

Regimes of Exclusion in the Reproductive Healthcare Setting

Exploring the Experiences of Syrian Refugees in San Diego, California

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Introduction

“If she was going to make special requests, she should have arrived on time.” I stood in the waiting room with Rima, who was both excited and nervous for the day’s appointment. Though she had received ultrasounds during her previous pregnancies in Syria, she was still eager to meet the newest addition to her growing family. Since the earliest stage of this much-anticipated pregnancy, Rima had kept careful track of her appointments—from her initial visit to the OB/GYN who had removed her IUD, up until that moment when we stood together in the clinic awaiting her first trimester ultrasound. In her hand, she clutched the appointment reminder card provided to her at her last visit, where the time of the appointment was clearly printed, 2:45 pm. Taken aback by the receptionist’s reprimand, I looked down at my phone to check the time. It was 2:41.

The “special request” she referred to had, in fact, been made several days prior to the appointment. Rima had gone to great lengths to call the clinic and remained on hold for thirty minutes before being connected to the phone interpretation service in order to express her preference for a female ultrasound technician. It was unclear if this preference had ever been recorded or communicated to the office staff, who emphasized that her request could, perhaps, have been accommodated if she had arrived fifteen

minutes prior to her appointment time, as required by clinic policy. By the time we checked in, the female tech had already begun to examine another patient and the only tech available was male. Since Rima had failed to comply with the clinic's policy by arriving "late," her only options were to allow the male technician to perform the ultrasound or attempt to make an appointment for another day within the three-week window in which her insurance would cover a first trimester ultrasound. Although Rima was willing to wait until the last patient of the day had been seen if necessary, the staff remained firmly insistent that the day's schedule could not accommodate her unless she was willing to see a male technician.

I first came to know Rima in June 2018, while conducting ethnographic research in San Diego to investigate the challenges faced by resettled Syrian refugees in accessing reproductive healthcare. Over an eighteen-month period, I accompanied Rima and others like her to their medical appointments, leveraging my own privilege and insider status as a medical student to assist them in navigating the intricacies of the American healthcare system. In this chapter, I discuss some of the challenges Rima encountered during her pregnancy to illustrate how this system excludes refugee women, perpetuates social inequities, and produces health disparities. Drawing on long-term fieldwork in San Diego, I illustrate how structural vulnerabilities interact with contextually specific discourses surrounding Muslim Syrian refugees to create regimes of exclusion in which refugee women struggle to obtain respectful, high-quality care in the clinic even after overcoming substantial access barriers. After describing my own research methods, I offer a brief summary of Syrian refugee resettlement in the United States and review recent interdisciplinary literature relating to refugee women's reproductive health. I provide some background information about Rima (a pseudonym) before delving into an analysis of my ethnographic observations.

This analysis is necessarily informed by dual positionality as both an ethnographer and a medical student undergoing training in many of the same clinics and hospitals that provided care for the refugee women I came to know through my research. For example, I am confident that the staff could probably have found a way to integrate Rima's brief ultrasound into the female technician's schedule if they had been less invested in teaching her a lesson about being on time and more interested in ensuring her access to culturally sensitive healthcare. Even if obliging Rima's request would disrupt clinic flow and cause them to run fifteen to twenty minutes behind schedule—during my rotations at clinics throughout San Diego as a medical student, I saw similar accommodations made on an almost-daily basis for much less significant reasons: patients running late, techs wanting to see their favorite patients, or any number of exigencies. The staff's refusal to accommodate Rima's request was, of course, linked to her characterization as a particular type of patient who was "late" and made "special requests,"

a process which, I argue, began from the moment she entered the clinic dressed in a black abaya and hijab.

Methods

This study draws on fourteen months of clinical ethnography, participant observation, and person-centered interviews (Levy and Hollan 1998) with twenty Syrian refugee women recruited through chain-referral sampling in San Diego, California. Person-centered interviewing takes place with a number of key informants over a sustained period of time and oscillates between treating the interviewee as an “informant” and “respondent” (Levy and Hollan 1998). Informant-style questions implicitly frame the interviewee as an expert of sorts; for example, one might ask, “Where do women in your community go when seeking family planning services?” Conversely, questions that treat the interviewee as a respondent ask about an individual’s emotions and engage participants in reflection about their personal experiences. Person-centered interviews reveal the ways in which large-scale social transformations are embedded in the fabric of everyday lives (Desjarlais 2003) and allow for close analysis of the interpretive schemas (Strauss 2018) employed by interlocutors in describing their reproductive experiences. Person-centered interviews provide an immersive opportunity to explore explanatory models (Kleinman, Eisenberg, and Good 1978) and experiences of reproductive healthcare services among refugee populations, with an emphasis on “how the individual’s psychology and subjective experience both shape and are shaped by social and cultural processes” (Hollan 2005: 219). Interviews were conducted in Arabic, transcribed, and imported in NVivo for iterative coding and qualitative analysis.

Context and Background of the Study

Since the conflict began in 2011, more than half of Syria’s initial population of twenty-two million has been displaced. Among the 5.5 million Syrians who fled the country, the majority remain in the neighboring countries of Turkey, Lebanon, and Jordan, while only a small fraction (approximately 275,000) have been resettled through the United Nations Refugee Agency (UNHCR 2018). Despite the clear and dire need, the United States has been reluctant to facilitate Syrian refugees’ resettlement, citing concerns related to national security and the potential threat of terrorism. This response has been vehemently critiqued domestically and abroad, especially following Trump’s enactment of Executive Order 13769—popularly known as the Muslim ban. Though the order has faced multiple legal challenges

and undergone subsequent revisions, the original clause explicitly banning the resettlement of Syrian refugees has achieved its intended effect; in 2018, a mere forty-one Syrians were resettled through the U.S. Refugee Admissions Program (RAP), compared to the nearly fifteen thousand resettled in 2016 (Refugee Processing Center 2019).

While many critics have denounced the travel ban as contrary to the American values that the Refugee Admissions Program supposedly exemplifies (Bresnahan, Chen, and Fedewa 2018; Vega 2018), scholars have illustrated how humanitarian rhetoric obscures the reality that U.S. refugee policy originated as, and remains, a critical tool to advance the country's foreign policy interests and ambitions across the globe (Benson 2016; Espiritu 2014). Similarly, domestic resettlement policies reflect the nation-state's efforts to cultivate—at the level of the individual—particular types of citizen-subjects and—at the level of the population—to shape the demographic composition of the nation, a form of governance Foucault classically termed biopower. These policies specifically endeavor to mold resettled refugees into self-sufficient subjects by promoting early employment and limiting their eligibility for state assistance programs.

Originally, the 1980 Refugee Act provided refugees with thirty-six months of cash assistance and health coverage to support them as they studied English as a Second Language (ESL), adapted to life in the United States, learned to drive, and dealt with the bureaucratic hurdles skilled professionals must overcome to work in their field of specialty, such as additional formal training and recertification (Brown and Scribner 2014: 108). Over the years that followed, the United States adopted increasingly neoliberal policies that reduced government subsidies and funding for social services in response to conservative anxieties surrounding the “overdependence” of the poor on the welfare state. The promotion of neoliberal ideology led similarly to amendments of the 1980 Refugee Act, first reducing the original period of assistance from thirty-six to eighteen months in 1982 and then again, in 1991, from eighteen to a mere eight months of cash assistance and state-subsidized health insurance (Brown and Scribner 2014: 108). Furthermore, the original 1980 Refugee Act stipulates that local resettlement agencies will manage the design and implementation of programs to support refugees' adaptation to life in the United States. These agencies are then reimbursed by the state government which receives, in turn, federal funding through the national Office of Refugee Resettlement (ORR). According to the 1980 Refugee Act, this federal funding must be used “primarily for employability services designed to enable refugees to obtain jobs within one year of becoming enrolled in services in order to achieve economic self-sufficiency as soon as possible” (45 CFR § 400). To further this aim, the Act requires each agency to create a “Self-Sufficiency Plan” for each refugee or refugee family that they serve. These plans are intended “to lead to the earliest possible

employment and not be structured in such a way as to discourage or delay employment or job-seeking” and must propose a “definite employment goal, attainable in the shortest time period consistent with the employability of the refugee in relation to job openings in the area” (45 CFR § 400). Additional federal funding is available for programs that promote employment within the first 120–180 days immediately following resettlement (Brick et al. 2010). Evidence suggests that prioritizing refugees’ immediate employment at the expense of long-term investments in skill development through programs such as English as a Second Language or vocational training has had detrimental impacts on long-term financial and employment outcomes (Capps and Newland 2015; Steimel 2017). Nevertheless, current policies effectively force resettlement agencies to prioritize funding for programs that are narrowly focused on promoting employment within the first year after arrival. Given that few individuals are able to develop sufficient fluency in English to function in a professional setting within this strict timeline, they are almost inevitably forced to accept positions as minimum-wage, unskilled laborers, regardless of their level of education or prior qualifications.

Even if we were to accept the questionable neoliberal premise that promoting refugees’ integration into American capitalism via full-time employment should be the first priority of resettlement organizations, it seems glaringly obvious that the current policies are ultimately counterproductive to achieving this goal. Specifically, the minimal level of support provided to resettled refugees and the coupling of cash assistance with an employment requirement creates an environment in which they are all but forced to work long hours at minimum-wage jobs in order to survive. This leaves little time for them to invest in improving their English language proficiency, an ability that would ultimately allow them to transfer skills acquired prior to resettlement in medicine, accounting, business, and many other fields to the U.S. context and secure jobs that are both fulfilling and more financially stable than minimum wage labor in the long term. Nevertheless, the U.S. Refugee Admissions Program continues to prioritize policies designed to promote self-sufficiency in the short term in the context of widespread racialized fears about immigrants’ alleged overdependence on the welfare state.

In addition, scholars have pointed out the irony of the United States’ Refugee Admissions Program’s rhetorical commitment to resettling the most vulnerable of all refugees in light of punitive practical policies that then require individuals who have been selected *because* of their exceptional vulnerability to immediately and efficiently demonstrate financial independence mere months after resettlement. The Refugee Admissions Program intentionally seeks out candidates for resettlement who are especially vulnerable—a classification that in practice means prioritizing individuals who have been injured in conflict zones, tortured by military regimes, and exposed to other forms of extreme trauma—and then asks why, several months after

resettlement, these individuals have not succeeded in meeting federal goals for employment (Brown and Scribner 2014; Kerwin 2012). Refugees are thus selected for resettlement in the United States *because* of traits that will more than likely impair their ability to achieve immediate self-sufficiency as it is defined by the Refugee Assistance Program. These paradoxical policies select refugees who have the greatest need for social support as they tackle the challenges of resettlement in an unfamiliar country while, at the same time, eliminating federal fiscal support for programs that provide these services to resettled refugees (Brown and Scribner 2014).

This context informs my conceptualization of the health system as part of a larger regime of exclusion in which refugees are effectively denied access to services such as respectful, high-quality healthcare—enshrined in Article 12 in the Universal Declaration of Human Rights as one of the most fundamental of human rights (United Nations General Assembly 1948). I employ the concept of exclusion to theorize what are more commonly referred to as barriers to reproductive healthcare access. While references to “access barriers” remain ambiguous in identifying the part(ies) responsible for their alleviation, describing them as regimes of exclusion draws attention to the neoliberal policy structures discussed above that intentionally prioritize programs designed to lead to immediate employment in minimum-wage jobs over those that might more holistically support refugees’ long-term well-being. For example, the extreme difficulties Rima experienced in navigating the healthcare system are often described as an aspect of “low health literacy” (Henry, Beruf, and Fischer 2019), a term that blames Rima for her lack of familiarity with the structure of the American healthcare system. In contrast, to analyze Rima’s experience as a result of *exclusionary* policies and practices is to argue, as I do, that the state has failed to meet its ethical responsibility of ensuring access to healthcare not only for resettled refugees but for the American population at large.

Responsibility, Rationality, and Regimes of Exclusion in the Reproductive Healthcare Setting

In addition, a grasp of the fundamental principles that have informed refugee resettlement policy in the United States since 1980 is essential for understanding the larger cultural discourses that contribute to refugees’ experiences of discrimination and disrespect in healthcare settings. In the U.S. context, where neoliberal policies render healthcare a commodity rather than a right and place the responsibility for maintaining one’s health on an individual’s ability to make “good choices,” low-income individuals who receive government-subsidized healthcare must demonstrate their “deservingness” of support by complying with physicians’ instructions and, in do-

ing so, affirming their moral status as responsible individuals (Bridges 2011; Gálvez 2011, 2019). Similarly, refugees are expected to express appropriate gratitude for the “gift” (Nguyen 2012) of resettlement and the services provided to them through the generosity of the American people (Robinson and Cort 2014). A crucial means of demonstrating one’s gratitude is striving toward self-sufficiency by pursuing productive activities such as employment and English language training. In this context, becoming pregnant acquires the opposite moral valence as a supposedly irresponsible act that will ultimately prolong the family’s dependence on the welfare state (Feder 2007; Kandaswamy 2012).

It is within this larger context that refugee women are frequently labeled as “noncompliant” by reproductive healthcare providers (Balaam et al. 2013; Heslehurst et al. 2018; Higginbottom et al. 2014, 2015; Tobin, Di Napoli, and Beck 2018; Wikberg and Bondas 2010; Wittkowski, Patel, and Fox 2017; Winn, Hetherington, and Tough 2017). As Niner et al. (2013) and Robinson and Cort (2014) suggest, perceptions of refugee women as ungrateful, undeserving, or noncompliant contribute significantly to their experiences in healthcare settings, where they often are subject to “openly racist and discriminatory care, cultural stigma, disrespect, hostility, stereotyping, and being treated as ‘primitive’ people” (Heslehurst et al. 2018, citing Balaam et al. 2013; Mengesha, Dune, and Perz 2016; Small et al. 2014; Wikberg and Bondas 2010). For Muslim refugees, these experiences are deeply shaped by a nationwide climate of Islamophobia (Inhorn and Serour 2011; Samari, Alcalá, and Sharif 2018), which, as I will argue, has particular implications in the reproductive healthcare setting.

Islamophobia has been defined as a “social stigma toward Islam and Muslims” as well as a distinct form of “racism towards Muslims or those perceived to be Muslim” (Samari, Alcalá, and Sharif 2018) and thus must be understood as a form of discrimination that is both religious and racialized. In the contemporary United States, the racialization (and conflation) of Arabs and Muslims must be understood in relation to its critical role in justifying American military imperialism in the Middle East, including the 2003 invasion of Iraq. This process—referred to as “race thinking”—is described in detail by Shereen Razack:

Although race thinking varies, for Muslims and Arabs, it is under-pinned by the idea that modern enlightened, secular peoples must protect themselves from premodern, religious peoples whose loyalty to tribe and community reigns over their commitment to the rule of law. *The marking of a group as belonging to the realm of culture and religion, as opposed to the realm of law and reason, has devastating consequences.* There is a disturbing spatializing of morality that occurs in the story of modern versus premodern peoples. We have reason; they do not. We are located in modernity; they are not. Significantly, because *they* have not advanced as we have, *it is our moral obligation to correct, discipline, and keep them in*

line and to defend ourselves against their irrational excesses Evicted from the universal, and thus from civilization and progress, the non-West occupies a zone outside the law. Violence may be directed at it with impunity. (Razack 2012: 221–22, emphasis my own)

Critical theorists have persuasively shown how the gendered body represents a central vehicle through which race is produced (Kandaswamy 2012; Martinot 2007). The trope of the oppressed Muslim woman remained central to discourses that rationalized America's wars in Iraq and Afghanistan as means of promoting worldwide gender equality (Abu-Lughod 2002, 2013). These transnational discourses construct Muslim women as victims of patriarchy who must be taught—often by Western feminists—to exercise their right to freedom, equality, and individual autonomy. In the context of reproductive healthcare, clinical interactions may be subtly structured by Islamophobic stereotypes that portray Muslim refugee women specifically as “premodern, unruly” subjects who “must be taught responsibility” and gender equality by healthcare providers (Ong 2003). In practice, these lessons emphasize that “responsibility” entails spacing or limiting one's pregnancies and that modern rationality requires abandoning the traditional religious principles of modesty in favor of clinical efficiency.

As I began to discuss the focus of my research with community stakeholders, healthcare providers, and friends in medical school or residency, I was struck by the overwhelming similarity of their responses, which lamented what they viewed as the inappropriately high birth rates among newly arrived refugees. One resident expressed frustration with the “irresponsibility” of refugee women who “can't afford to properly care for the kids they already have” yet “still go on having more.” While most providers did not directly discuss religion, their opinions were clearly shaped by Islamophobic discourses that portray Muslim women as victims of male oppression and cast doubt upon their ability to exercise agency and autonomy, particularly in the realm of reproductive decision-making. Although providers emphasized their ethical commitment to providing culturally respectful care, I sensed throughout some of our conversations that many who espoused this commitment nevertheless clearly viewed particular “cultures” as inferior to their own.

Assessments of Muslim women's reproductive decisions were at times informed by the tacit assumption that those wearing the hijab might be forced to do so by their husbands, who could have similarly pressured or coerced them into having “so many” children. Such assessments were additionally informed by stereotypes about Islam. For example, health disparities among Muslim populations are often explained as a result of a “fatalistic” orientation that is supposedly inherent to Islam and thus antithetical to the biomedical ideal of rational action and the secularism such rationality demands

(Hamdy 2009). In this way, the stigma already associated with high fertility is further compounded by its representation as yet another unfortunate consequence of Islamic theology (Johnson-Hanks 2006).

As the means through which communities expand or decrease in size and labor power, reproduction has long been a central site for the exercise, establishment, and contestation of power. Since the colonial period, the norms distinguishing socially desirable from deviant reproduction have been shaped by hierarchical ideologies of racial inferiority that justified Euro-American imperialism. In the 1960s, when most postcolonial nations had been nominally granted independence, the fields of population health and demography became increasingly more prominent in response to international, neo-Malthusian anxieties surrounding the growing world population. Malthusian logic suggested that the “unfettered fertility” (Sanger 1920) of women of color, particularly in the Global South, threatened not only the economic growth of the newly independent, ostensibly “developing” nations but the human race as a whole, in the context of increasingly scarce natural resources. Racialized fears of overpopulation prompted massive coordinated efforts to curb the reproduction of women of color across the globe: from the forcible sterilizations of Latina women in Los Angeles county hospitals that continued throughout the 1970s to the coercive IUD camps funded by USAID and other humanitarian actors in the developing world, to the most recent, nonconsensual tubal ligations performed on more than 150 incarcerated women in California between 2006 and 2010 (Castro 2004; Gomez, Fuentes, and Allina 2014; Oparah and Bonaparte 2015; Van Hollen 2003).

During my fieldwork, several community stakeholders expressed their suspicion that Syrian refugees in particular pursued pregnancy for the purpose of increasing their welfare benefits, preferring to maintain a perpetual state of dependence on state aid rather than earn an honest living through wage labor. These accusations were often, puzzlingly, followed by explanations that framed these pregnancies as the result of a “village mentality” and an inability to plan ahead, despite the fact that a significant number of families had been born and raised in the cosmopolitan centers of Damascus and Aleppo. Paradoxically, these narratives simultaneously portray Syrian refugee women both as incapable of the forethought required to rationally plan and space one’s pregnancies and, at the same time, cunning enough to intentionally pursue pregnancy for their own self-interest—an action which, by definition, presumes a rationally acting subject. The logical incongruences inherent in these representations illustrate Kandaswamy’s (2012: 42) observation that hegemony is constituted through “complicated and *often contradictory* articulations of race, gender, sexuality, and class” (emphasis my own).

In their everyday interactions with refugees, clinicians, their staff, and stakeholders in the field of refugee resettlement repeatedly attempt to ed-

ucate Syrians about the moral importance of self-sufficiency through hard work and formal employment, thus shaping them into productive capitalist subjects. For example, Rima had asked her obstetrician to sign a form attesting to her temporary disability so that she could be excused from ESL classes and qualify for subsidized childcare during her third trimester of pregnancy. The obstetrician, whose misunderstanding, I suspect, was largely feigned, cheerfully reassured her: “No, no, you don’t need to worry about that; you can actually keep on going to school up until the day you give birth! Don’t worry about that at all!”

Since her arrival to the United States, Rima had learned the importance of showing up to appointments on time, participating in job training, and attending classes—skills that assured her continued access to resources provided by resettlement and service provision agencies. These skills enabled her to enact the role of a good, compliant patient despite frustrations that she expressed in private: “In Syria, if you are healthy [during pregnancy], you go only three times [to the doctor]. Here they give you paper after paper and ask you to go constantly.” Although Rima attended a clinic that served a large Arabic-speaking population of several thousand Iraqi and Syrian immigrants, none of the papers she referred to were translated into Arabic. As we drove to the clinic, she showed me how she had used Google translate on her cell phone to try to decipher an intimidating legal document, which requested her participation in a statewide genetic screening program. She carried with her additional documents that explained the purpose of her upcoming glucose tolerance test, the risks of gestational diabetes, and brochures about the importance of a proper diet during pregnancy. All were written in English and of limited use to her, yet she kept careful track of the files and diligently brought them to every appointment, including the reminder card for her 2:45 PM ultrasound. Nevertheless, despite these efforts, she was reprimanded for her “late” arrival by office staff, who forced her to choose between violating her religious commitment (not to mention her own sense of personal comfort) and rescheduling the ultrasound for a later date with no guarantee that her preference would be accommodated. The at-times-contradictory assumptions that shape perceptions of Syrian refugee women contribute to their experiences of disrespect and discrimination within a larger regime of exclusion and stigmatization in healthcare settings.

While this analysis has focused on the ways in which refugee women experience multiple forms of exclusion and stigmatization in reproductive healthcare settings, we also see how refugee women—albeit with varying levels of success—take advantage of the resources available to them to challenge, negotiate with, or appropriate the disciplinary norms of biomedicine. Morgan and Roberts (2012: 241) have shown how some women’s reproduction is perceived as “responsible” and “rational”—that is, as aligning with the demographic ambitions of the state, while other women’s reproduction is

stigmatized as “irrational” and viewed as a threat to the progress of the nation. These discursive regimes of “reproductive governance” (Morgan and Roberts 2012: 241) presuppose and valorize particular types of modern, calculating subjects who seek to plan and space their pregnancies (Baker 2009; Fordyce 2012; Hirsch 2008; Johnson-Hanks 2006; Ong 2003). By the same logic, populations viewed as hyperfertile are denigrated as irresponsible citizens who have, in the case of refugees, failed to properly internalize the “American” values of rationality, forethought, and self-sufficiency.

Conclusion

As I listened to the obstetrician’s cheerful reassurance that Rima could, thankfully, continue to fulfill her responsibilities as a productive and responsible future citizen by attending ESL until the moment she entered labor, I recalled the many times I had heard analogous sentiments expressed during my medical training. I had observed similar situations, in which pregnant patients would request an obstetrician’s support in qualifying for reduced hours or exemption from work and were dismayed when their requests were received with the same cheerful reassurance that they could absolutely keep working throughout pregnancy, often accompanied by a personal anecdote: “When I was pregnant, I delivered my patients’ babies up until the day I gave birth myself!” Refugee women, clearly, are not the only patients subject to disciplinary governance in clinical settings.

In this sense, I view my own research on refugee women’s experiences as contributing to the field of critical refugee studies, which, as Espiritu (2014: 10, quoting Agamben 2002) has argued, attends to “‘the refugee’ not as an object of investigation but rather as a *paradigm* ‘whose function [is] to establish and make intelligible a wider set of problems.’” The disciplinary gendered norms that structure the experiences of my research participants remain pervasive in contemporary sociopolitical discourses and define the hegemonic models of “responsible motherhood” toward which all women are expected to aspire. These models are, in turn, shaped by regimes of exclusion based on race, class, and immigration status that pervade past and present discussions of reproduction in the U.S. context. In this way, the practice of critical refugee studies (Espiritu 2014) provides a lens through which to identify and articulate the more widespread neoliberal ideologies that inform contemporary practices of biomedicine as well as U.S. policies related to immigration and healthcare. As such, the findings presented here not only illustrate several of the systemic injustices faced by refugees resettled in the United States but also illuminate the ways in which these injustices more generally reflect the larger morally laden principles that structure the American socioeconomic and healthcare systems.

Anthropologists Willen (2012), Ticktin (2011), and Giordano (2008) have shown how race, religion, and gender impact perceptions of which migrants “deserve” to be classified as refugees, showing how the imperative to enact proper modes of victimhood is undergirded by the gendered logic of racialization. Bridges (2011) and (Gálvez 2011) have illustrated how race and immigration status inform healthcare providers’ moral evaluations of patients as “responsible” mothers, and demonstrate patient responsibility and deservingness as intertwined in the reproductive healthcare setting. The study discussed here advances critical anthropological inquiry into the discursive construction of “deservingness” by considering how recently resettled refugee women experience the double burden of enacting their responsibility and deservingness as both racialized Muslim refugees and future mothers. This chapter illuminates inequities experienced by refugee women seeking reproductive healthcare and points to the ways in which the ultimate root causes of such inequities are intertwined with the classist logics and racist assumptions that structure American welfare policy.

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