to go. The woman, also Congolese, took her in and even later attended the birth of her son and supported her through her first labor and delivery.

Navigating National Identity and Belonging in Resettlement

J: Can you talk about...your experience of displacement and how do you make sense of it in terms of the culture you came from, the Congolese culture is very rooted and family and homeland so how have you made sense of being Congolese here or do you consider yourself Congolese?

E: Compared to here?

J: While you're living in the US.

E: Yes, I consider myself Congolese because that is my origin, anyway. But, sometimes I don't feel like I really belong. Because I never had a good experience in Congo. It's like, yes, I'm Congolese but so what, you know?

...

J: Do you see yourself as an American citizen? Do you consider yourself an American citizen?

E: Not yet. But I know I will be in a few years. And for me it's not a problem, you know? Like others, they'd rather not be American citizens because they don't want to lose their Congolese citizenship. But for me, I'm like, go away Congolese things. Like really.

J: Really?

E: Yes. Because I'm from Congo, but what did Congo do for me?

J: Right.

E: Nothing.... Here, I have a job. I have peace. I have security. You know? I have a lot of opportunities. It's not like in Congo, if you are not this son of someone wealthy or if you are not, you know, at category kind of person, you know, you will not live well. So yeah, I am happy to be here.

J: I am happy you are here.

...

E: And for the second baby, everything was fine. The only thing is, she was not very active.

J: So your 4th pregnancy?

E: Yeah. She was not very active and I remember my husband didn't want a baby by then. Because we were preparing to come to America so we would be delayed, we can't get pregnant to avoid delays. So then when I told him that I was pregnant, he was like, why did you let it happen? And I was like, it just happened. And it's because I did an MRI because I was having really crazy migraines. So they did an MRI and they had to remove it because if you have metal in you, it can just come out. It can hurt you.

J: What metal did you have in you?

E: The IUD. They removed it and then in between those days I forgot that I didn't have an IUD and we had unprotected sex and I got pregnant.

...

J: But your children born here, are they American? Are they considered to have American citizenship?

E: My children were not born here.

J: But any future children?

E: Yeah.

J: They will immediately have American citizenship?

E: Yes.

J: And how does that make you feel?

E: They are still my kids. I don't know.

J: But that they are going to have a different citizenship than you, at least initially?

E: It's fine.

J: It's not symbolic to you?

E: No.

J: Is it because you know you're going to get it eventually too?

E: Uh-huh.

J: And you will all have the same one eventually? And your husband wants it?

E: Uh-huh.

J: Dual citizenship or just American?

E: The Congolese citizenship is difficult. It's one and exclusive.

J: So you either are Congolese or you are not. Oh interesting.

For Engji, it seems that loyalty and protection by the DRC are big factors in whether she reciprocates loyalty to her natal state. Yet, as she mentions, "...but what did Congo do for me?...Nothing." Because she does not feel this sense of support and protection from the DRC that she feels from the US by way of job security and therefore economic security and a related peace of mind. She also mentions security in the sense that, for many reasons and in many ways, she was not safe and secure in the DRC. Therefore, unlike the other Congolese refugee mothers that she mentions that struggle with and/or do not want to give up their Congolese citizenship since the DRC does not permit dual citizenship, she looks forward with confidence and anticipation to the day when she and her children will hold US citizenship.

The fact that any possible future children that she may have in the US will, depending on timing, technically and temporarily hold US citizenship before her and the rest of the family seems like a non-issue to her. This is not because it doesn't matter but because she seems committed to pursuing the next step of declared loyalty to the US - a state where, as she remarks, has already given her far more than the DRC did. This is not to say that other or even many Congolese refugee mothers share this sentiment.

This struggle with national belonging and identity may be further enhanced when women have children in the US - making the children US citizens, before they the parents receive US

citizenship. This is a significant symbolic shift out of the liminal period of displacement and even early resettlement into a new familial identity and thus, a possible sense of duty to reciprocate the security and resources provided by a host country in resettlement as their children now bear this new nationality that they soon will too. It certainly marks the end of a chapter, while not conclusively as many refugees fully intend on one day returning to their natal country through voluntary repatriation.

However, this is historically and statistically rare. According to UNHCR, in 2020, the durable solution of refugee voluntary repatriation was at an all-time low. “In 2020, an estimated 251,000 refugees returned to 30 countries of origin. Some of these returns were facilitated by UNHCR and its partners, while others were self-organized. This figure is 21 per cent less than the 317,200 returns reported in the previous year” (UNHCR, 2021). Further, voluntary repatriation is far more likely and possible to occur when displaced persons are either IDPs or displaced in neighboring countries, as opposed to many miles away in resettlement in Western states.

Let us continue to examine refugee belonging with a political economy lens. National belonging, as we can see from Engjy’s sentiments, has a good deal to do with the politics and sociocultural norms and expectations in the home country *and* the host country. For example, how are single mothers - or mothers in general - perceived in the DRC versus in the US? What about minorities? As discussed in Chapter I, the patriarchal, militarized, and nationalist culture of the DRC often excludes women from government or local leadership roles, targets them as prey for sexual assault, and specifically marginalizes and targets those who are seen as minorities or outsiders.

Belonging is not only a personal or communal matter of emotional attachment but also a national and political endeavor (Antonsich 2010) mediated by the politics of belonging

(Yuval-Davis 2011) and negotiated through social interactions and in relation to discourse (Wernesjo 2015). The politics of belonging involves **‘the construction of boundaries and inclusion/exclusion of particular people, social categories and groupings within these boundaries by those who have the power to do this’**.

Those with hegemonic power in a nation state play a key role in shaping, maintaining, and reproducing boundaries of national belonging, thereby determining who belongs and who does not. Personal feelings of belonging are mediated by national (and nationalist) discourses and practices that construct, claim, and justify who is included and excluded in the nation (Antonsich 2010). It is through these nationalist discourses and practices that local communities are separated into ‘us’ versus ‘them’ (emphasis added, Cohen, 2021, p. 3).

We have seen examples of the reproduction of boundaries of national belonging in Engjy’s life history several times. These boundaries of who is and is not considered “us” or Congolese appear for her on local and national levels. Such boundaries are embedded not in a shared cultural heritage or a shared birthplace but in historical ethnic and racial tensions and discriminations. The assumption that Engjy was Rwandan, instead of Congolese, based solely on her physical appearance, caused her to be the target of several acts of discrimination throughout her life in the DRC. Most significantly, this nationalist discrimination caused her to be the victim of a vicious sexual assault by multiple Congolese soldiers. These armed professionals should have *protected* her, a fellow Congolese and more importantly, a fellow human being.

Instead, they made her the “other” - in part forcing her to flee her homeland, her family, and what should have been a space of comfort and support. These are the instances that she refers to, among others, when she asks, “...but what did Congo do for me?”. Thus, Engjy chooses to lean into her and her family’s soon-to-be American citizenship when considering between her Congolese and new American identities, taking into deep consideration her experiences with various local and national patriarchal, militarized, and nationalist boundaries that excluded her in the DRC.

Finding Belonging in Resettlement: Agency and Local Belonging

Engjy mitigates these feelings of being “othered” in the DRC in the past by her daily proactive and agentive involvement in local organizations and institutions in resettlement in Syracuse, NY. There, she lives, works, and fosters community connections with other Congolese women refugees who have also been excluded by similar boundaries. For example, her role as a community worker at a refugee agency allowed her to assist her peers at medical and maternal health appointments.

These Congolese peers are both similar and different to Engjy. Their backgrounds overlap in many ways from East African displacement to past sexual traumas to being marginalized and targeted by nationalist and patriarchal norms in the DRC. However, they also differ in Engjy being apathetic to renounce her Congolese citizenship where the norm for her peers is a strong hesitation and sadness to give up this symbolic identity. Further, Engjy’s background is certainly not the norm in terms of access to economic and educational opportunities in the DRC and also now in the US with her blossoming career. Despite these differences, she focuses on their commonalities and finds purpose and community in working with her fellow Congolese women and mothers in her job as a community worker supporting other refugees.

This role not only gives her a community tie to other Congolese women refugees but also in female-specific health needs often dealing with maternity healthcare access. This is another area of her past trauma that is eased, though never fully healed, by her ability to help other women navigate the many uncertainties of maternal health and healthcare in resettlement or otherwise. In many ways, she serves as a resource that she did not have but needed at various stages of her own maternal health journey.

Furthermore, in addition to holding this role as a community worker, she agentively leverages local resources in resettlement to further work (more below) toward finding belonging, heal past traumas, and help her peers of Congolese refugee women. For example, in her use of local mental health resources to address her past traumas and in her sharing her life history with me for the purpose of this research to hopefully help other refugee women.

... refugees navigate around structural, policy- level exclusion and cultivate local forms of belonging by accessing local resources, contributing to the local community, and using their knowledge and skills to shape their daily lives to create a space for themselves in the community. The ability to find safety, access resources for livelihoods, and build relationships can cultivate a local sense of belonging (Chopra and Dryden-Peterson 2020; Hovil 2016). Local belonging helps maximize the quality of life for refugees and, thus, “is considered to be as important, if not more so, than forms of national belonging” (Hovil 2016, 90)... (Cohen, 2021, p. 3).

Various studies have been completed on similar agentive actions by resettled refugee women from conflict contexts, whether as a means of fostering belonging in resettlement, finding a connection to a new national and/or cultural identity in resettlement, or focusing on healing past traumas in resettlement (Hajdukowski-Ahmed et al., 2009).

Another common form of building community in resettlement for refugee women is in choosing to have more children once resettled as a means of rebuilding lost family and friends in the conflict they fled. Sometimes these decisions of further childbearing are not necessarily the desire of the woman but of her husband or the male community members. There are anthropological studies (Royer et al., 2020) that focus on this phenomenon of rebuilding lost community, especially after displacement and/or after flight from conflict regions, by way of physically replacing lost family or citizens by having more children who will also bear these familial, national, and cultural identities. These new generations are expected to carry the torch of ethnic and cultural traditions in the new country. As such, native cultures, traditions, and community are repopulated in resettlement in a new country.

Community bonds from home countries are forged and strengthened through having children and new generations. While having more children in the US to rebuild Congolese culture and community is not something that Engjy chose to do, instead agentivity deciding to foster a connection and ties to an American identity, it is a practice by refugees in countries of resettlement (Allotey et al., 2004). Related studies have also linked education levels of resettled refugees to refugee family planning and fertility rates in resettlement, with income level also being an influencing factor (Sarkis, 2010).

A Refugee Mother's Intersectional Approach to Mental Health Struggles in Resettlement: Claiming Agency by Leveraging Past Experiences, Public Resources, and Professional Knowledge in the Throws of Ongoing Struggles

In Chapter II, through Engjy's targeted life history example, I explored the phenomenon of dissociative thoughts experienced by refugee mothers as a coping mechanism to manage and process past compounding traumas. However, what happens when the trauma continues in the liminal period between displacement and resettlement or into resettlement? I have explored a few of the horrific traumatic experiences that Engjy experienced in the DRC and then in Uganda with the loss of her second child. Engjy graciously and bravely shared the story of the loss of her fourth child, again likely due to the structural inadequacies in the international refugee resettlement system and her experiences not being taken seriously by medical professionals because of her race, class, and/or station in life. Given these compounding ongoing traumas and Engjy's past struggles with mental health, she began to experience what she calls mental breakdowns soon after arriving in the US. As she explains below, each breakdown was triggered by a certain date or a general sense of overwhelm due to compounding stressors that she was experiencing at the time. Each of these breakdowns required Engjy to be hospitalized.

J: You had two mental breakdowns since you've been here?

E: Not two. Wait, I was admitted I think three times if not four times here.

J: And each time, it was where you would black out?

E: It was not like a blackout, I was always hyper alert, I was very lucid but with no sleep.

J: But you didn't know the people around you each time?

E: No, I didn't black out like that.

J: Oh, okay.

E: Here, I didn't black out like that.

J: Okay. So you were hospitalized four times here in the US for that?

E: Uh-huh. I think it has been four times.

J: And it had been stressful, like mounting and you hadn't addressed it?

E: Yes. What happened the first time, it was supposed to be the due date. Then I was like, oh, this is the time that I would have my baby. This is a time when everything went south.

J: And that was within two months of you arriving?

E: Yes.

Engjy mentions several times throughout her targeted life history that in her experience in resettlement in the West, she came prepared with a deeper familiarity of Western cultural practices than most incoming African and/or Congolese refugees. As she explains below, this is due to her father's employment with a European company growing up and then her early education in a Belgian primary school in the DRC. Further, as explored in Chapter I, she had her experiences from childhood of how her mother's struggles with mental health were alleviated by Western providers and approaches in Belgium and from Western resources in the DRC.

Given this background, she explains that the transition to life in the US was not as much of a struggle for her as it generally is for mostly rural displaced Congolese refugees coming to the US and experiencing Western cultural contexts, norms, and practices for the first time. Her

unique positionality in this regard is an outlier from the vast majority of incoming displaced East African refugee women or refugees in general. These accounts of her unique background shows a deep self awareness of this privileged perspective that her fellow resettled Congolese mothers don't have. It is this positionality that not only allowed for a smoother transition to life in the US but also allowed her to excel at her then job as a refugee community worker to help other Congolese refugee women navigate the many cultural barriers that they face in resettlement and especially in Western healthcare systems.

E: ...the culture here, yes it's complex, it's really different from African cultures but I can say I had the chance to live like a westerner when I was young. And when I grew up, it was still in me, deep inside. So having to understand the culture here was not really hard for me. Because I knew from a young age how things are done out of Africa. How people live, you know? So I can say I adjusted quickly.

J: And when you were younger, you were saying your western influence, can you talk about that?

E: That's when my father was still working, before the war. And a little bit after, my dad had business partners from Belgium, and not only that, I went to school to a Belgian school. It was Ecole Prive a Programme Belge. That's where I went to school up until the 5th year of primary. So it was quite a long time period since kindergarten. No, preschool to the 5th class. So yeah, I think it was that which influenced the culture, the mixing culture, yeah.

J: Can you remember what kind of things that, maybe the way classes were taught or certain cultural things that happened your Belgian school, that you knew weren't African that were Belgian specifically?

E: For example, how to punish someone. Because you are kids, we do things sometimes that are stupid or you can make a lot of noise or act a little bit weird. so the punishment was not to hit or to kick. They would give you a punishment regarding with your personality. And the other thing is, they were kind of studying us. And have, for example, a character, you know for example Tom and Jerry, you know those type of characters. They had those type of books and each one of us was someone like, in a small book. So they take the way that you behave, which is kind of similar that the way that cartoon behaved, it's such a shame that I can't remember the names but, but that was really different.

J: So they connected you with a character, a western character, cartoon character. Based on your personality?

E: Not a cartoon but from books.

J: And if someone was outgoing, they would be aligned with a character who was outgoing?

E: Yeah.

J: Oh wow, that is so interesting. So they would call you or the other student by that character name?

E: No, they will encourage you to do better than the character itself.

J: How interesting.

E: And also, different other classes that I didn't have in Congolese schools. Like art, judo ... dance - I didn't do dance though, I didn't like it. I don't know why. But I was like, it's not for me.

J: But you knew, did you have friends that went to African schools that knew that that was not a normal offering?

E: I knew that it was not what others we're offering because I lived it myself. Because after the war, we changed schools. So it was really different.

In a similar vein, at another point in the conversation, she makes a point to emphasize how she is not like most African women. In this context, she uses the comparison of how most African women choose to have many children. In this excerpt, she also shows a deep self-awareness that at the time, she was not mentally prepared to keep having children given what she had been through with past child loss.

E: For African families, mostly, they want to have a lot of kids. It's, maybe it's my personal choice not to have kids just everyday. Because I know it's tiresome... for me, I always have to think like, ahead. Because I know, if you are not well prepared, things will go wrong, like really. So that's why, don't get me wrong, it's not that I don't love children. But so far, I've already had four pregnancies, even if two are alive.

J: That's a lot on your body. A lot mentally to process.

E: Yeah, you know, so yes come out now I'm ready to have a baby. But, I'm not like a typical African woman. Like after a year, she has to be pregnant again. Or after two years, she has to be pregnant, you know?

While Engjy was dealing with her mental health struggles in resettlement, in attempting to simultaneously process her past and ongoing traumas, she decided to claim her personal agency to regain control of her mental health. In addition to leveraging her past knowledge of a Western focus on mental health resources, her growing knowledge of related resources was facilitated by her then job as a refugee community worker. Therefore, while bravely attempting to face past personal traumas, she sought out treatment from one Syracuse-area facility that supports individuals with different problems in varying capacities. Below, Engjy explains how she navigated these tumultuous times, frequently reverting back to past events, all while holding her ground in the present.

E: [After many pressures in life in resettlement,] I even reached the point to go, just away - I went to Berkana house¹¹ for four days.

J: What is that?

E: Berkana house? It is a place where if you have mental health issues, you want to get away...

J: Here in Syracuse?

E: Yes, here in Syracuse. So I went to Berkana house.... I felt like I needed alone time. I think I'm a runner. If things get too, too much, I'd like to have some space, you know? In process everything. So it was really difficult....Then I was supposed to start a job and I had a breakdown again.

Engjy's empowered and agentive approach to finding mental health support for herself reflects aspects of the aforementioned intersectional approaches to stabilizing her mental health. From her choice to focus on processing past traumas and building mental dexterity with employing local resources she was learning of at the time in her then capacity as a refugee community worker to leverage a more individualist Western mindset and claim personal agency

¹¹ Berkana House is “an innovative crisis respite program that helps adults in need of mental health or substance abuse support to begin their recovery in a calm, peaceful, and supportive environment”.
<https://www.accessny.org/services/berkana-crisis-respite-adults/>.

to fight generational trauma. In these instances and various others, Engjy truly exemplifies resilience and resourcefulness in otherwise dark moments by navigating her new trajectory in resettlement defined by personal agency and a focus on supporting and healing generational mental health struggles and trauma.

Engjy's Unique Role as an Intermediary

At this point, we have been privileged to learn from Engjy about her lived maternal health and healthcare experiences pre-flight, in displacement, and in resettlement. However, we have not yet explored her unique role as an intermediary in two significant periods of her life in displacement and resettlement. In both of these contexts, she worked in various capacities to be a linguistic, cultural, and political intermediary for various populations for various reasons.

Leveraging a life history analysis to study intermediaries is rarely done in refugee literature and helps us understand a crucial role in neoliberal migration and refugee flight. Specifically, examining Engjy's lived experience of living and operating in undefined cultural and knowledge spaces in this capacity allows us to understand the depth, complexities, and power of those who have this unique lens and skillset. Intermediaries can work in various capacities, formally and/or informally. Below, we will explore all of the ways that Engjy leveraged various of her skill sets to accomplish that and in doing so, became a paid professional translator for a Western media outlet, staunch advocate, cultural translator, and medical support liaison for those in her community.

Engjy's Intermediary Role via Formal Translation and Informal Sociocultural Lens

Within the periods of her targeted life history in displacement and resettlement, Engjy worked in a formal capacity as a translator, between English and Swahili and French, on two occasions. The first time that she held this role, she was living in Uganda in displacement.

Refusing to live in a refugee camp due to her fear of refugee camps from seeing them in the DRC after the 1994 Rwandan Genocide, as she recounts “...living in the camp was scary for me. Because, during the genocide, I saw how people were living in the camp. Like really miserably”, Engjy had to find reliable, consistent funding to survive. Initially, she was the sole provider for herself and her infant son as a single mother, and later, for her new husband and infant daughter as well. Therefore, she leveraged a skillset that she learned well before she fled the DRC - her fluency in English from her time at the Belgian private primary school. This early European education was where she acquired her early working knowledge of the English language, as well as Western perspectives, value systems, ways of interpretation, cultural norms, etc... Engjy would go on to become fluent in English through her college studies and from interacting with English-speaking aid and media professionals in displacement.

One day, while she was living in Gulu, she was introduced to a foreign media reporter for CNN who was there doing research on the protracted violence in the DRC. As Engjy explained to me, the man quickly recognized her language and intellectual capacities and asked her to be his translator not only for her fluency in various languages but also for her different cultural lenses and perspectives, which she had gained earlier on in her childhood from her Western primary education. They worked together to report on various news reports to cover various series of events in the DRC Kivu Conflict. In addition, they stayed in contact when he returned to Australia and they remain friends, intellectual partners, and surrogate family members to this day.

This perspective was leveraged again in resettlement. As we saw earlier in this Chapter, the circumstances around Engjy’s arrival in the US were unthinkable. However, throughout the traumatizing medical procedures and disturbing medical care that she experienced upon her

arrival to the US, she received an outpouring of support and care from a new support community in the US: the staff of the refugee resettlement agency that was originally meant to help welcome her to the US, get her settled with lodging and basic initial resources, and then be a peripheral support resource. However, in these early interactions with her in some of her darkest moments, the leaders of the agency got to know her and eventually offered her a full-time, paid position as a refugee resettlement support worker. As she puts it, dating back to even before meeting her when reviewing her application for resettlement, they read her information, and “they were like, this is a strong woman.” In this capacity, she had various translation and community support roles. In most of her responsibilities, she would leverage not only her various language abilities but her unique sociocultural lens’ from her experience with Western education systems and her media liaison role to formally and informally facilitate communication between the resettled East African refugee communities and the refugee resettlement agency staff. However, one of her translation responsibilities in this new position is of particular importance as it relates to this refugee maternal health research and the importance and value of intermediaries in this space.

For Engjy, one of her responsibilities in this refugee resettlement support worker position was to accompany resettled refugee women to their Obstetric and Gynecological medical appointments. She would also attend the labor and deliveries of many refugee women. During COVID, she would call in for entire nights to virtually translate for her clients. In this role, she was not only a language translator but also a cultural translator, connecting the dots for the women for various Western norms, traditions, and values that would otherwise deeply confuse them. In this role supporting women’s health appointments, while Engjy fulfilled her role as a translator, her unique abilities to be a sociocultural translator were one of a kind due to her aforementioned past experiences in Western sociocultural settings and experiences. For example,

she spoke at lengths of her distinctive, culturally-sensitive approach to explaining Western medical concepts and procedures like Cesarean sections (see Chapter II for the strong cultural aversion to this practice after giving birth in refugee camps), explaining what an epidural is and pain management in general, discussing post-birth contraception options, among other Western-rooted medical practices and concepts to resettled East African refugee women.

Despite Personal Trauma, Resolve as an Intermediary in Client Obstetrics Appointments

When I asked her if attending the appointments which she described were mostly healthy prenatal appointments, pregnancies, and labor/deliveries of her clients could be difficult if there were difficulties with the client given her then-recent trauma with her own lived experience with maternal health and child loss. She said that they did not bother her because she can compartmentalize. She explained that she knows how to separate her stress from her clients' stress for her own mental health. Her responses below show her level of EQ, emotional intelligence - self-awareness, which is truly remarkable. Again, this is a very unique skill set and ability to leverage past experience for the benefit of others while protecting oneself.

J: But how do you really handle it...I think you said you haven't been to an appointment with a client where there has been a miscarriage, is that still the case?

E: My going with a client to an OBGYN appointment? Here? Yeah.

J: And it's only been healthy pregnancies or has there been a miscarriage?

E: No miscarriages.

J: Good. And if that does happen in the future... how do you think you would handle that? Do you think it will be triggering for you?

E: I don't think so

J: Because you have worked through your past trauma?

E: Maybe - it will depend on how close I am with the person. That's the first thing. But also, at this point, I'm not putting myself too much into someone else's life. For example,

for my clients, yes I can feel sorry. I can empathize, you know? But, I will not empathize at the level that it will affect myself.

J: You don't sponge in their stress?

E: Because if I do that, I will trigger something.

J: You compartmentalize? You say, this is your stress, this is my stress? I feel sorry for your stress, but it's not my stress. It's not mine to carry.

E: But it's not mine. Yeah. Because that is the safest way to take care of yourself.

J: To be sustainable with the work that you do?

E: Yeah. So that's what I do.

I would like to reiterate again that her job in this role is generally for language translation with maybe some cultural contextualization. This excerpt reiterated just how much farther she goes with her community and individual engagement and how unique, diversified, and complex her intermediation abilities are - all rooted in her own, vast lived experiences.

Having a Baby in the US with Personal Maternal Trauma

I also asked if attending Western healthcare appointments for expecting mothers specifically in Western healthcare settings put her at ease for any future children (or child) she may have in resettlement in Syracuse, as she mentioned this as a possibility for her. Again, for context, Engy lost two babies in displacement in Uganda, due to medical malfeasance in poorer-quality healthcare settings.

J: ... do you have any other reservations about getting pregnant [in the US]?

E: No

J: So it's the service [being your only hesitation]?

E: It's just that and the fear of losing the baby.

Therefore, this is another way that Engy serves as a unique intermediary in maternal healthcare settings. She can empathize with any potential maternal health trauma of her clients who also

previously lived in resettlement and many of whom gave birth in these settings as well. This positionality did not change when, recently, she gave birth to her beautiful, healthy baby girl in Syracuse. Because trauma does not go away when new babies are born. For some, they intensify. For Engjy, she has shared that her past losses continue to affect her present, in her maternal experiences, and in general. She continues to empathize with her clients' trauma, loss, and grief while providing support, hope, and linguistic and sociocultural clarity on the situation at hand.

Commitment to Community Over Western Job Descriptions: Continuing to Intermediate after Promotion

Due to Engjy's consistent dedication to ensuring that her clients not only linguistically understood what was going on but that they felt heard, respected, agentive, and comfortable in their entirely new sociocultural surroundings in their female and maternal health appointments, it was only a matter of time before she was promoted from her role as a community worker to a more senior position which is more removed from attending and supporting individual healthcare appointments. However, given her commitment to building community and ensuring her clients' sociocultural understanding of their female and maternal health appointments, she has shared with me that she still occasionally attends these appointments in the same language and sociocultural support capacities.

Based on her contextualized cultural responses throughout her targeted life history interviews - consistently focusing on her values of community networks and support, of empowering and supporting resettled refugee women, of equitable and humane treatment in healthcare settings, Engjy's insistence, despite her promotion, of stepping back into her old role when she has the bandwidth (and sometimes when she doesn't) roots back to her cultural upbringing where community members support each other. Not for Capitalist gains from a paycheck but because it is deeply ingrained in the cultural fabric of Congolese society for

women to gather around a female community member's bedside and support her in all of her needs. To bring her food postpartum. To offer to watch her newborn so she can rest.

Based on the data collected, I believe these are the reasons why once promoted, she still attended appointments and births from a social responsibility as a community member living together in resettlement in Syracuse. This commitment could also tie back to her personal experiences of being alone in foreign, terrifying, and dangerous maternal health and healthcare settings before and not wanting others to feel what she felt since she experienced many of these horrific events alone. Thus, while Engjy has formally held these two formal translator roles, we can now see just a few examples of the varying levels of cultural and social translation that Engjy provides in an intermediary capacity and the context around them.

Engjy's Unique Intermediary Identity & Necessity to Amplify the Impact of her Role

Engjy's background as a woman in flight is truly unique. Her formal Belgian primary education, a wealthy early childhood, her college coursework, her experiences as a translator and cultural intermediary for one of the largest Western news outlets, her experiences with past sexual assault and rape, her unthinkable loss of two almost full-term babies due to medical oversights - all may seem like an abnormal personal and educational background for a woman with a "refugee" designation. As exemplified in this research, all individuals in flight have rich, complex, and nuanced lived experiences. Engjy's specific targeted life history perspectives of her many intermediary roles at these two points of flight are invaluable. Not only for building out refugee and migration literature with more nuanced and complex examples of intermediaries in maternal health and healthcare and the role of communities and networks therein but also for contextualizing refugee policy reform. Specifically, identifying and partnering with those who work in intermediary capacities in refugee communities is paramount for public administrators to

begin the necessary work of placing community-specific refugee needs, values, and perspectives into the core of refugee policy.

Concluding Remarks to Chapter III, Resettlement Pt. 1

The first half of this chapter was a brief review of significant topics and contemporary concerns in maternal health and healthcare of resettled African female refugees in Western contexts. In the second half of this chapter, I examined qualitative data from Engjy's targeted life history with maternal health and healthcare in transition to and while in resettlement. Key issues covered included structural violence in pre-resettlement agency protocols for pregnant refugees, conceptualizing family in conflict, flight, and motherhood, navigating national identity and belonging in resettlement, and a refugee mother's intersectional approach to mental health struggles in resettlement.

Chapter IV is a continuation of this chapter. In that chapter, I examine additional qualitative data from interview responses from resettled Congolese women in Syracuse, NY, and interview responses from maternal healthcare providers in Syracuse, NY who have worked with refugee patients. Collectively, Chapter III and Chapter IV provide context for a comprehensive political economy of health analysis. Additional theories and concepts of structural violence, cultural hegemony, intersectionality, and agency are applied in the analysis of data in both Chapters III and IV. It is my sincere hope that the analysis of these invaluable perspectives be leveraged in refugee maternal health and healthcare policies to apply a more holistic, political-economic, and tailored approach to time-sensitive issues in the current period of record-breaking refugee flight.

Chapter IV: Experiences in Contexts of Western Resettlement (Part 2)

Overview

This chapter examines recurring themes from semi-structured ethnographic interviews with resettled Congolese refugee women who gave birth at Crouse Hospital in 2019 and 2020 in Syracuse, NY and with medical professionals who work with Congolese and other refugee patients at Crouse Hospital in Syracuse, NY. These narratives of lived experiences focus on refugee sexual, reproductive, and maternal health and healthcare of Congolese refugee women in Syracuse. Therefore, Section I focuses on experiences of pregnancy, labor/delivery, and/or postpartum of resettled Congolese refugee women in resettlement.

Section II focuses on accounts of medical professionals who work with refugee populations in Syracuse. My partner and I interviewed include OB/GYN medical doctors, OB/GYN medical residents, labor and delivery nurses, and postpartum unit nurses. I analyze the responses after I introduce each narrative account theme. I continue to use frameworks from the political economy of health, structural violence, cultural hegemony, and cultural relativism where relevant. Studies on related Western-resettled African refugee populations supplement my interviews on the unique backgrounds and needs of this population in Western healthcare, cultural, and social systems. The narratives are deidentified and pseudonyms are used to protect identity.

Overview of Syracuse, NY & Refugee Resettlement Demographics

For context, Syracuse is the fifth largest city in New York State, with a 2020 population of 145,170. In 2019, when I began my research there, household incomes and residents living at or below the poverty line were far below the national averages.

	2019 Average in Syracuse, NY	2019 National Average
Median Household Income	\$38,276	\$69,560
Residents at or below poverty line	31%	13.4%

Syracuse is comprised of the following self-identified demographics: 54.8% White, 30% Black or African American, 9.4% Hispanic or Latino, 6.5% Asian, 1% American Indian and Alaska Native, and 5.4% who have two or more racial ancestries (US Census Bureau, 2022). Further, in 2018, the Syracuse City School District had the second-lowest high school graduation rate in New York State of 58.3% (Mulder, 2019). Syracuse is a federally designated refugee resettlement city. In 2018, Upstate New York¹² resettled 1,139 refugees, with 428 from the Democratic Republic of the Congo. Of the 1,139 refugees resettled in Upstate New York in 2018, 223 resettled in Onondaga County, the county which encompasses Syracuse (otda.ny.gov, 2018).

Ethnographic Data and Analysis: Thematic Narrative Accounts from Congolese Refugee Women’s Health and Healthcare Experiences in Syracuse, NY

Research Protocol

In March 2021, I conducted seven interviews with Congolese refugee mothers and nine interviews with refugee support professionals with my research partner, then-SUNY Upstate Medical Student, Gretchen Goble. All individuals interviewed resided in Syracuse, N.Y. at the time of the interviews.

Eligibility criteria for the Congolese refugee women we interviewed were developed to maintain consistency of maternal healthcare experiences. IRB eligibility criteria for the refugee women were: Congolese female refugees, ages 18-45 years old, who live in Syracuse, received

¹² In this study, the region of Upstate New York is represented by the following counties: Erie, Monroe, Onondaga, Oneida, and Albany.

prenatal care through SUNY Upstate, and gave birth at Crouse Hospital in 2020 or early 2021. For the refugee support professionals. The IRB eligibility criteria were: healthcare professionals who worked with refugee female patients at Crouse Hospital or an affiliated prenatal care office in Syracuse, NY in the licensed position of any of the following: obstetricians/midwives, OB residents, or L&D nurses.

The main research question for my interviews with resettled Congolese refugee women was: What are the lived sexual, reproductive, and/or maternal health and healthcare experiences of Congolese refugee women while displaced in East African refugee camps and in resettlement in Syracuse, New York. Further, how do these experiences affect, on both a micro and macro level, refugee experiences in flight, displacement, and resettlement in the West as they pertain to maternal health and healthcare?

Research during COVID-19

The births of the Congolese refugee women interviewed took place just before or after COVID lockdowns in 2019/2020 and represent the strict one support person policy. When forced to choose, as seen in Theme 2, three women chose a traditional female figure over the husband (or for one woman, there was not a father involved). Three women chose their husbands to be present over the traditional female support system. However, with the husband at the birth, there were still female support systems behind the scenes at home caring for the children. Finally, lacking a husband or family in Syracuse, one woman chose doula support through a local healthcare clinic where she received prenatal care.

Theme 1 - Demographics of all seven women interviewed were similar in age, arrival to the US, and having had past labor and delivery experience with previous children

By chance, all seven women were in their mid-30s and arrived in the US within the last five years of the interviews (between 2015 and 2019). This denotes the ongoing flight of

Congolese refugees from the protracted conflict in the DRC, but also reflects the data provided in the Introduction showing the Trump Administration's refugee quotas being far higher during his presidency for Christian refugees than for refugees of other religious faiths, mainly Muslim refugees.

Since most Congolese persons identify as Christian, usually Catholic denomination, this could explain how these women arrived to the US recently despite the majority of them arriving during the period of overall low incoming refugee quotas under the Trump Administration. Finally, the labor and delivery experience that they described in detail in their interviews was not with their first child. Six of the seven women had had children in East African refugee camps, usually Tanzania, prior to their arrival to the US. This past experience with labor/delivery should be considered in examining their descriptions of their birth experiences in the US. This is especially important since the last birth experiences were in refugee camps for six of the seven women and were generally characterized as abusive and traumatic (as detailed in Chapter II).

Theme 2 - When forced to choose one labor support person during COVID, choices split between maternal figures and husbands

Four out of seven women had a doula or maternal figure (sister, mother-in-law, mother, etc.) present at birth as the one allotted support person. Doulas represented a "fill-in" for the traditional female support system in the cases where supportive individuals were still living in displacement, diseased, or otherwise unavailable. Those without female family or doula support tried to leverage support from the female medical professionals, mainly L/D nurses, in especially painful periods of labor/delivery. Further, three out of seven women chose their husbands as their one support person, calling into question the shifting gender roles of refugee men from traditionally patriarchal cultures once resettled in the West.

Female Family Members Support Narratives

For one refugee woman, her support came from female family members both remotely and in person. As one woman recounts below, she had her sister on the phone supporting her during labor and also translating for her with the medical staff in person in Syracuse. Additionally, her mother-in-law was physically there as her one chosen support person. Further, this was one of several instances where I saw the female family member, despite it being her mother-in-law and not a blood relative, chosen over the husband/ baby's father. The father was dropping food off for her but mainly staying home to care for the older children and also working when they were in school. More on this phenomenon of shifting gender roles below.

Another woman delivered her tenth child in Syracuse with the emotional and translation support of her sister after spending over two decades at a refugee camp. However, she explains that being able to have her sister present at her delivery, or even in Syracuse and in her life, was a tumultuous journey that dates back to when she lived in the DRC. She details how one day her entire life was suddenly uprooted, separating her from her sister and family for many years:

W: When the war started, she was at the river washing the dishes. Then when she went back home, she found that everyone was not home. So she decided to just run. For her life. And on her way, she met a group of people, said she was alone, she entered into that group so they can just go together. And her husband was in the group. So in the road as they were going, they were talking together and then when they reached their camp, they just fell in love and that's how it started.

This woman explained that after this event, she never heard from her mother again but she believes that she is still alive. She was in contact with her father years later just a few times before he passed away. She and her husband remained together throughout their over two decades in the refugee camp and the birth of their previous nine children before arriving in the US and delivering their most recent child. She notes that her husband stayed home with their children and dropped food off for her at the hospital when she was in the postpartum unit. She

mentioned that her sister also came to stay with her and her family afterward to help her cook and clean.

From a political economy perspective, this woman has experienced elements of Western influence with her husband staying home to watch the children and cooking and bringing her food after she delivered their child. Traditionally, elder women from the village, family, or friends would do this for a mother after giving birth. Conversely, she still had her sister, who also had a Western education and spoke English enough to translate, attend her delivery, and temporarily live with her to help with the baby afterward. The dichotomy of these two elements certainly reflects the various influences of different stages of migration and more liberal gender norm influences in resettlement.

Doula Support Narrative

One woman interviewed was a single mother giving birth to her second child in the US without any family support. She had two doulas present who were provided gratuitously through a local non-profit group. (The one support person policy allows for a trained doula to also be present but they are generally required to show proper documentation. In this case, there was a doula and a doula in training and the woman did not have any other support person so the two doulas were both allowed in the room.) Though this was her second child, she explained that her first child was kidnapped in the DRC and she does not know where she is. The father of the baby was not mentioned, nor was his absence during the woman's labor/delivery discussed. It was later privately suggested by the translator that this second child was from the woman being raped. Below, she explains that during her first delivery in the DRC, her mother and sister were her main support, as is traditional in the culture.

I: Did she have any family members at her first birth?

W: Yes....There were two....Her mom and her aunt.

I: And did they help with the baby after the baby was born?

W: Yes.... traditionally when you give birth, your mom comes over and takes care of you. She stayed with her mom...

She went on to explain what the doulas did to support her during her labor/delivery for her second child at Crouse:

I: And what kinds of things did the doula help her with in the hospital?

W: So they were taking care of her, like if she wants to go to the bathroom, they could take her there. If she needs some water, they will give her. And like trying to comfort her when she is in pain, plus breathing exercises. Those are the things that they were doing.

I: And they stayed the whole time?

W: Yes, until the baby was born [and] they stayed up until 2 pm. The baby was born at 9 am.

It is important to note that the two doulas were non-Congolese American and did not speak Swahili. Therefore, as the woman explained, the doulas required the use of a local translator on the phone throughout the process. All doulas who support refugee women during birth in Syracuse are certified doulas, and most are refugees themselves. However, in some instances, non-Congolese and/or non-refugee doulas are called on to assist refugee women and are faced with various cultural and linguistic barriers. These barriers exist for most doulas who do not share cultural and/or linguistic similarities, or the experience of refugee flight, with the woman that they aim to support in labor/delivery (Doenmez et al., 2022). Further, in a city like Syracuse at least, where there are many Congolese refugees and refugees from around the world, the chances that non-refugee doulas have attended and assisted a previous birth by a refugee woman are quite high.

Looking to L/D Nurses for Support (emotional support during labor beyond job requirements)

During labor, one of the women was looking for someone's hand to hold as they would a female family member or to supplement the one support that was allowed to be there. This technically goes beyond the job description for L/D nurses, especially if they are needed to support other ongoing labor/deliveries. This Congolese woman may have assumed that the traditional role of women in birth in Congolese culture is the same in the US. If a woman did have a female family support person present already, the assumption may have been that large groups of women support labor and delivery in the US too and that this was part of the job of the labor/delivery nurse - a role in most cultures often held by females.

W: When she went to deliver her first baby here, she was with a nurse who didn't want to be touched. Like, she could tell her don't touch me. While she was in pain, she needed someone to hold her hand or something but the first nurse was not ...So the nurse was really rude. The first nurse was like not responsive and cool.... She was giving her a look that was not good. Like as if she's disgusted or something like that.

In a Western culture, and especially in Western healthcare, when one examines standard medical support practices from the lens of non-Western healthcare practices, cold, sterile reactions like these from healthcare staff during an especially vulnerable time for Congolese women can be triggering and/or isolating for the refugee women for a variety of possible reasons. A few healthcare workers I interviewed regarding their experiences of working with refugee patients (detailed below in Section 2) echoed similar cold responses to customary Congolese cultural practices, though it was not a common response from the small number of people we interviewed. It is important to note that there were far more positive, warm, and educated responses from the healthcare professionals I interviewed, and a few negative responses are not necessarily cultural. Finally, also detailed below, other Congolese women mentioned that they chose their husbands as their one support person which could represent, at least for some, a

possible shift in traditional Congolese male roles, among other new Western sociocultural influences.

Husband as Support Person during COVID

From a political economy lens, the context of COVID and living in a new Western culture, there is a shift away from the traditional birth norms and customs that would have historically taken place in the DRC. However, their previous births in refugee camps versus in the DRC were also a shift away from the norms, as detailed in Chapter II. None of the women had, in fact, given birth in the DRC but knew that their maternal healthcare experiences were a far cry from those of their mothers and female family and friends in the DRC which were shrouded in a constant stream of traditional female support, guidance, nutrient-dense, indigenous prepared foods, and childcare support for older children. As much as possible, the female elders tried to replicate the female support system in the hospital (as detailed below by the medical professionals). Yet, once COVID policies restricted support people to one person, the traditional large groups of female support present for labor/delivery were no longer permitted. However, COVID restrictions also give us a unique look into which cultural norm the Congolese women chose to lean toward when forced to choose.

As evidenced above, more than half of the seven women interviewed chose a female family member over their husband as their one allotted support person. This trend is in line with historically traditional Congolese practices. This lens would also cause us to look at the economic contexts of this phenomenon, which shows us that for most resettled Congolese families, the husbands hold a full-time job and the wives stay home with the younger children. With the strict hospital COVID support person policies, the one support person cannot come and go and must stay in the room with the mother. Thus, because the husbands need to go to work

every day, this could be another reason that the husbands were not chosen as the one support person. Further, this reasoning was also cited by several of the healthcare workers for why the husband was not chosen as the one support person. Alternatively, it could also reflect a Congolese cultural norm where fathers are traditionally not involved in the birthing process.

This practice also reflects the capitalist, industrialized society and culture where these individuals now live, where, similar to many native-born Americans as well, their lack of industry-specific experience, language skills, formal education, and likely their racial minority status, results in being forced into low-paying jobs that do not come with benefits like parental leave, which would allow them to attend the birth of their child (Campion, 2018; Cain et al., 2021). Maybe they could have missed a day or two of work, leveraging vacation time, but not a few days that the COVID protocol would require to be the sole support person.

However, the fact that three out of seven of the women chose their husbands is still remarkable and could reflect an influence of Western gender norms where men are generally more hands-on with their children and play a more active role in child-rearing activities and responsibilities. Conversely, it may have been because of COVID and the men came and stayed to minimize COVID exposure. In summation, through a political economy lens, this COVID protocol permitting one support person in the hospital during labor and delivery has ultimately allowed for a unique opportunity to better understand the contextual influences and barriers that refugee women and their families face in their maternal healthcare experiences in resettlement in Syracuse specifically.

Theme 3 - Underlying fears and cultural myths regarding pain management and C-sections

Six of the seven women delivered their children at Crouse without any form of hospital-provided, medical labor pain management¹³. The only woman who did have pain management had an unplanned cesarean section and had to have an epidural in this case as is the hospital policy. The initial reasons provided for deciding to forgo pain management vary. However, the most commonly cited reason was precipitous labor - labor that progresses quickly. Therefore, there is not time for an epidural or even IV pain medication, even if a woman does want it. Since subsequent labor and deliveries generally progress faster each time and since four of the seven women who passed on pain management had four or more children, with one woman having nine, this reason for not using pain management would make sense.

However, using a political economy lens, I found that there were more reasons at play. Mainly, the common sociocultural view among refugee and/or other resettled immigrant populations from rural African societies which spreads the falsehood that certain common Western medical procedures will lead to the death of an unborn child and/or of the mother. This myth regarding epidurals and C-sections in particular was mentioned by both refugee women and medical professionals. As one medical professional added on their experience working with epidurals with the general refugee female population in Syracuse:

And from my experience, I feel that some women have been told that epidurals can cause all kinds of complications or scary things. So when the women, not all women, but many refugee women choose not to use an epidural for that reason. It can be quite tricky coming from a professional standpoint because if we have concerns about the baby's well-being, technically an epidural is a safer option for the baby and the medicine stays in the mom's spinal region instead of being transmitted to baby which is where the

¹³ Henceforth, reference to “pain management” means hospital-provided pain management which mainly means epidurals but can also mean oral medications, usually opioids, local anesthetic injection, nitrous oxide, among others. Pain management that is patient-driven or provided by a support person can also include massages, relaxation techniques, walking, etc.. However, in my reference of pain management in this text, I am referring to an epidural specifically.

medicine in the IV can get metabolized and sent to the baby as well. So if we have concerns about the fetal wellbeing based on the fetal heart racing, there have been bad circumstances where I have to explain to women that, you know, if you truly want something for pain unfortunately the only option I can give you at this moment is an epidural based on my concern for the baby's well being.

It is important to emphasize here that this particular response is pure speculation of the possible reasons behind a refugee woman's possible fear of epidurals, and not meant to represent actual reasons why refugee women feel the way they do about epidurals.

For many women, their only prior knowledge of Cesarean deliveries comes from their time in the refugee camps, or maybe even before in the DRC, where Cesarean deliveries are still mainly only used for dire emergencies and many women die from them. For example, Cesarean deliveries are used in the US for fairly common issues such as a breached infant or placenta previa, where the placenta is partially or totally blocking the cervix. In countries where medical care, resources, and obstetrics staffing are limited, C-sections are reserved for specific instances in labor where the lives of mothers, babies, or both are in imminent danger. As one professional that we interviewed said on the topic:

One of the things that we have sometimes found in certain regions, or certain individuals, the idea of people needing Cesarean sections. So in some regions, in different parts of the world, the idea of needing a C-section is almost thought of as a death sentence for certain women. And having to have sometimes heated conversations about that, can be sometimes difficult. So the idea that maybe from the area where you were, that that is something that can be very worrisome.

In our region where we are, although there are risks and there are complications and those sort of things, it is by no means as scary or as worrisome as can be thought. So sometimes, that has led to some conflicts where some patients have decided against it and have wanted to go another way. Or wanted a different method of care than the medical professionals have stated for them. And not in a paternalistic or in a patronizing way, it's just a very frank conversation about the pluses and minuses of this and that. So sometimes that, has been problematic. Fortunately, not as often, over the last few years I would say.

From a political economy perspective, another reason for what some call the over use of C-sections in the US goes beyond medical necessity to the capitalist bottom line. More C-sections bring in more insurance dollars and more money out of pocket from patients for the hospitals and professionals. The documentary film, *The Business of Being Born* (Epstein, 2008), explores the various capitalist mechanisms at play behind obstetrics and hospital practices in the US and other Western cultures. Convenience for providers (and sometimes mothers) is also a big reason for C-section over use. In the past decades, for this and other reasons concerning increased safety and personal agency, there has been a small shift by mostly non-Hispanic white women to delivering babies at home or at birthing centers (Boucher et al., 2009; MacDorman et al., 2013) with the support of midwives and doulas. Choosing these options allows them to avoid hospitals, OB practitioners, and drugs for pain management.

Returning to refugee women and their fears of Western pain management and C-sections, there is also the belief that if you deliver a baby via C-section in the US, medical professionals will only let you deliver via C-section in the future. This can cause concern because there is usually a standard limit of three C-sections for any woman due to the increased risks with each subsequent surgery. Considering that more children mean more social capital and prestige in Congolese culture (as detailed in Chapters I and II) despite now being in the US, this causes most refugee women to avoid C-sections at all costs. This can include instances where a C-section is medically necessary to save the life of the child and/or mother, such as in extended labors where baby and/or mom are too tired to keep laboring, in cases where the baby is breech or transverse, or when the mother has preeclampsia or gestational diabetes and an earlier delivery is necessary. However, contrary to this belief, a growing number of doctors *will* allow subsequent babies to be delivered via VBAC (vaginally birth after C-section) if the mother is otherwise healthy.

As one of the refugee medical professionals said on the topic:

I definitely think that [there is] more so a hesitancy with respect to C sections..... I think it ties to the desired parity. Because the patients generally will want a potentially large family or higher parity and although we are quite supportive of VBAC even in patients who have had upwards of two previous sections, they are fearful that one C-section will equal a repeat C-section.

As one of the refugee women we interviewed explained, she was denied a VBAC from another Syracuse area hospital which led her to deliver at Crouse. She had had a C-section before in the US in the first city she was resettled in and was afraid of having another due to the aforementioned reasons of this potentially limiting the number of subsequent pregnancies/deliveries she could safely have. Crouse agreed to her request as long as complications did not arise during the vaginal delivery and only after they called the last hospital that she delivered to confirm that her last C-section was due to a unique circumstance and not to an ongoing, underlying health issue.

I: Did she have a C-section or vaginal delivery in Syracuse?

W: So this pregnancy, the second one, she went to [a local Syracuse hospital]. And they were telling her that no matter what, you will deliver with a C-section. And she was not OK with it. That's why she was like, let me go and try somewhere else.

I: Some hospitals won't allow a vaginal delivery after a C-section. But Crouse does. Though some others won't. The VBACs.

W: Why?

I: It puts them at greater risk.

W: So she then went to [a local refugee healthcare clinic] and she asked them to let her try first before they could decide to operate on her and they accepted. That's why she waited. Because she was saying that the last thing will be to have another C-section. That will be the last thing if she doesn't deliver vaginally. And then she delivered vaginally.

I: How did she go about finding a new place to try?

W: So when she reached Upstate, they asked her if, when she delivered, was it just because she couldn't push or she was not physically fit or was it just because of

something that had happened. So she told them that the baby had drink a lot of water so that's why they decided to operate on her. So for them to be sure that it was true, they asked for the number of the hospital where she delivered and the address. So they called ... So that's what they did. They called and then they confirmed that it was not because she couldn't push. It was just because the baby had consumed an amount of liquid.

This crucial additional research on the part of her medical team at Crouse is vitally important in refugee maternal healthcare and refugee healthcare in general. Refugee medical records are scant, usually not written in English, and/or often inaccurate, when they are available at all, as mentioned by various refugee medical professionals in their interviews. Additionally, for some refugee women, a lack of medical records could be from being born and raised in more rural areas in the DRC where the lack of records could be due to any number of reasons, including a possible lack of formal healthcare practices where they were born, a lack of resources for extensive medical records management, and/or due to a home birth. In response to a possible lack of medical records, one medical professional mentioned that most medical records on file for the refugee patients state that their birthdays are January 1st of a given year. This is apparently used as a universal default date by resettlement agencies when women don't know their birth date but need to put down a date on their resettlement paperwork.

It is for this lack of records that the medical professionals who treat refugees must go the extra mile and gather any and all past records that they can to best treat their patients. Still, this crucial and factual piece of information is not included in the frequently-spread myth of epidurals and C-sections being potentially fatal. It is important to note that these myths are spread within refugee circles but my interviews revealed that healthcare professionals may also be responsible for spreading misinformation. As one refugee woman mentioned from her experience giving birth another time at a local Syracuse healthcare clinic that mainly works with refugee patients:

W: No. She didn't get any pain management. So her OBGYN, she told her not to accept the epidural because it has some effect on the back. It brings some pain long term. So that's why she was like, no, I will not get the pain medication.

I: Her OBGYN from...

W: ...from [the local healthcare clinic].

Despite this cited experience, other women we spoke with who have received medical services at this local healthcare clinic spoke highly of it. This was mainly due to the fact that their services were tailored to refugee women and their unique needs and barriers living in the US. The professionals in these settings are also apparently older and/or have years of experience which seem to elicit more respect and trust from the refugee women and therefore, more comfort in this clinical setting.

This could be a correlation to the fact that most individuals who traditionally assist with birth in the DRC are also older females with years of experience. Furthermore, past related studies have also noted that female refugees had a much higher comfort level in receiving OB/GYN care and translation services for this area of healthcare from female professionals and translators over males (Roussos et al., 2010; Asif and Kienzler, 2022). Conversely, many professionals at Crouse are medical students, generally younger, who, according to some of the women interviewed, looked at them as case studies to learn from instead of as human beings. (This is not to generalize medical students who may be balancing a strong sense of purpose, compassion, and even idealism in their work *and*, at the same time, trying their best to be successful in their rigorous and costly medical school training.)

W: So the other negative thing that she saw at Crouse is that most of the students, they want to come to you and make you the... I don't know how to say it... like a sample, you know?... Like a specimen. And that's when she didn't like it also. But at [another local healthcare center] where she went to deliver the second baby, she was welcomed, they took really care of her and the demographic was also different because it was nurses who have been there for a long period you can see they're really like... they are not young like

the students. Like they were more gentle with her, they were good with her. Through childbirth.

Medical and academic literature on this topic frequently cites similar myths being spread about the use of contraceptives. Cited reasons to avoid contraceptives range from fear of them being a Western reproductive tool that some believe lead to infertility - some considering it a form of eugenics, to fear of being regarded as sexually promiscuous. These myths are often spread by males in refugee communities too, either due to these same fears or due to wanting to purposely perpetuate these falsehoods in order to encourage frequent, subsequent pregnancies from female community members (Royer et al., 2020; Zhang et al., 2020).

Thus similarly, regarding pain management, social scientists and medical professionals alike have suggested, based on ethnographic and lived experience, that this myth is spread by men in these societies partially out of fear of their unfamiliarity with these Western practices with concerns that their wives and female family members may be limited in their fertility from these procedures (Zhang et al., 2020). Others argue that alternatively, or additionally, these myths are spread due to patriarchal social views where in certain societies, the men decide how much pain their female relatives can and/or should endure. In such cases, it is not the woman's decision. This issue of controlled female pain tolerance is also seen in forced female circumcision based on cultural traditions in certain societies (Mwanri and Gatwiri, 2017; Shell-Duncan et al., 2021). Further, this cultural practice of men executing these and other medical decisions for their female family members was also a theme from the refugee medical professional narratives, detailed further below in the second half of this chapter.

Theme 4: Hybrid breastfeeding and formula-feeding babies at hospital & once home

Six out of the seven women interviewed used a hybrid of breastfeeding and formula to feed their babies between their time in the hospital and once home. The one woman who exclusively formula fed her baby did so because her milk supply did not come in at all.

It is generally universally acknowledged that breastfeeding is by far the best way to provide infants with the maximum amount of nutrients, early immune and digestive support, emotional regulation, and countless additional health benefits (Clark and Bungum, 2003; Walker, 2010; Lyons et al., 2020). This is the promoted method of feeding infants in the US, in all Western countries (Blum, 2000), as well as the main, and in many cases, only available method of feeding infants in rural non-industrial societies due to a lack of baby formula, clean water, and bottles. Hence, most societies promote and use breastfeeding as the preferred method of feeding infants. However, as my findings from my small sample also support, refugee women statistically use formula more than breastfeed. Why is this?

Using a political economy analysis, I first discuss the history of this phenomenon. In the DRC, before flight, it was traditional practice, especially in rural areas where many refugee women are from, to breastfeed their children. This is due to a variety of factors. However, in the 1970s, bottle-feeding was common in many developing contexts, largely pushed by capitalist formula giant Nestlé in neocolonial contexts where dire economic conditions prevented low-income mothers from being able to breastfeed (Sasson, 2016). Still, in the present period, pre-flight, breastfeeding was (and still is) the preferred baby feeding method for rural women in the DRC. Then, in the Western-run refugee camps, this was still the common and generally only available option, even when many women cited a lack of sufficient food to feed themselves and their families. This was especially an issue when the woman was pregnant or breastfeeding and

was not getting enough food, let alone enough nutrient-dense food. Chapter II highlights women's narratives of lacking sufficient, nutrient-dense food while in refugee camps, especially while breastfeeding.

In instances where this lack of food likely led to a lack of milk supply for some women, they could not resort to bottles and formula as it was cited that these were not available in the camps. Even if they figured out how to gain access to formula and bottles from external sources, they lacked the financial means to do so. As one woman I interviewed mentioned, she resorted to feeding her children soy porridge as that was her only option to feed her babies:

W: All of her children, she didn't have milk.

I: And so she got bottles and formula at the refugee camp for her other children?

T: No. [Surprised tone at the question.]

W: All of her children, she was feeding them with porridge of soya.

I: In replacement of breastfeeding?

W: Yeah.

I: Because that's what was available at the refugee camp?

W: Uh-huh.

As another woman whose milk did not come in noted, no money meant no bottles. No bottles meant that her babies cried often due to their unmet hunger pains.

W: Because like sometimes she could breastfeed and the breastmilk is not enough. She could need to bottle-feed the baby but who will give her the bottles or even the milk? No one. So that's why it was difficult.

I: It was a question of money? Amafaranga?

W: Yeah. The baby could have bad health because of that so yeah, it was not pleasant.

I: How did she get the money to buy the bottles?

W: No, she didn't get any money.

I: Did you strictly breastfeed then even if you felt like sometimes it wasn't enough?

W: Yeah. So the breastmilk was not enough. The baby could cry a lot so, you know, no choice. No alternative.

I: So did she feel like she had enough food after she gave birth to make enough milk for the baby? Was that an issue?

W: There were no food in the camps so they were starving.

I: The whole family?

W: Yeah.

Moving on to the resettlement period, when refugee women are just arriving to the US, in the case of the women I interviewed, they are still exclusively breastfeeding (or, in rare cases, giving their babies formula alternatives like the woman who mentioned soy porridge). Once they give birth in the US, with their enrollment in Medicare and other federal programs like WIC, refugee families can access formula if they want to use it. They generally learn about formula from other refugee women who have been in the US longer and have used it and accessed it using the same federal WIC¹⁴ benefits. Still, even with this access to formula, according to my findings, refugee women still generally prefer to exclusively or partially breastfeed, when it is their choice. As one woman noted, "... she was breastfeeding the baby and they were also giving bottles to the baby. In the hospital and at home". Exclusive formula-feeding is generally used long-term by women whose milk does not come in. As the one woman who exclusively bottle-fed shared:

W: She couldn't breastfeed, so it was bottle only.

I: Is that what her preferred...

¹⁴ The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

W: She doesn't have breast milk. She usually doesn't have milk...at the hospital, she put the baby on bottles.... All of her children, she didn't have milk.

However, in the first few days post-birth when milk has not come in as is the case for all women, formula is used by *most* refugee women. In these early days, a thick, sticky, generally yellow liquid called colostrum precedes milk production. Colostrum is very minimal in volume but biologically provides babies with the nourishment and immune protection needed in the early days when their stomachs are the size of a pea and do not require any more than that small amount (Santoro et al., 2010). So why, with this ample nourishment from colostrum in the early days, do most refugee women opt to supplement with formula? Perhaps, refugee women feel a sense of scarcity from their past experiences of not having enough food to feed their families and/or themselves while pregnant, breastfeeding, or otherwise (details in Chapter II).

If formula is available for free, it feeds their children, and they are offered it in the hospital, it makes it very attractive to use this resource. This convenience, with many other stressors, responsibilities, and likely other children at home in resettlement leads some women to partake in the federally-funded program, WIC that provides women with free formula over the more time-consuming breastfeeding. As stated in my interviews with the refugee women, there is also information learned from other resettled refugee women before the woman arrives at the hospital that generally sees formula use in resettlement as good for babies, initially easier than breastfeeding in the early days of teaching baby to latch and while balancing many other responsibilities, quicker night feedings, etc.

These reasons and many more might explain the use of formula in the early days in the hospital and also for other mothers once home. For three of the women, they mentioned that they tried to keep using formula once home but that their babies soon refused bottles and therefore they had to exclusively breastfeed. These instances and the instance of the milk not coming in

also reminds us that reasons for any type of feeding are sometimes out of the mother's control all together and therefore the methods used may not align with the preferences of the mother. Still, as I have noted, in the case of six of the seven women interviewed, breastfeeding or a hybrid was still the main method used to feed baby between the hospital and at home.

Let us return to the statement from a nurse that says that refugee women use formula more than breastfeed in the postpartum period of their hospital stay. It was the nurses, particularly the postpartum nurses, whose job in part is to assist with breastfeeding support, who gave deeper insight into the nuances behind this statistic and who ultimately disproved it. First, we must broadly acknowledge that one main issue with statistics is that they can generalize, look at only one point in time (in this case, in the hospital versus what happens once home), and/or do not show the nuances of a situation. Secondly, this is yet another reason why context matters. In this case, context was provided when the nurse indirectly explained why the statistic and my findings do not align. Specifically, she says that even if a refugee woman uses formula only in the hospital, and even only once, she is marked as a formula-feeding mother. Even if she exclusively breastfeeds or hybrid feeds her child from then on.

P: So postpartum, the mom themselves, they typically like to breastfeed. However, they do not believe that they have breast milk immediately following delivery. And so they say, don't put the baby to breast. Unless they have other children that are nursing. Or that have recently weaned. They oftentimes will say no milk, and they want a bottle. Which is very difficult for the hospital numbers for breastfeeding friendly and only having exclusive breastfeeding because a lot of times, these women say, no milk, and they want a bottle. But they have full intentions of breastfeeding this baby for its duration but just not for the first couple of days until their milk comes in.

I: And so the hospital keeps track about how often people are exclusively breastfeeding?

P: Yes. Any use of formula is considered not exclusive breastfeeding regardless of their reason. Even if it's maternal request. Even if it's a cultural request. So it's even almost seen in a negative light. Like it is frowned upon to offer these women formula even though they're asking for it specifically with full intentions of breastfeeding exclusively once their milk comes in. That's her black and white thinking doesn't quite fit.

This reflects the narratives of all but one of the seven women interviewed who exclusively breastfed or hybrid fed their children between the hospital and once home. And again, the one woman who did not was the same woman mentioned above whose milk did not come in at all for this or any of her previous children.

The nurse also mentioned a key piece of information here - that these specific markers on each woman count toward the “hospital numbers for breastfeeding friendly” - meaning the hospital’s designation of a breastfeeding friendly hospital which equates to more funding. Again, a capitalist bottom line - whether the hospital is public or private, money and funding is always needed. This formula-fed marker, and plausible subsequent judgment on a woman could therefore equate to subpar care that she receives. Specifically regarding this “negative light”, in my interviews, I noted a clear judgmental tone from the few medical doctors who mentioned this fact. As if to allude to the fact that refugee women are not educated enough to know that “breast is best” - the common phrase pushed in Western healthcare that isolates and ostracizes not only refugee woman but all women who, for any number of reasons, are unable or unwilling to breastfeed their children.

Not only is this factually inaccurate, as breastfeeding in Congolese culture is and has always been the norm, but it also ignores the very role that their Western medical norms and Western social structural violence play in the use of formula to begin with. As noted above, their use of formula only begins in the US with access to it through public funding. Yet, beyond that, as a response phrase touts, “fed is best” - creating inclusion and support for any mother who opts or has to use formula instead of breastmilk to feed their baby. This discrimination against formula use spans all of US society yet is especially used to marginalize socioeconomically disadvantaged communities in the US - linking it to a lack of education, motivation, and other

false rhetoric. Further, privilege plays a large role in choosing to breastfeed for many women who have the time, money, and resources to take frequent breaks to breastfeed and/or pump.

In summation, a political economy lens is imperative to understand the full picture behind the major themes from my ethnographic interviews with resettled Congolese refugee women. While I briefly alluded to or mentioned partial narratives from the refugee healthcare professionals above, the second half of this chapter explores common themes from those narratives and like Section I, ties them to themes from the refugee women's narratives where applicable. This section continues to broadly use a political economy lens of analysis but also layers in the theories of structural violence and cultural hegemony in its analysis.

Ethnographic Data & Analysis: Thematic Narrative Accounts from Medical Professionals' Lived Experiences Working with Congolese Refugee Women's Health and Healthcare in Syracuse, NY

The following themes were taken from nine ethnographic interviews with medical professionals from Crouse Hospital who have experience working with refugee women with prenatal, labor/delivery, and/or postpartum care. Medical professionals interviewed include OB/GYN medical doctors, OB/GYN medical residents, labor and delivery nurses, and postpartum unit nurses. It is important to note that during the interviews, we asked the professionals about their experiences with Congolese *and* Somali refugee women¹⁵ in particular and with refugee women in general if they were unsure of the country of origin of the women they have worked with.

We were given many anecdotal examples, many included below, where the professional usually included if the women in the example were Congolese or not. Therefore, it should be

¹⁵ This is because these two demographic groups were both initially the focus of the research by the research team (a SUNY Upstate Medical student and myself). I later shifted the focus of my study to just Congolese refugee women's health and healthcare in Syracuse, NY.

noted that this section of common themes from medical professionals who work in refugee maternal healthcare is a more generalized overview of all refugee female patients in Syracuse, NY. However, Congolese refugees are the most populous of all refugee communities in Syracuse, NY. **Yet, due to the generalized nature of these qualitative findings, there will be less analysis in this section as the data is not in reference to Congolese women and communities specifically.**

Theme 1: FGM/C requests post-birth

The first major theme from these interviews with refugee medical professionals is that, on occasion, there are male family members from these refugee communities who seek to have Female Genital Mutilation/Cutting (FGM/C) performed on their female relatives post-birth. Specifically, several instances were cited where husbands asked medical professionals to perform *more* labial/tissue cutting immediately post-birth when fixing natural tears from delivery. In every instance, the response from the professional was an emphatic rejection to these requests.

Brief Overview of FGM/C and Migration

Over 200 million women and girls have undergone female genital mutilation or circumcision (FGM/C). Further, it is estimated that “30–70 million girls under the age of 15 at risk of FGM over the next decade” (Barrett et al., 2020, p. 186). FGM/C is a sociocultural traditional practice that generally seeks to uphold the social construct of virginity. The practice impacts the “physical, mental, and psychological health of affected women” (Im et al., 2020, p. 363) and is seen as an act of violence and clear violation of international human rights by Western-run global human rights organizations. However, there are some in the academic and policy spaces (Shweder, 2000, 2005; Ahmadu, 2017) who defend the practice, arguing that it is far more nuanced than what people culturally understand. For example, if a woman is uncut in

practicing communities, this can also have deep social implications as she is seen as “impure”. Family and religious community members are the main enforcers of the practices who promote and sustain FGM/C in practicing societies.

As the qualitative data of this study supports, male family members in particular make many of the decisions around FGM/C for female family members. The practice of FGM of consists of:

all procedures that involve the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons. According to the WHO, FGM is classified into four types: (I) clitoridectomy, the removal of the clitoris, (II) excision, the removal of the clitoris and the inner labia, (III) infibulation, the narrowing of the vaginal opening by creating a covering seal by cutting and repositioning the inner or outer labia, sometimes sewing them together; and (4) perforation, which has varying degrees of severity within each type of mutilation (Berthe-Kone et al, 2021, p. 2).

Examples of the short-term consequences of FGM/C include “haemorrhage, infection and shock”. Long term consequences include women having “clitoral neuroma, epidermal cysts, fistulas, bladder dysfunction, sexual dysfunction, pelvic pain and obstetrical trauma” (Berthe-Kone et al, 2021, p. 2), among other potential risks. However, others have studied the existing literature on the practice and argue that while discourse on the topic of FGM/C sees the practices as detrimental, even fatal, to women’s health, the evidence does not necessarily support these specific outcomes (Obermeyer, 1999).

The practice is most prevalent in Sub-Saharan Africa, parts of the Middle East, and Asia, including Indonesia (UNICEF, 2016). However, due to international migration flows, it has become a global public health issue with cases continuing to increase in the West, including Europe, Australia, and North America (Berthe-Kone et al, 2021, p. 1). For example, the European Parliament estimates that there are “approximately 500,000 women and children in Europe who have undergone FGM and another 180,000 at risk, although these figures may be

underestimated, as they do not include undocumented immigrants” (Berthe-Kone et al, 2021, p. 1).

“We don’t do that here” - Ethnographic Data on FGM/C Expectations in Refugee Populations in Syracuse, NY

Given the large presence of African refugees in Syracuse, New York, the refugee medical professionals interviewed shared their experiences working with refugee women who had undergone the practice and the implications for their OB/GYN care. Furthermore, several of these professionals shared anecdotal examples from working with these patients where the traditional expectations of FGM/C met Western culture and healthcare standards by way of requests for them to perform and/or further past FGM/C on their patients. In each instance, the Western medical professional flatly refused to perform any procedure past what was medically necessary for the woman’s health and safety post-birth. These experiences are shared below. I will mention again that unless specified as a Congolese patient, these responses were shared referring to Congolese and Somali patients and sometimes to all refugee patients that they have worked with in Syracuse in aggregate.

As one medical professional mentioned, she generally sees signs of FGM/C in “less than half” of this patient population. She describes an instance below where, early on in her career, the request was made by a refugee patient’s husband to the OB doctor to perform *more* FGM/C on his wife. In what seems to me as a Western-centric reaction, the doctor emphatically refused the request. I will also point out the ethnocentrism - the “us versus them” mentality - in the responses by both the professional interviewed and in her recollection of the OB doctor's response. “We don’t do that here” and “...it’s not cool. I don’t like it...”. While various social scientists have attempted to reframe and/or better understand this practice of FGM/C with the lens of cultural relativism (Nyangweso, 2014; Mende, 2018; Abubakar; 2021), I think that it will

be very difficult to find a Western healthcare professional who will approach the practice, while still refuting it, without a strong bias and judgment against it instead of contextualizing it in the culture where it comes from. Reasons for this repudiation likely come from the fact that FGM/C is illegal in the US and there are therefore ethical career implications. Other reasons certainly stem from personal biases if the professional was raised in a Western cultural context. Further, it is worth mentioning that certain anthropologists disagree with the lens of cultural relativism all together, such as Anthropologist Lila Abu-Lughod, who argues that cultural relativism dangerously emphasizes notions of “others” in understanding different cultures, paying more attention to our differences than our similarities (Abu-Lughod, 2002).

P - And it's not every one of them but I have seen them and it's uncomfortable. Years and years ago, there was this one where the father of the baby had wanted, the patient's husband, had wanted to do more. Had wanted the OBGYN doc to do more mutilation and take out more tissue. And our doctor was like no, we don't do that here. And I didn't understand, I was really young in my career and I didn't understand. It was a new concept to me. But I remember going wow, that's...wow.

And the doctor was like, absolutely not, this is not something that we do here. This is not something that I will be doing for you. No....Yeah, like the doctor was still there cleaning up and checking to make sure things were okay and intact. There was a tiny repair that needed to happen. Just a laceration just from delivery. Not from anything we had done. But it was... I have seen, it's not cool. I don't like it...

I: Overall, what percentage of the time would you say that you do see this occurrence?

P: I don't know. Less than half.

Though this does not seem to be the case here, this lack of cultural relativism in patient care, despite the WHO and many others concurring that the practice of FGM/C indeed constitutes as human rights abuse, can easily influence the quality of patient care provided. Conversely, another professional interviewed approached the topic with some self-awareness on their own personal biases against the practice. This professional also contextualized the practice

of FGM/C in the context of Western obstetric care that is largely dominated by privileged, white female professionals who generally lack self awareness or cultural relativism in regards to this practice in their patient populations. I would say that about half of the professionals who spoke on this topic had this same level of self awareness and were able to separate their own views on the practice from the culture behind the practice.

“And it is one of those practices that is very difficult to silence one's biases against it. And although we try to remain respectful, it's one of those things where, you know... why? ... And that's kind of it. Because again, you are having women from regions where they don't necessarily have a voice, they're not allowed to be a part of the conversation and are doing these things as young girls, and they are being taken care of by autonomous, mostly white females who have been privileged their entire lives who, the idea of doing something like that wouldn't even come up. ...So we do see it, we are aware of it, and we try to keep our biases, our own personal biases out of it.”

Another professional spoke to the logistical and medical OB complications that these practices introduce, as well as the training that the hospital staff receives on this topic beyond the standard training due to the hospital's location in a refugee-hosting city. Again, some anthropological reviews do not find results that correlate with some of these medical complications (Obermeyer, 1999).

Yes. So we have seen quite a few patients, that's actually one of the things that we do grand rounds [for] and we do education for their residents, for the faculty every year. And that is something that is in the national curriculum for OB GYN's. But it's something that our program particularly makes sure that everyone is very well versed and I think most OB GYN's would probably put that on every two or three or four year lecture series. And for us it's very much a part of the teaching because it's so necessary.

We regularly see a very good volume of patients with 3rd to 4th degree circumcisions where the entire labia has been removed, the clitoral hood has been removed where there is a very small opening, just for menstrual flow egress and for the urinary flow egress. ... we do counsel them that having the natural expansion of tissue and potentially there will be a small tear at the time of delivery as well. We actually teach the residents that thinking about putting in a catheter early on and having to think about, if you had to do a C-section, how would you get the catheter in quickly because we need a catheter in

place... a full catheter in place to be able to do a C-section and we've actually had simulations with the residents and the attendings too thinking about that.

So that's one of the elements of things with the 3rd and 4th degree circumcision that we have to consider. And then also counseling the patients and their partners about the fact that we will not re approximate that procedure that was done for cultural purposes. And we teach our residents and our attendings... that's actually against the law for us to do that. Unlawful for them to re approximate that circumcision, it's unlawful, so we can put sutures in for the purpose of hemostasis but we would never re approximate the circumcision.

Finally, another professional reflected a strong degree of cultural awareness and sensitivity in how she explains to patients that FGM/C cannot be performed again once the baby comes out. Instead of an immediate repudiation of the request, she accepts that this is a cultural norm while still explaining that it cannot be practiced in this context *and* the medical and safety reasons why.

Many of our Somali refugees have experienced female genital cutting. And many different types of it as well. And that can lead to some difficult conversations as well. Often times the opening where the baby has to come out can be very very small and that can have some significant challenges with the delivery. Sometimes I have noticed that family members have requests that we create an episiotomy or a cut in the opening to make it easier for the baby to come out and then sometimes they may request that we provide surgical repair.

And I think having a discussion about what that repair may look like. And so oftentimes, what I've been taught by my supervising doctors is to repair back to normal anatomy. Which may not be the anatomy that they started with. In a way where they are not going to have a high risk of bleeding or infection but not necessarily providing a repair that creates the same look that they had when they walked into the hospital. Some more of an anatomic repair that is going to have the least amount of risks for bladder infections, or excess bleeding, which can be quite tricky....Sometimes that's not exactly what the patient or her mother likes but trying to explain our reasoning and that we don't want to have excess bleeding or infection risk . We want this to be as safe as possible for her. But that definitely is a really tricky conversation.

I will also point out that in her response, she suggests that the mother figure or the woman herself are the requestors of the reparation of the initial FCM/C which is an interesting contextual point to note.

Theme 2: Mixed uses and views of language-line interpreters

The second recurring theme from the interviews with refugee healthcare professions on their experiences working with refugee female patients in the area of maternal healthcare centered on varying uses and views they had of the professional medical translator service. To provide some context, when a patient is seen by a healthcare professional at one of the various healthcare facilities in Syracuse, NY (and likely in most US healthcare settings) and English is not their first language, they are provided with translation support. Years ago, this translation support came in the form of a physical person who was trained to translate in healthcare settings or through a phone service. As I gathered from the professional interviews, the in-person translators were the most difficult option because, for one, there are so many regional dialects that different refugees in Syracuse speak that it was hard to find enough people who spoke the dialects, even though many of the translators were refugees themselves from the same communities and lived locally.

Second, there was the issue with different sexes between translator and patient, especially concerning maternal healthcare translation and especially with male translators physically present to translate for labor/delivery. Following cultural tradition, the refugee women would *never* have a male present for the birth, oftentimes not even the child's father. This issue therefore inevitably caused issues. There is also the issue of logistics with maternal healthcare. Many labors last for 36+ hours and most births happen at night. It is therefore difficult to have

one translator there the entire time or in the middle of the night for the delivery - especially when staffing is short for specific dialects.

Finally, another issue is that because many translators were from the same resettled refugee communities, some refugee women did not want those that were familiar to them outside of their family to know so much about their medical history or medical procedures. In this same vein of personal familiarity with the translator, there is also the possibility that a translator speaks a needed specific dialect but that person is from an opposing ethnic group that the patient is from. These are just some of the issues that in-person translators presented.

Additionally, in-person translation was not safe during the COVID-19 pandemic. Some of these issues carried over to local translation lines as well, such as the gender issue, the timing logistics, and finding translators for regional dialects. Therefore, with the advancement in technology in the last decade, an international language-line service via a live teleconferenced translator on an iPad has become the main method of translation for refugee patients. Most translators live in different time zones and there are more translators for each regional dialect with the advancement of technology on the translator's end. There is also an added layer of anonymity with translators that are perfect strangers. Gender preferences of the translators are also easier to make with this language-line method.

But what about friends or family translating for the female patients? While professionals must use these professionally licensed services for important medical conversations with patients per hospital guidelines, they can use any friend or family member present to translate for general conversation with the patient. Still, this presents an issue when there is nuance and there is always nuance. For example, some professionals mentioned that while they know that it is often culturally appropriate in most African refugee cultures for male or elder female family members

to make medical decisions in this context, if a family member was translating, they would look at and speak to the female patient despite the family members trying to answer/ make decisions for her. As one professional mentioned, COVID seemingly simplified this task of connecting directly with the patient with less support people present to sway patient decision making:

What we try to do in any of those situations is to... when it does come up, is this your decision yes or no? And again, one of the advantages or disadvantages of the COVID world is that we have to limit the amount of people who are around for the decision process. So if you are in a situation where we can have a person making her own autonomous decision without influence of anybody else, that's much more beneficial. Yes I really want to do this or no I really don't want to do this. That's fine. But when you have the influence, especially of a male partner who maybe guiding things one way or the other, then sometimes it's worth having a separate conversation with the patient alone to see if those are her wishes.

While this example has layers of culture clashes, it presents just one of several issues that can present when family members translate for refugee female patients in maternal healthcare settings.

However, in this same vein, one professional mentioned that the cultural clash comes in the questioning itself by the medical professions to the female patients via translation with the support people in the room (more so pre-COVID when larger support groups were allowed). As the professional perceives it, the questions that require translation, the intake or important medical questions on pain management or medical intervention like C-section, are seen as a subversion of traditional birthing methods. More specifically, in the instance described below, the issues with pain management options that are translated during labor are intervened and answered by family members, usually female support groups, as they see pain management as *their* job and purpose being present at the labor through traditional methods, not in the Western sense of an epidural or other medication.

...I've seen people who speak English well, and if I were to look at them and say 'Oh my gosh, you want an epidural', and have them say no. So it's not that. But the frustration is more like, I don't have the ability to have a more thorough, complete conversation with the patient because it's cutoff by interpretive services or either the patient's significant other or even the women that are with them. Like the family and support women that are with them.

'No, they don't want that'. Because it's almost like, that's their role. That's what they're there for. That's why they are brought with them to help her through. And some of them are very hands on with the patient. So they are providing that, you know that diversional therapies. Talking to them, singing to them, working with them. Some of them are very hands on. Massaging their back and helping them move around. Which it does help the laborers but it's... I guess I'm more Western world trying to intervene in my mind. I wish I could be able to speak more freely to them but that's definitely a barrier that I have found.

Other instances where friends or family translating can present a conflict of interest or complete ethical concern is in maternal health appointments that discuss culturally taboo topics and options for women such as contraception methods, pain management planning for an upcoming delivery, delivery options when a C-section is medically necessary, etc.. Having a friend or family member translate can pressure a woman into making certain decisions about her own health that she may not want to make but might feel pressured to adhere to sociocultural norms with a relative present and translating - potentially adding to or editing the initial message.

As two professionals note below, there are also logistical issues with using a translator, especially with the sometimes lengthiness of natural labor. Other times, serious decisions need to be made through contractions and pain and this makes it difficult to filter important and pressing information through a third party on an iPad. Therefore, there is a preference for the simplicity of having a physically-present family member translate over using the language line iPad person, when appropriate.

And I think having to call a translator for every little thing would actually interfere with the flow of taking care of the patient, you know, as far as support - you know, like let me like, call up this person, wait two minutes, and they'll call up, and then we'll hang up, because we don't have anything else to say. So, I do think it is easier if they have a family member that can translate to some degree.

...I've been in a labor situation which can be kind of difficult to do. So you're trying to communicate with a woman who is delivering a baby or going through labor, you know, with a language barrier with a person in front of you and then having to talk through the interpretive services over the telephone or the iPad or whatever. So those are some of the challenges that can happen. So in a in person, post COVID world, we have to be much more cognizant of that. A real live body in front of you who can act as a liaison is always going to be much better than electronic means and that sort of stuff.

In other cases like the one below, professionals want to connect with their patients beyond the small talk provided by the translator. They want to get to know the person and their unique contextual background and the language line, intended for medical translation, does not allow for this.

Definitely the language issue because I think that it makes it harder to make a connection. I have patients from a wide variety of backgrounds and I try to approach each person as an individual and kind of understand where they're coming from and meet them where they're at. Sometimes that context is lacking for patients who are refugees and I'm using a translator. It's much more just about getting through the mechanics of the encounter, as opposed to really having a chance to feel like you're creating a bond. Small talk is very hard and just sort of understanding them as a person.

While it is not the job of the translator, they may sometimes further explain a topic or issue if they understand or come from the given cultural context that the woman comes from. However, this becomes a much larger issue when the translator layers in their personal and/or cultural interpretations to the professionals' initial words. This is not only unethical but can have serious, potentially fatal, health implications for the female patient if she is not receiving the professional medical information that her professional is attempting to communicate to her via translation.

Still, it is often hard to know when and whether translators are misinterpreting information. In one anecdotal instance shared below, the patient's family member was present and understood enough English to identify the misinterpretation and flagged the issue

immediately. Others are not as lucky to catch such instances of egregious structural violence in the medical translation system. Hence, with the aggregation of logistical and ethnic concerns with the language-line translators, as detailed below, professionals have mixed feelings on the use of translators.

... there was this woman who came in with her mother... aunt... something of that sort. And so that person, we would say something to that interpreter then the interpreter would then say something to the patient. And so we did our admission questions and stuff like that and stuff we would say to all patients. When we finally had that admission question done, we turned the interpreter off. Now the thing is that the mom or the aunt or the support person had actually said we don't want to use that interpreter service again. And so she realized, she spoke English but we don't use friends or family for consent or official questions because, just for legal purposes.

But apparently that interpreter, by what that patient's family member or support person was saying, was not actually saying the proper, like they were not interpreting properly. They were taking what we were saying and putting their own spin on it and kind of presenting it like, they had presented pain medication like, as a way of killing their baby. Like, the mother, like to the point where we had to do an incident report and this interpreter, and we get their interpreter ID numbers and stuff. But it was a big thing. We said we do not want to use this interpreter service ever again. So then we were forced to figure out exactly how to interpret for them and provide them with the service that they needed but at the same sense not go... not use that particular service to meet their needs. So it was a challenge.

In other instances, the professionals want to make sure that their messages are being properly understood even with the use of interpreters and use unique methods like drawing or simplifying medical jargon by circumlocuting the jargon to explain procedures or processes.

I often will draw pictures for them especially when there are language barriers and you don't 100% know how things are being interpreted even with a professional interpreter. And so I will oftentimes take a pen to the whiteboard and draw pictures of what I'm doing and how I'm doing it and why it's going to work and why it's important. And sometimes that can help to set the expectations for women so that they can have a more visual understanding of what's going on.

...
I tend to try to avoid strict medical terminology when possible. And so sometimes I might say epidural but I will also explain what it means. Just in working with an interpreter. So

describing it as a medicine that goes in the back and helps with pain. Kind of saying what the effects might be. They might not be able to feel their legs, they have to stay in bed, that we put a catheter in to help with their bladder since they don't have sensation there. Then also explaining that it is not 100% pain relief period because there are different pain fibers. You know, it will help with some of the sharp pain but it won't help with the pressure sensation. That that is a necessary sensation for them to be able to successfully push the baby. So being very cautious of the words that I choose, and trying to explain everything instead of relying on medical terminology can help with common understanding.

Other professionals are ultra cautious and will always use translators with refugee patients regardless of their English proficiency.

So many of them do pick up quite a bit of language very quickly. But we have to make sure that we don't use that as a false assurance that we are not... that we make sure that we use the interpreters so that we are adequately communicating with them.

Theme 3: Varied sensitivity by maternal health professionals to refugee past sexual trauma

There is a plethora of gynecological and obstetric literature on the importance of awareness to possible past sexual trauma in all female patients and a sensitivity to this potential trauma in patient care (Halvorsen, 2013; Blackmore, 2016; Gisladdottir et al., 2016). In working with refugee communities in particular, whether in Africa or in the West, this cognizance is fundamentally important in all patient care, especially in maternal healthcare. This is because the potential for past sexual trauma is significantly higher given the instability and danger of living in conflict zones and throughout refugee flight (Rojnik et al, 1995; Adanu and Johnson, 2009; Verelst, 2014; Ivanova et al., 2019).

In our interviews, the refugee medical professionals were asked about how they navigate this delicate area of refugee care for all of the refugee women that they work with in Syracuse, NY. The responses ran a full spectrum in terms of the perceived level of the professionals' sensitivity and empathy to patients' past sexual trauma and how it might affect their current patient care in pregnancy, labor/delivery, and/or postpartum. For example, some professionals

note the importance of the OB medical community's understanding of the level of trauma that these women have been through.

One refugee medical professional that we interviewed provided an anecdotal example of a female refugee patient that she had worked with who had severe scaring from past FGM/C with the pain from labor seemingly triggering past physical and psychological pain from past sexual trauma. She explains below, first, how she and the other nurses on duty at the time went about supporting the woman who was in active labor alone.

There is one case in particular that really speaks out to me....But this women, who was here all by herself, no support person at all, and she had the worst genital mutilation that I have ever seen... that anyone in the room has ever seen. Like I get goosebumps thinking about what this woman went through. And she didn't want any medication initially and we did get her the epidural but to see her in pain, it is a different kind of pain. Like, I'm in pain and this hurts [casual tone]... like, this is a 'I'm in fear for my life' pain.

And so I think sometimes, any type of discomfort in the vagina, urethra, whatnot, is very triggering for them. And I just remember, during this specific case, there was probably about six nurses in the room because we are all like 'Oh my god, this is terrible, like we need to be here for this woman' and it was all women in the room and I feel like for that patient, on some level, it was very empowering for her to have a midwife in there with her and other women taking care of her. And then also in other countries it is not uncommon for them to have different types of vaginal surgeries and whatnot that I don't think they necessarily need. We can't get operative notes on them. So I think maybe on some level when they hear up talk about C-sections, maybe they are thinking that that is what we are going to do to them? But this woman, I will never forget her, she was amazing. I cannot believe the things that she has gone through. And she laid in that bed and labored for that baby all by herself. And it had to be traumatizing.¹⁶

Then, she explains how the maternal health staff generally navigates supporting these refugee women with physical and psychological scars from past traumas and the importance of context of care. For example, she explains that the necessary sensitivity does not just apply to the patient and the care they receive. It also applies to various circumstances where best judgment is

¹⁶ This and all following underlined sections are my additions to correlate to key finding themes and not an emphasis on the original spoken words.

paramount regarding if and when to ask the woman about her specific scars and/or reproductive history as they relate to current or upcoming procedures.

I: Mm-hm. You mentioned past vaginal surgeries. What type – or you can just see what you can see because you don't have any notes?

P: Right. We will see different types of vaginal lacerations, abdominal scars. And again, it is a very difficult conversation to have when we have to use a translator and there is that significant other right there. Because what if she has something that she doesn't want that person to know? So those are things that we are always trying to think of. We are very fortunate and our doctors are very mindful of 'maybe we shouldn't ask this question right now', and we have the surgical curtain up and we are like, 'what is this... like, what is this scar?' and we'll search through the chart and there is nothing and we can't ask the patient in front of that person.

I: So does that mean that the question doesn't get asked? Or do you wait until the woman is alone, maybe even postpartum, to ask her?

P: Um, we will try if there is an opportunity to ask her. But a lot of times in their situations, there is a reason why it was not communicated. Maybe they had an abortion they didn't want anyone to know about, maybe they were pregnant before and had a baby that they don't want anyone to know about, I mean – including the women in the room. So unless you have the language line and you have all of these things set up, like the opportunity, that window is very limited. And then, we also don't know if the patient is going to want to open up to us. You know, like 'Hi, I know I have rushed your entire admission and asked you a thousand questions so what's this all about?' So if it was mission critical, then we would have to ask. But if a surgery is going as expected, and there's not a complication, we don't need to stop in the middle of what we are doing to investigate, especially if we don't know what the ramifications of this patient answering these questions will be.

Another professional cited an instance where she saw physical scars on a Congolese patient while she was in labor but could not initially discern the cause of the scars. She soon found out that they were from gunshot wounds that ran from the patients' legs to her rectum. The patient therefore showed signs of psychological trauma as well as she tensed up, possibly disassociated at times, during her labor from the physical contact from the staff. Throughout

recounting this experience of piecing key facts together to understand the context of the woman's scars and tense demeanor, the professional displayed a deep sense of respect and empathy.

At one point, she started to cry when explaining the details, putting herself in the patients' place as a non-English speaking refugee who has seen unspeakable physical sexual violence and has to expose herself to triggers of this violence in giving birth. Finally, the professional notes that due to these signs of trauma, her colleague did additional research to better understand the cause of the woman's scars to ultimately help improve her patient care with such a delicate traumatic history.

Not long ago, I had a patient who was from the Congo... I go in to do my nursing assessment and I lift up her blankets and she speaks fine English and she's got these welts on her legs and I go like, 'Oh my goodness, like did you fall?, what is this?' and she totally clammed up. And then I had gone over to our little nurses desk in our room and I looked at her date of birth and it was one, one, whatever the year was and I was like, 'oh' [not-surprised shock] – typically one, one, is the birthdate that they give a refugee. So I was like, 'okay, this is interesting', and I recognized the way that she clammed up and was like, very cut off from the rest of the conversation after I had asked what had happened to her and so I went to ask one of our residents, Dr. [X]. And I explained to her what I found and she did a little more research.

As it turns out, they were gunshot wounds from wherever she was a refugee and they went all the way up to her rectum. I mean, like, it is sometimes really hard to see and think that this is a human, I'm sorry, it just makes me so sad, like this is a human and this is a woman and this is how she was treated. And so then I feel like she was lucky in the fact that she could speak fluent English and was familiar with everything but I couldn't imagine being one of these women and having gone through that and then having my legs spread at this hospital that no one speaks the same language and everyone is talking over you and... I just couldn't imagine. But I think that the doctors, especially the doctor that I found, was so kind and was willing to do a little bit of research on this woman because had she not, we wouldn't have been able to know that.

Going the extra mile with the little things can make a difference in working with refugee women's maternal healthcare and especially with the already painful experience of labor and delivery. As one professional mentioned, when they are caring for refugee patients during labor,

they make sure to bring them warm or room-temperature water as opposed to ice water as refugees generally do not drink water with ice as a cultural preference due to their lack of access to ice in their home country. This small attention to detail can go a long way to bring sometimes one piece of comfort to painful or awkward moments.

Another professional mentioned learning select phrases in the languages where larger groups of refugees are from and using these little bits of familiarity to build rapport with the women in the initial meeting before things get hectic during labor. As this professional suggested, this is a small yet impactful act of respect to say, as they put it “I see you. I see where you are coming from”. This may help the women breathe just a little easier...have a little bit more trust in their providers, as they embark on a painful OB/GYN procedure or practice.

And so if I am told or find out through one of my colleagues that this patient speaks [the regional language], I'll try to go in the room, introduce myself in their local language, tell them 'Good Morning', ask them if they slept okay, and have just a little bit of time to build rapport in the language. Obviously, I'm limited to pleasantries and greetings and introductions. But I've seen women, their expression and experience completely change just by offering some greetings and some kindness in reaching out a hand in a language that they understand. And then after that, I will of course get the interpreter on the line to help with the more detailed or more complex conversations.

But I think having that ability to uniquely connect with these women, I can say 'I see you, I see where you are coming from'. It can truly help to build that rapport and build trust with patients. Oftentimes, it can be quite chaotic when a woman is actively delivering a baby. And so even with interpreters it can be hard when there's a lot of different voices and people are yelling and screaming and saying do this, do that, and the interpreter can't always interpret quick enough. With the chaos in the room. And so being able to calmly ask a woman in her local language, would you like a sip of water, can definitely provide some comfort. And I think that that helps too.

Meanwhile, there was also an account of professionals who showed far less concern for these traumas and how they affect the present moment where the professional is working with them. As one of the fundamental components of the political economy lens, the history of a

current issue in migration, globalization, and colonialization is fundamentally important to acknowledge if we are to fully understand and help present circumstances. As one of the professionals shared, he has had to call out colleagues when this attention to history and lack of empathy is displayed:

You have to be, as professionals, we have to be very cognizant of what these women have gone through. And that is very important. I remember once...some of the nurses were talking about some little insignificant thing about her, and I said, 'Do you realize what this woman has gone through? Do you realize having members of your family being killed in front of you and the trauma that goes along with that?' So I think we have to be that much more cognizant of those sort of things..... So that's one aspect of things which is really, really important.

Finally, several providers displayed emotional intelligence and empathy in refugee patient care through attention to logistical details of the exams which incorporate aspects of the woman's past *and* present. This is done to avoid "retraumatiz[ing]" the women. As the professional below details, this is done in multiple ways from taking the time to hear and absorb any sharing of past traumatic life experiences to ensuring it is a female provider performing certain exams.

So we have to be careful to make sure that our patients understand the counseling, that we are understanding what they are communicating, that we are also taking the time to understand their life experiences and potentially sometimes their life experiences have been really truly traumatic and that we are avoiding retraumatization in care. And that can be true with the exams, that can be true with the professional whether male or female professional is an issue with sensitivity of the exams that we are providing...

Additionally, another provider similarly noted that they give very intricate, step-by-step explanations before and during all patient care so as to do everything possible to avoid retraumatization. This includes emphasizing an element of personal agency by making a point to remind the woman that she can say "no" or "stop" at any point in the procedure or process.

I: Have you noticed instances with this population, maybe more in their prenatal appointments, with somatization or manifestations of their trauma from the past fleeing various contexts of violence and war?

P: What I can think of with respect to this question, sometimes pelvic exams can be very challenging for this population. And I am aware from my training but many times, women in refugee camps can be victims of sexual violence and so I have to be very cautious that when you are doing an invasive exam or a pelvic exam that it can be traumatizing for a woman. So I always use an interpreter and I always say what they are going to feel before I do it in order to provide that educational opportunity for them. Or also giving them permission to tell me to stop or say no. Or I say why I am going to do an exam, what I'm looking for, and I make sure the interpreters interprets – you are going to feel this, you are going to feel that – before I do whatever exam I am doing. And then I notice on the labor floor as well, sometimes these women can really struggle with examinations.

And it's easy for professionals to get frustrated because it takes twice as long to find the patient's cervix and to be able to figure out what to do next for their labor but really having a thought process of where does this woman come from, what might she have experience in the past, and how might that be influencing these sensations that they are feeling right now or what she might be experiencing. So trying to be sensitive to what these women needs might be. These women sometimes won't tell me what they are thinking or feeling or what it's reminding them of, but I try to keep that in my mind and have compassion and empathy. It's very possible that these women may have been victims in the past of some sort of sexual trauma or violence.

Theme 4: Versions of cultural hegemony in agency around medical decision making

Another theme in the refugee medical professional interviews was versions of cultural hegemony in medical decision-making agency for the refugee women. Specifically, types of power around who makes decisions for the refugee woman in any aspect of her maternal healthcare. In the theoretical lens of cultural hegemony, the oppressed internally accept a system where they are convinced that their position is what it should be.

Familial Example

One version of cultural hegemony is the traditional sociocultural structure of most refugee cultures which is patriarchal and grants power to elders. As noted at various points in this dissertation, it is the husbands, male family members, and also female elders who navigate and ultimately make decisions regarding the younger female's reproductive healthcare in and

outside of maternal healthcare. This is largely due to a notion called “secondary gain”, where the decisions being made around the woman’s health often benefit the greater family and/or community. In this context of reproductive and maternal health, such decisions would focus on ensuring that the woman is able to have more children in the future. Therefore, in this theoretical lens, the refugee women are internally accepting this traditional system where they believe that they should be subservient and let these other individuals, males and female elders, make decisions for them regarding aspects of their maternal health.

Autonomous Example

Refugee males and elder females operate under and uphold a social structure where the younger, child-bearing females acknowledge a system of subserviency around their lack of agency in their personal healthcare decisions. However, in resettlement, Western culture is dominant within healthcare settings. In this context, women generally make their own decisions in most aspects of their healthcare. Thus, the professionals in this cultural setting leave these decisions to the refugee women, often intentionally bypassing the males and female elders who would traditionally make these decisions. Hence, in this version, it is actually the refugee males and elder females who are accepting a system where they have little to no clout in situations where decisions are made regarding the refugee women’s health in this Western context.

This approach of intentionally or unintentionally endorsing more agency over one’s body with refugee patients was a common view found throughout the interviews with the refugee support professionals in Syracuse. The Western healthcare professionals thus, either intentionally or unintentionally, uphold this system of more gender equality by giving the decision making power to the refugee female patients themselves. In many cases, this took the form of the professional explaining how they managed to bypass the large support group in the

labor/delivery room to make it to the woman to specifically ask her opinion/decision on a given medical issue. And as the cultural majority, they have the power to do so. As they do this, they take the traditional power away from the males and elder females in these refugee communities that interact with these Western healthcare providers. This could reflect elements of a hegemonic Western cultural structure that is upheld in most areas of Western society and thus not the first time that the refugee males and female elders are seeing their traditional power removed, with most accepting it for better or worse as it is the dominant cultural power dynamic in their new resettlement culture.

There is a large body of literature (Morokvasic, 2015; Ritchie, 2018) on social dynamic shifts from migration to the West when women start to get jobs, bring in equal income, and/or begin to share household and childcare responsibilities with their husbands in resettlement. Further, in resettlement, the traditional large community support systems are smaller or nonexistent to help raise children and community members generally live further apart. Therefore, the capitalist system in Western resettlement that has both parents working does not support the traditional power dynamics that were more easily upheld in rural settings in home countries. Below, I curated select responses from medical professionals that reflected this two-tiered hegemonic system of (tier one) the decision-making power being given to males/female elders by refugee women *and* (2) the decision-making power being given to refugee women and taken from refugee males/female elders by Western healthcare professionals. In most cases, these two tiers are happening simultaneously. While this two-tiered system is common in the interview responses, it is not always present in everyday occurrences in refugee patient care. One anecdotal story that was shared reflects this two-tiered structure:

...it's not a lot of American women who are waiting for their husband to decide for them. Some of the women are waiting for their mother - so it just kind of depends on the

dynamics of the group but then sometimes they are deferring to the older women you know or if a man can come in or if they know it's going to be awhile before he shows up with they will discuss it amongst themselves. So yeah, it's not always that we have to wait. But it's something that I am now aware of may be the situation. ... Uh-huh, yep. Oh yeah – in some cases, it's actually the younger person who makes decisions - frankly, rarely, it's been the women who is actually in labor who makes the final decision. There is usually a lot of discussion and then the decision is finally made. But I don't often see a lot of everyone looking at the patient to insinuate, ...and, 'what do you want?'

Another professional confirms this two-tier hegemonic structure and also how she discovered that displaying more authoritative traits won her clout in this context (as well as being a medical professional and member of the cultural majority).

My particular favorite is, back when we could have a whole squad of people in the room with the patient when they are in labor, we had one patient... she came in with like six other women and part of our process is to consent patients for everything when they come in and when things are kind of calm and you know, not in a big uproar, and one of the things she didn't want to do was agree to a cesarean section should the need arise. And so I spent about 45 minutes talking to her and I would talk to the interpreter and she also had a friend or sister or somebody who spoke English so between the two of them we were going back and forth with the patient. But she kept referring back to the older women, and you could see the younger women were on board with us, the physicians, and the older women were not. And you can see them going back and forth and you know they are arguing without knowing what anyone was saying and they finally got down to, well, you need to wait till her father or husband comes in like – OK, I've got this hoard of women but we're waiting for the one man and knowing that he is the only one who can make the decision, somehow he is the last person to show up.

So then he comes in, and we go through the whole spiel (schpeel) again. And, you know, I'm cajoling and altering based on like facial expressions in whatever kind of way - like trying to figure out how to maneuver my words as he finally agrees and so she signs. And then, as I'm walking out, he asks for something else that was inconsistent with guidelines and whatnot and I just looked at him and said "No" and he said "OK" [slightly laughing]. I'm like, are you kidding me? All I had to do was just, like, be authoritative. ...so I managed to project a little more authority ... but it was just like, after all of that, I am going the nice route and I could have just said, "nope, this is how we do it".

Another professional specifically describes how they go about upholding what I call the second tier - the medical professional making it a point to have the refugee woman make her healthcare decisions on her own. In this case, the professional does this by way of isolating the woman to bypass the other males and elders present.

In certain Somali populations, some decision making is definitely deferred to the husband. And that is a cultural issue and whatever. And I've had to have private conversations with individuals saying, this is you, this is your body, this is a decision for yourself. And those are empowering things that I'm sure you have been a part of as you've been in this process. So there is some degree of deference to the husband about the decision process. And sometimes that can be disconcerting because that's not necessarily something that we, that is an issue in traditional United States society. In my whole clinical career, I have never deferred to somebody else for the decision process of a person unless you're talking about a minor or something like that. And even in mental health situations or do mental health capacity situations we make those differences but if you make a decision to do something, I will abide by your wishes or not abide by your wishes depending on which way we do. So that has sometimes been an issue....What we try to do in any of those situations is too, when it does come up, is this your decision yes or no?

Another professional noted their strong hesitancy to use family members for even basic translation due to concerns over this issue of secondary gain by family members who might change her message in translation:

So we try hard not to [use family members as translators]. Because they are not trained in medical terminology. And they, we first of all don't know because we don't speak the language....And then the other thing is that they may have secondary gain in a certain outcome – the family member. So especially if it is the partner, they may have some secondary gain with respect to having her contracept or for that matter, not contracepting. When it comes to procedural consent, we absolutely won't ever use the family member for C-section consent, any type of surgical consent, we absolutely will not use a family member.

In another case, a professional notes that all medical professional staff are trained to uphold this second tier and “redirect the conversation and always look at the patient” while knowing that this is not the cultural norm.

So we work very hard to make sure that we are speaking to the patients, but it's rarely the patient who's the first person who speaks up when we go into the room. We work very hard and we teach the residents also to redirect that conversation and always look at the patient. But culturally, we definitely see that that is not the norm.

Another professional notes that they do confer with the entire group, including the female patient, on decisions that need to be made as opposed to how most professionals single the woman out to make the decision autonomously. They also note that this has changed during COVID with the absence of the large family support groups.

Oftentimes, when decisions were made, they were familial decisions. And so I might go in the room and talk with the patient and her family about our recommendations and what was going on throughout her labor course. And then oftentimes I would give them the chance to talk amongst themselves as a family about what their thoughts were.

And oftentimes the decision would be made as a group. That might have involved the patient as well as her partner as well as her mother or her mother-in-law or her sisters and they would all talk together and come to a conclusion of what they wanted. So having respect of the family dynamic can be important in decision making. Which is quite different from the American approach. And that also has been quite challenging in the setting of the pandemic as we have limited guests and provided additional screening requirements can make it challenging to have that same experience.

Furthermore, with COVID, the two-tiered structure might not apply if the one chosen support person is not the one who is traditionally in charge of the woman's medical decisions (i.e. if the person is more of a peer like a sister, sister-in-law, or friend). In these cases, the support person would likely not be trying to make the decisions for the woman, and the medical professionals would therefore not feel the need to intentionally bypass the males/elder females and narrow in on the woman to make the decision. However, the one support person might still be instructed by these same individuals to steer labor and delivery decisions one way or another. As one professional specifically noted about patient care and patient decision making during COVID:

And again, one of the advantages or disadvantages of the COVID world is that we have to limit the amount of people who are around for the decision process. So if you are in a situation where we can have a person making her own autonomous decision without influence of anybody else, that's much more beneficial. Yes I really want to do this or no I really don't want to do this. That's fine. But when you have the influence, especially of a male partner who maybe guiding things one way or the other, then sometimes it's worth

having a separate conversation with the patient alone to see if those are her wishes. Sometimes I've had conversations with women who don't want certain things like IUD's or whatever because 'those will affect my period' and 'that will have an effect on our relationship' or that sort of stuff. So those things happen every so often. Not all the time but every so often.

Finally, in this regard, another professional noted that she mostly sees the one chosen support person be the elder female, who in this case would still be steering the decision making for the female patient:

What's happened, and I have seen a difference with the refugee population over some of our other populations, is that their selected support person has been that maternal elder. So whether it's an aunt or whether it's their mother that come with them over the father of the baby, and then they conference in or video chatted the father of the baby when it's time for delivery.

Theme 5: Varying degrees of cultural relativism in medical professional's thoughts and approaches to refugee patient care

The theory of cultural relativism, introduced by Franz Boas, states that we must view other cultures in their own contexts and not judge them through our native culture's standards. It is meant to serve as a way to remove personal biases when examining cultures and societies outside of our own. Again, various anthropologists and social scientists have argued that cultural relativism dangerously emphasizes notions of "others" in understanding different cultures, paying more attention to our differences than our similarities (Abu-Lughod, 2002). Despite these critiques, I feel that this underlying promoted practice of questioning and reexamining our positionality, without "other-ing", is fundamentally important in working with cultures, traditions, value systems, social structures, and so on that differ from our own as opposed to looking down on those who are different and/or forcing acculturation in the case of refugees in the West. In the course of the interviews with refugee medical professionals, I found that general views of refugee patients and their respective cultural practices in the hospital and in resettlement

in general spanned a spectrum of deep cultural relativism to a strong lack of cultural relativism. Below I provide examples and accompanying analysis from each end of the spectrum.

Examples of Cultural Relativism by Refugee Healthcare Professionals

If a medical professional thinks that they know everything there is to know about a given refugee culture by working with patients from a specific community, this is a gross generalization as one person cannot possibly reflect all of the intricacies, nuances, and complexities of a given culture. Whether intentional or not, this generalization is dehumanizing. Despite some over generalizations from one professional, such as noting that a lot of patients are “coming in from Africa”, they did put themselves into the perspective of their patients in taking into account a pre-stated, specific cultural norm that was not being upheld during her birth and also noted other social and historical elements that the patient had shared that do not align with their current birthing environment. Specifically, this professional noted that due to COVID policies allowing only one support person in the labor/delivery room, it must be hard as most refugee groups that she has worked with from the same Congolese community tend to have large female support systems in the room with them during labor and that was not possible during COVID.

Another professional noted that they take extra steps to accommodate alternatives to COVID challenges that do not allow for the traditionally large refugee support teams during labor. Again, this professional also showed a deep sense of understanding that these circumstances are far from traditional refugee birthing norms. Therefore, since only one support person is allowed, the professional ensures that there is video conferencing with the father and additional family members. They even go so far as to put iPads on IV poles to accommodate the various video conferencing devices in addition to the interpreter iPad, bypassing normal

pre-COVID policies that limited video conferencing. She likens the importance of this video conferencing to a military family labor/delivery when a spouse is deployed overseas.

It's definitely been hard. They are not having all of the community that they normally would have and the support. The not being able to switch out and not having the technology, having an additional iPad in the room to be able to FaceTime the additional, say if they came in with their mother or their aunt as their support person, making sure that we use some of the resources on the floor to bring additional people into the room. Making staff aware that it's okay if we, because we don't generally video, we try to get them off their phones if people are generally on their phones to understand that culturally this is the reason why. We are on a continuous video chat just as we would be with somebody who had a military family member who was deployed. We are going to keep the continuous video going. That is something that would be a little bit different as well. And then that continuous iPad interpreter as well. We may have an iPad, we put them on IV poles.

Another professional notes that they understand that the culture of labor and delivery is different in the US. Therefore, they make a point to talk through expectations of the process beforehand and with the group as they know and respect that this is the way communication about medical issues is done in these respective African cultures - “[I speak] with them and with their family members who help with the decision making process...”. “The culture of obstetrics in the United States tends to be very hands-on. And some of these women have had a less hands-on approach with previous labors....Having an understanding of what their expectations are can help with the discussion of what the expectation or what the experience may be like in America which may be very different.” Finally, another provider acknowledged that while the way that the female support system showed up during labor pre-COVID is not the norm in the West, they were there supporting their family member as was traditional in their culture.

Oftentimes it can be a family experience. So prior to the pandemic, I remember seeing sometimes 3, 4, 5, 6 family members in the room with the mom while she was laboring. And they would all bring their own bedding and mats and lay on the floor and really be there to support the woman.

This professional applauded this instead of judging the way the female support group conducted themselves in the labor room per their cultural norms like another provider did in the next section.

Examples of a Lack of Cultural Relativism by Refugee Healthcare Professionals

When asked how many female support women were typically in the support groups in the labor rooms with the laboring refugee patients pre-COVID, one professional displayed a deep lack of respect and ethnocentrism in her response:

Oh, more than I would prefer. I've had... I think five was the max that I have seen. But it was typically three and four. And they just come and they just stay. And they're just there with them. Even prior to COVID. And there was not a lot of come and go. There was, you know they bring their own foods, they're there it's kind of like a collective. They all just kind of come with. I think that that has actually changed the way that patients are able to deal with labor because of COVID. They don't have that full support system that they had....it's different for them. It's just a very different experience.

This professional is generally missing the point of patient care. The point of care is not to make the providers comfortable with their preferences - “more than I would prefer”. They are called *providers* as that is their job - to provide care and comfort for each individual patient. Further, this provider’s use of “they” as a means of otherizing the support women displays a glaring lack of cultural relativism, though I include this quote as a *lack of* and not complete non-existing example of cultural relativism since at the end, they do reflect on perhaps a norm of a vast support network present at the births and then that being taken away during resettlement *and* COVID and how that can be different and harder to deal with. Another professional displayed a general apathy to learning about the culture or context of this population they are treating.

I: What have you learned about traditional and/or indigenous practices and working with Somali and/or Congolese mothers during pregnancy, labor & delivery, and postpartum care?

P: Very little I would say...

Further, they equally displayed a lack of concern for this new cultural context that these women are in in giving birth in the West for the first time and ignores any opportunities that they can take to ease this enormous cultural shift for the female refugee patients:

P: ... I know that women who are having their first delivery in the US who delivered children prior to coming to the US often it's their first experience with the hospital or the medical system. I don't really know a lot about anything that they might do either at home or like just when they're not at the hospital.

Finally, I asked a professional if they noticed if any of the refugees that they have worked with had brought cultural traditions from their time living in refugee camps to their maternal health or birthing practices in Syracuse, NY. The transfer of cultural traditions not just from home countries but from displacement contexts can impact cultural norms, traditions, and values in migration, though it is important to note that culture and lived experiences are complex and nuanced and neither fit neatly into classified, temporal boxes, as Malkki (1995) might argue. Her response suggested that the Western hospital system is a difficult setting to assess any of these cultural details, whether from home country or displacement contexts, as patients are “obliged” to act a certain uniform way once in the hospital - “basically everybody delivers in the same position”.

She explains that there is a standard protocol for patients in labor and delivery that essentially ignores or omits any outside practices or beliefs that will steer this standard Western protocol off course. Thus, she cannot see any cultural elements of these refugees as that is the way the hospital system is intentionally structured - a sterile assembly line of pregnant bodies to efficiently birth children while dismissing all other unique, rich details of each individual patient, whether the patient is a refugee or not.

I: Just circling back to indigenous birth practices, you mentioned sometimes they will bring food that's from their home country. I'm wondering since a lot of refugees have come from refugee camps if there's any only maybe birth practices or customs traditions that you've noticed that don't align with what you would expect. I'm trying to see if there's cultural influence along the way. So, if they had given birth at a refugee camp if they picked something up along the way that they practice here.

P: I think all of that is hidden by what people are sort of obligated to do once they enter the hospital system. They're almost always hooked up to monitors full time, restricted in terms of movement because of the monitors and basically everybody delivers in the same position. Unless a woman really proactively says "I'm going to be in this position while I'm delivering because this is what I want" or "this is what seems like it's going to be comfortable" nobody is asking those questions. They're positioned the way we eventually position patients. I don't think that there's really like... I think that that's completely suppressed by the system.

I then asked if, as she suggested, a refugee patient was “proactive” in communicating a unique delivery method of choice, whether she thought that, if on the unlikely occasion that they were asked, that they would feel empowered enough to share a different desired delivery method from the standardized process used in the hospital. Her response did not answer my question but did reveal what I believe is a major misunderstanding on behalf of Western healthcare providers who work with refugee women. That is, she went on to explain that most Somali patients seem to her, despite previous unmedicated births, to not know how to “effectively” push and don’t seem in “control” of the labor process. Therefore, she defaults to the belief that this community does not have traditional birth practices because they tend to scream during labor and do not have quick births.

I: Do you think that if women were asked if they want to give birth in a different position or wanted to practice some other ritual or method of childbirth in the hospital that they would say yes I want to give it.... I want to try this or that?

P: I have no idea because what I very frequently see is that even women who have delivered many times in the past, they don't have like a process. Sometimes you'd think that women who have been through delivery before especially an unmedicated delivery.

they kind of know what's going to happen and they know what to expect and they know how to kind of like and letting you know. When you have the urge to push you respond in a way that is effective and I very frequently don't see that amongst Somali women. It makes me wonder what their birth experiences outside of the hospital are like because it looks like a lot of screaming away from the pain, not understanding what's happening, not being able to control.

So to me, I would think that if there was some kind of birth practice that was taught or supported or passed on from woman to woman that that's something that they would be able to do automatically without necessarily saying like "oh I need to do this" but they would just like physically do it and they don't. **So, my conclusion based on nothing other than my observation is that there isn't, that that doesn't exist, and sometimes I think that that's maybe because they're displaced. That they [Somali women] didn't really come from a place where there was any kind of structure with historical cultural structure that was supporting them in childbirth.**

I: OK so what I hear you saying is they're just adapting to their new environment to get the baby out. There probably aren't any norms or traditions around childbirth that's "just get the baby out"?

P: Yeah but they're not doing it effectively. It's not "get the baby out" it's like "I'm in this process and this process is going to be happening until the baby is out."

I: What could they be doing to do it more effectively?

P: So if you have a contraction it's very painful and there are two ways to respond to that: one is to scream in pain and one is to use the power of the contraction and use your muscles that you have control over to work with that contraction and push downwards. This is not something that comes naturally to most people. It's very common for women who are delivering their first child or had a child in the past but for some reason now are having an unmedicated birth (whereas they had an epidural) to not understand how to use that. If they had unmedicated births before, by the time the baby comes out they've figured out how to use the contraction and a lot of times next time they deliver they are much more effective in that and they're not screaming away from the pain. They're [women delivering] dealing with the pain in a productive way in terms of delivering. I don't see that with Somali women who have definitely had multiple unmedicated births before outside the hospital.

Whether this misunderstanding comes from a lack of cultural relativism in patient care - of not caring to understand the contexts that these women have come from or just from being

blinded by the Western, capitalist healthcare structure of assembly-line deliveries, or a nuanced mix, I do not know. While there is a great deal to unpack here, the main points I want to make are 1 - that this professional is completely ignoring or ignorant of any possible effects of past traumas that these women may have experienced from living in conflict zones, possible sexual assaults, triggering pain from past births in refugee camps where they were likely verbally/physically assaulted the entire time (see Chapter II for qualitative details from the refugee women on violent refugee camp birth experiences).

2 - This professional is employing the hospital's definition of a "successful birth" which is generally seen as quick and medicated. Again, the capitalist system of in-out, time is money. The faster the labors, the faster the bed turn around, the more money earned. Meanwhile, there are many different metrics in different cultures to qualify a successful birth. For this woman, her baby was born alive and she survived. This may well be considered a successful birth for her despite her intense labor pains and her difficulties with pushing. Further, her cultural norm of labor may very well *include* and embrace screaming through labor pains. Yet if she does not take the time to observe and ask, she will continue to default to assuming that there are not any cultural practices taking place and that the woman is unsuccessful in labor per her ethnocentric Western definition.

Furthermore, 3 - she chalks up what she calls a lack of a traditional birth practice to this community being displaced. Yes, the displacement certainly could have interfered with the continuity of birth practices that were passed down between generations. However, being displaced does not erase culture. Which ironically allows us to circle back to my initial question of whether this professional saw new cultural birth practices that these refugee communities may have adopted or changed in displacement. We soon see that this professional was not in a place

to answer this question. Overall, this professional's response showed that at least occasionally, not only are any possible new cultural nuances not acknowledged, but they are intentionally ignored or overlooked in a system set up to do just that. This oversight and assumption that all cultural practices are somehow lost from displacement, instead of altered or combined with other cultural birth practices, is a grave issue in Western healthcare and one that needs urgent attention with the ongoing influx of refugee arrivals mostly from African displacement contexts.

Finally, as most of this chapter has shown, there is generally a strong awareness by most refugee medical professionals from Syracuse, NY on the cultural nuances and needs of refugee patients. This includes a willingness to flex their care to meet these non-Western needs. However, rare responses like this one tell us that there is still a long way to go to optimally serve this population that is in every way deserving of tailored and compassionate maternal healthcare.

A Note on Ethnocentrism In and Beyond Patient Care: Large-scale Implications of Biases Against Refugees

In all themes listed and detailed above, there were instances, both minor and major, of ethnocentric perceptions and views of refugee patients and their respective cultural practices that intersect their maternal healthcare in the context of a Western healthcare setting. Unfortunately, this judgment of the different cultural practices by these refugee communities may unfortunately result in sub-par patient care. This issue needs more education, regulation, and oversight in Western healthcare settings and especially in areas with large refugee and/or immigrant populations. But what happens in the broader context of refugee and immigrants' cultural practices being judged in Western resettlement contexts?

How and why can this judgment escalate in the context of nationalism and “us versus them” to full blown violence? Anthropologist Arjun Appadurai has brilliantly theorized and written on this issue that many refugee and immigrant populations face in the US and in any

setting where they are the minority. Under the lens of political economy, we must not be naive to think that seemingly benign statements like, “we don’t do that here” do not contribute to the larger, nationalist narrative in the US of “us versus them”. This perspective is deeply embedded in the culture of the white majority in the US. On a small scale, it negatively impacts refugee maternal health and all patient care (Garrett et al., 2008; Mengesha et al., 2017).

It does so by maintaining a barrier of humanity between patient and practitioner. How can we treat patients to the best of our ability if we are still “othering” them? Done “here” versus done “there” is a simple shift of words but carries an enormously polarizing, discriminatory implication. This “othering” mentality is a slippery slope to justifying discrimination, which can turn to violence, against minority groups. We have seen this happen time and time again throughout history (Appadurai, 1996; 2006).

Conclusion

This chapter examined recurring themes from my semi-structured interviews with resettled Congolese refugee women and with medical professionals who work with Congolese and other refugee patients at Crouse Hospital in Syracuse, NY. The recurrent themes from the interviews with the refugee women were 1 - that all women interviewed were similar in age, arrival to the US, and in having had past labor and delivery experiences with previous children. 2 - When forced to choose one labor support person during COVID, choices split between maternal figures and husbands, with one woman choosing a doula without the other support options. 3 - The refugee women interviewed displayed clear underlying fears and cultural myths regarding pain management and C-sections. 4 - Of the women interviewed, there was a theme of hybrid breastfeeding and formula-feeding babies at the hospital and once home.

These recurrent themes from the interviews with the refugee medical professionals were 1 - there were requests for FGM/C to be performed post-birth. 2 - There were mixed uses and views of language-line interpreters. 3 - There were varying levels of sensitivity by the maternal health professionals to past refugee sexual traumas. 4 - There are variations of cultural hegemony in agency around refugee women's medical decision-making. And finally, 5 - The refugee medical professionals interviewed showed varying degrees of cultural relativism in their thoughts and approaches to refugee patient care, from very educated on unique components of refugee flight and sympathetic to what the refugee women have experienced before arriving in the US to outright discrimination toward refugee patients and varying approaches in between.

These narrative accounts shine a light on the complexities, inadequacies, and human factors that affect receiving and providing maternal care in resettlement, what is going well with refugee patient care in a refugee-hosting city in 2020-2021, as well as clear areas for improvement. As I have noted previously, the influx of refugee groups, especially from the ongoing conflict in the DRC, into Syracuse, the US, and other Western countries is only going to keep growing and so it would behoove the hospitals and medical communities in these regions to take the time to learn more, open eyes and hearts wider, and continue to add more humanity and less mechanics to refugee maternal patient care. In the next and final chapter, the Conclusion, I reflect on my most salient findings and close with concluding remarks on my overall research.

Conclusion

The purpose of this research was to examine and analyze the lived sexual, reproductive, and maternal health and healthcare experiences of female Congolese refugees before flight, while displaced, and during resettlement in Western contexts. By leveraging a political economy frame of analysis, among others, my hope is that, more broadly, this research brings new insights to the interdisciplinary fields of refugee and migration studies. More specifically, I hope that it fosters greater understanding and empathy for the ongoing suffering that refugee women face in the context of their sexual, reproductive, and maternal health and healthcare at all stages of flight - including the fact that these struggles do not end in resettlement. Moreover, I hope that my research brings new insights to enhance the efficacy, sustainability, and subject-focused nature of East African refugee maternal health and healthcare policies.

A decades-long plea in policy-oriented anthropology, these policy enhancements must be led by, either directly or indirectly with consent, the voices, experiences, and histories of those they are meant to serve - Congolese refugee women. The fact that this has been such an ongoing, crucial argument highlights the structural gaps that persist between refugee communities (and professionals who advocate for their agency and voice in policy) and the policymakers who are meant to serve these refugee community needs. Moreover, an additional overarching goal of this research is to fill the gap in existing refugee and migration literature that does not examine various components of refugee flight with a political economy lens. This lens must be used to dismantle the Western-centric knowledge and power structures at play in the institutions and organizations meant to support the health and healthcare of Congolese, and all, refugee women. As Paul Farmer, public health physician and leading Anthropologist in the field of structural

violence argued, if we want to identify the worst cases of structural violence globally, a key indicator of this is the state of health of a given population.

...not all suffering is equal...careful assessment of severity is important, at least to physicians, who must practice triage and referral daily. It is possible to speak of extreme human suffering, and an inordinate share of this sort of pain is currently endured by those living in poverty. Take, for example, illness and premature death, in many places in the world the leading cause of extreme poverty...the world's poor are the chief victims of structural violence (Farmer, 2009, p. 25).

It is not enough to study and treat the ongoing health issues of vulnerable populations. We must take a step back to macroscopically, with a political economy lens, critically examine the structural barriers that perpetuate illness and health inequities. Specifically, we must call out and investigate the historic, cultural, socioeconomic, and political intricacies of these structural barriers. Accordingly, this is the approach that I employed to conduct my research of Congolese refugee women's health and healthcare in displacement and resettlement contexts.

Original Knowledge Contributed to the Field

Throughout this paper, I have noted various deficits of key perspectives, power imbalances, lack of correct representation, and oversight of key historical underpinnings in both the existing interdisciplinary refugee and migration studies literature, and in existing international and institutional policies that directly affect refugee women. Below, I have outlined four general categories of original knowledge that my research brings to these interdisciplinary fields and more specifically, helps, if ever so slightly, to fill the gaping hole of missing research and advocacy needed in the rarely studied Refugee Studies subfield of Refugee Sexual, Reproductive, and Maternal Health and Healthcare.

1. Spotlight structural violence in Western aid & refugee policy & prioritize refugee women as the primary policy creators of refugee health and healthcare policy

At various points in this dissertation, I have mentioned how the sexual violence in the “rape capital of the world” has caused international organizations, foreign donors, and international nongovernmental organizations (INGOs) around the world to flock to the attention of Congolese refugee women. Yet, my research is another example of the inability of Western aid charity to adequately and respectfully relate to, as well as hand off power and resources to, the communities it is meant to support. These Western responses are often rooted in Western ideologies and social justice norms. The focus of these groups is often on policy regulation, exploiting one-dimensional survivor narratives at will, to achieve these goals. Thus, support efforts often do not include pivotal, evidence-based stakeholder input from the Congolese women they are meant to serve.

Therefore, this quest for justice must first begin by identifying and deconstructing the exploitative and structurally violent Western power structures that exist in Western aid and healthcare positionality and resources. As we deconstruct and analyze issues like foreign aid, narrative framing, and media exploitation for these refugee groups through the lenses of political economy and structural violence, we must shift the power of policy decision-making to those who know best what resources their communities need at all stages of flight - the refugee women themselves. With or without official titles or academic or political credentials, refugee women are community, political, and social leaders in various capacities and we need to listen to them. However, for long-term sustainable change, we must go to the root of the cause of displacement and tackle the intertwined and compounding effects of multi-stakeholder resource extractions, rebel factions, territorial government forces, and many other actors whose motives collectively and consistently terrorize and displace local Congolese communities.

I have discussed here various, intersecting issues - sexual violence, physical abuse, and narrative exploitation, just to name a few, that African refugee women face in flight and at different and at times overlapping periods of migration. These and other contextual issues must be thoughtfully and thoroughly examined in order to create sustainable, ethical, and protective refugee maternal healthcare policies. It is for these pivotal reasons why we *must* allow, encourage, and advocate for refugee women to be the primary drivers of women's refugee policy, both internationally and domestically. Yet, I am not naive to think that the powers that be will willingly hand over all legislative decision-making power to communities of female refugees. However, while I still maintain my stance above that these women need to be in those seats of power eventually, a stepping stone would be to bring more refugee women onto policy research committees, promote their organic, un-altered and un-framed personal stories (with consent, of course), highlight the struggles of their communities in displacement and resettlement and the barriers to access to healthcare.

My general guidance would be that the logistics of this approach be managed and funded by a multilateral coalition of refugee-focused agencies and initiatives who work with refugee women's health and healthcare from grassroots efforts to global scale initiatives and support. Examples of such actors would include local medical stations in areas of conflict, state-run institutions that offer support to sexual assault survivors, Western refugee host countries, the governments of countries with refugee camps, and INGOs/NGOs: all actors who work with women's health and healthcare in conflict regions or contexts of resettlement or displacement. This multilateral coalition would regulate the oversight of such initiatives of bringing refugee women to the forefront of dedicated committees, managing longitudinal studies which spotlight

the nuance and cultural context of their various stages of flight, and making space at the table in the rooms where decisions are made.

In addition, to make this approach sustainable, it would be the responsibility of all members of the coalition, from grassroots agencies to UN bodies and every member in between, to apply these systemic cultural shifts to their operations. Furthermore, a dedicated focus to this coalition would be to tailor approaches to these goals of amplifying women's voices and experiences in policy to be context-specific and not a one-size-fits all application. As my research has hopefully shown, the history, culture, and social fabric of a given region drastically impact a capacity for change or shifting norms - especially when it comes to empowering women and making space for them in positions of power. Another fundamentally important necessity is for people who are not refugee women to stop talking, stop offering well-intentioned suggestions and policy focus areas, and just *listen*. This ethical lens in putting the power into the hands of the refugee women and their communities is drastically lacking in refugee literature, which victimizes, patronizes, and/or marginalizes the agency, intelligence, determination, and self-advocacy that refugee women have.

2. Importance of Context in Refugee Studies (Political Economy) & the Acknowledgement of the Interconnection between Neoliberal Capitalist Expansion, Conflict Regions, and Ubiquitous Consumer Products

If we are to comprehensively understand and support Congolese and any refugee women who are living in Western states, in the case of this research, to improve the quality and equity of healthcare experiences for refugee women living in displacement and resettlement contexts, we need to examine, to the best of our limited capabilities, the full, complex, and nuanced picture of where they come from and where they have been before and after arriving in their present locations. As iterated throughout the analysis of this research, the lens of political economy is, in

my opinion, the best tool for that task. In the vein of acknowledging how things are connected through time and space, it is my hope that my use of the political economy lens provides enough of a macroscopic perspective to show us how the issues in the DRC - the root of refugee flight - are connected to us all:

As war has ravaged the region in recent decades, many of those who sifted through its red soil for diamonds or other trafficked treasures were laborers who did so under coercion. Traffickers included modernizing chiefs, the always-trading Mandingo, Lebanese diamond dealers, warlords, politicians, and others held to have a heavy hand in the extractive trades—or who simply hoped to profit from war. But the more we learn about the shadowy dealings of these big men, the more it becomes clear that some of their patrons and many of their clients are us. Where do De Beers and other diamond peddlers find most of their customers today? In the United States, where the natives practice exotic marriage rituals that involve a powerful superstitious belief in the symbolic power of diamonds (Farmer, 2020, pg. 509).

Almost everyone carries around a piece of the Congo in their pocket because coltan is used in mobile phones and other electronic gadgets. Our riches, however, have historically not been used for the benefit of our people. In the late 1800s, Belgians enslaved Congolese men in their own country to harvest rubber. White settlers and the slave trade were, in later years, traded for warlords and dictators—centuries of people seeking to plunder and profit off the backs of Congolese. Despite our country's natural wealth, to this day the DRC remains one of the least developed countries in the world (Ntibonera, 2021, p. 18)

We are all, either directly or indirectly, a part of this problem. As Eric Wolf says, our cultures, our worlds, our realities are not homogeneous billiard balls that knock into each other without any physical evidence of the interaction. It's all intertwined. Certain forms of neoliberalism and capitalist expansion have added such complexity to neocolonialist contexts - to knowing exactly how many actors, usually capitalist forces or “local”, grassroots agencies backed by capitalist forces, are at play in a given region or issue or community with something to exploit. We buy the products that require the raw materials that are fought over in key regions of the DRC. I include this information to say that political economy should not just be used to look

at the cultural and social underpinnings of a given issue but also to examine our own broader impact on the global community and the way our lives are intertwined with the reasons for refugee flight.

It is, quite frankly, gutting to hear refugees described in a way that “others” them, or patronizes them, and/or sympathizes for their circumstances, maybe even donates to a cause that supports those in flight, but all without acknowledging, usually due to a lack of understanding, the layers and depths of one's own connection to the issue. I say this not to vilify everyone who owns a cell phone or who buys an engagement ring but to shed light on our interconnectedness to “terrible things happening far away”. As the background sections of this dissertation have shown, Western colonial and neocolonial economic and political imperialism have decimated much of East Africa, largely contributing to the destabilization of governments, economies, and the public safety and welfare in these regions (and many others, globally). Opening our doors to those fleeing these circumstances for which we are indirectly at fault is not enough. Providing policy decision-making for the most marginalized of affected populations - mothers - is the bare minimum that we in the West should be doing for refugee populations. Thus, it should be our shared humanity that brings us together to ideate sustainable solutions to drastically improve the conditions for refugee maternal health and healthcare and more broadly, to focus on the root of refugee displacement, that being, financially-driven motives from many actors on the world stage.

3. Intermediaries in the fields of refugee & migration studies: Examining the nuances of refugee identity and the ability of intermediaries specifically to bring vital, complex perspectives to the forefront of issues in this space

As my research has hopefully illustrated, refugee and migration studies require a nuanced lens when studying the complexity of how those in flight are understood. As Engjy’s life history

shows us, some individuals who have been displaced have unique perspectives that do not align with the endless homogeneous narratives and backstories given to most refugee women. While I believe that each and every refugee woman has a unique history, nuanced lived experiences, and is impacted by flight differently, some refugee women in particular have certain skillsets and backgrounds that can serve as invaluable tools to help in the cultural, linguistic, and social translation for refugee communities in displacement and resettlement.

Similarly, due to their diverse backgrounds, educations, and/or lived experiences outside of their immediate communities, these individuals can also speak to Western communities, actors, and agencies in their own sociocultural languages. They know what topics from their lives and/or their communities' lives are of interest to Westerners and why. This intermediary skillset of being able to communicate, more than just linguistically, and shift between or amongst several distinct groups is an indispensable proficiency. As I have highlighted, throughout Engjy's lived experiences from her European formal education, living in wealth *and* poverty, experiencing a range of qualities of healthcare, having experienced unspeakable acts of violence, having given birth in multiple contexts both culturally, socially, and circumstantially, she has an innate ability to make a personal connection with anyone she engages with.

She leverages this strength in her work in resettlement with community engagement and support - especially in supporting refugee maternal health and healthcare needs in Syracuse, New York. Therefore, generally, my research highlights a more intersectional and humanizing understanding of refugee women as complex and extraordinary individuals and specifically, focuses on the roles of intermediaries to navigate social and cultural milieus that not even the most accomplished scholar can reach. Accordingly, we must look closer at the roles and power of intermediaries in studying intersecting topics of refugee flight and migration.

4. Examining an Anthropology of Rape in conflict contexts and refugee flight

Given the cultural gravity and complexities of rape in conflict zones, how it is leveraged as a tool of war, especially against women, and its underlying tenants of control, dominance, and subjugation, my research demonstrates the need of an intersectional analysis of sexual, reproductive, and maternal health that an Anthropology of Rape lens supports. This lens must be leveraged to some degree in all studies of gendered power in conflict zones, in any study of refugee health and healthcare in flight, and in any study that deals with the detrimental effects of mental health in displacement and resettlement.

The study of rape in anthropology continues to morph as new perspectives and considerations are examined alongside the influencing factors currently being studied. Furthermore, rape in war is sadly not case-specific to the DRC and has historically occurred in many contexts of political and economic instability and war. I believe that an example of an underexamined consideration is the sociopolitical context of rape in war, such as the topic of this dissertation which, in part, examines rape in conflict rooted in varying intersectional gendered, racial, and sociopolitical factors. This is seen in multiple points of Engjy's targeted life history. For example, Engjy's terrifying account of gang rape in conflict on the bases that the soldier-rapists thought that she was Rwandan as there is a long, complex history between Rwandan and Congolese individuals. This goes beyond Brownmiller's argument that rape is a form of political violence against women since, in addition to the political violence, there is violence based on nationalist, racist, and other discriminatory sentiments.

Recommendations for Future Work on this Topic

I have many recommendations for future work on this topic. Many of these are outlined above as my original knowledge contributed to the field. However, as a more immediate need,

the influx of resettled refugee communities, especially from the ongoing conflict in the DRC, into Syracuse, NY, the US, and other Western countries is only going to keep growing and so it would behoove the medical communities, elected politicians, international aid organizations, and global community leaders in these respective regions to take the time to learn more, open eyes and hearts, and continue to add more humanity and less capitalist mechanics to refugee maternal health policy and patient care.

Additionally, anthropologists and other social scientists who have conducted research on any corresponding topic of refugee women's health and healthcare should aggregate these resources for the aforementioned education of the various groups who support refugee women but also for the refugee communities themselves to agentively approach given issues on their own. Moreover, in what ways can anthropologists and social scientists perhaps offer their knowledge base to support refugees on an individual or group basis for said given needs? Is there a way to systematize this support function that brings these support services to refugee individuals and/or communities in real-time with the respective necessary translation services included?

I conclude these suggestions with one more: that those not displaced or in resettlement stay curious and compassionate about the ways to support these remarkable communities of refugee women. Because while suggesting changes and new approaches in this space is easier than implementing them, we must stay the course, remaining steadfast in our convictions - if there is ever to be sustainable and meaningful change for refugee women in flight.

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August 2017 – August 2018 **United States Agency for International Development (USAID)** New York, NY & Nairobi, Kenya
Graduate Policy Consultant

- Worked in partnership with the USAID and DFID-funded Agile and Harmonized Assistance for Devolved Institutions (AHADI) Devolution Policy in Nairobi, Kenya. This program worked to delegate power from the central Kenyan government at the subnational level to the county level
- Gathered quantitative data on program performance by reviewing past devolution program success markers and expenditure reports
- Conducted qualitative fieldwork using the methods of semi-structured interviews with Kenyan government officials in three counties to study how gender and climate change are prioritized in devolution programming

May 2014 – January 2020 **NYU Stern School of Business – Leadership Development (LD)** New York, NY

August 2018 – January 2020

External Consultant

- Coached eight MBA Leadership Development students as an external leadership coach to develop personal leadership goals and action plans

May 2017 - August 2018

Program Manager

- Developed & implemented programmatic and administrative operations for 140 students in the NYU Stern Leadership Development Program (LDP) and NYU Stern Leadership Speaker Series. Managed team budget and a team of seven graduate fellows and administrative staff
- Researched Leadership theory and practice to incorporate into MBA Leadership Development Program curriculum and workshops
- Leveraged certifications in professional personality assessments, MBTI & HBDI, to administer overview workshops to students and faculty

May 2014 – May 2017

Program Coordinator

- Coordinated and instituted logistical aspects of large and small-scale programming for the Leadership Development Program (LDP), such as guest speakers, technical workshops, trainings, leadership coaching, and the LD Social Media presence (Instagram and blog)
- Curated the NYU Stern Leadership Development website and blog (nyusternldp.blogs.stern.nyu.edu/) on the WordPress platform

2012 - 2013

United States Peace Corps

Rwanda, East Africa

Educator & Community Planner

- Educated 400+ Rwandan youth in French and English Language at the secondary level and administered national exams
- Founded branch of national female empowerment GLOW (Girls Leading Our World) Club for secondary school girls
- Taught malaria prevention methods to 100+ community individuals and ran monthly female empowerment initiatives for 100+ adolescent girls
- Spearheaded community outreach teaching modules for HIV/AIDS prevention, malaria prevention, & hygiene/ clean water best practices

Languages, Certifications, Professional Organizations

- Fluency in French (government-certified) and basic knowledge of Kinyarwanda
- Certified to analyze and facilitate the Myers-Briggs Type Indicator (MBTI) and the Herrmann Brain Dominance Instrument (HBDI)
- Microsoft Office Suite, Qualtrics, Microsoft CRM, ATLAS.ti, Drupal, Symplicity, WordPress, & social media platforms
- Professional Memberships: American Anthropological Association (AAA), Association for Public Policy Analysis & Management (APPAM)