The Journal for Undergraduate Ethnography

Synthesizing Cultural Competency and Reproductive Justice: A Case Study of Afghan, Refugee Mothers

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ABSTRACT

Cultural competency and reproductive justice are two popular frameworks by which medical anthropologists, public health experts, and social justice advocates understand minority women's health; however, both frameworks present shortcomings which limit holistic visualizations of wellness. I synthesize these frameworks in a case study of Afghan refugee mothers in North Carolina. My exploration of the composite framework uncovers significant factors affecting Afghan refugee mother's reproductive health, including the persisting effects of gender inequality in Afghanistan. History and health merge as I explore the lasting effects of the Taliban's gender apartheid on the reproductive health of Afghan women living in America. In Afghanistan, gender apartheid inhibits women from mastering the same abilities as men, namely driving and speaking English. In America, these different abilities precipitate deficits in social and mental health of Afghan women as compared to their husbands. Infrastructure in America reifies these deficits and further hinders the women's agency. Mapping powerlessness from Afghanistan to America, this framework illuminates the architecture of power that extends across the two countries.

Keywords: Afghan refugee mothers, gender, reproductive justice, healthcare, Afghanistan, United States

While many scholars have investigated the compatibility between Islamic beliefs and American healthcare practices, and others investigate the impact of minority identity on reproductive health, the disjuncture between these studies perpetuate a fragmented paradigm of health (CDC 2022; Hammoud et al. 2005; Padela & Curlin 2013). In this study, I synthesize reproductive justice and cultural competency frameworks to construct a holistic model of the factors affecting the reproductive health of Afghan refugee mothers in Winston Salem, North Carolina. To understand the body of forces pressing reproductive health and autonomy, I collected ethnographic data through three rounds of participant observation by volunteering with World Relief and by conducting one focus group interview. Building from a foundation of cultural competence and reproductive justice, I aimed to collect and present health data within the network of life history, culture, and society.

The reproductive justice framework (RJF), interrogates the health challenges of minority groups, drawing attention to factors perpetuating health inequalities within and beyond healthcare with an emphasis on individual and community lived experience (Ross 2017); however, RJF lacks ethnographic attention towards nodes of cultural friction between patients and systems (Macleod 2019). Though the traditional cultural competence framework (CCF), seeks to identify and regulate cultural barriers to healthcare, it generally lacks awareness of the health consequences arising from socio-cultural positionality and circumstance (Cross 1989). Therefore, a synthesis of both strategies would optimize understanding of health realities for immigrant women.

Bridging the Reproductive Justice and Cultural Competency Frameworks

Biomedical healthcare frameworks are restricted in scope to an exploration of the physical body of the patient entering a healthcare facility, foregoing the vital context of their lives and environments. Cultural factors must be implemented into clinical practices as the experience of health and illness are inevitably bound to cultural factors such as religion, gender, and ethnicity. These factors influence one's health in many ways such as lived experience, self-assessment of illness, or willingness to seek care. Arthur Kleinman (1981) urges for the redefinition of patients' and healers' social roles within a matrix that identifies the social realities of all parties. Therefore, this study presents individual narratives and community histories as a central vein connecting accounts of cultural barriers to healthcare, as per CCF, and social and environmental factors which affect health, as per RJF.

The reproductive justice framework considers the dimensions of women's lives that relate to wellbeing. These dimensions span from physical and mental health to political, social, and economic wellbeing (Onwuachi-Saunders 2019; Ross 2017). Reproductive justice is both a framework and a political movement. The term was coined by Black women in Chicago to capture the complex forces acting on persons-of-color (POC) women's health and autonomy (Onwuachi-Saunders 2019). It has since gained popularity in feminist studies due to its utility in analyzing what factors in a woman's identity, condition, community, and society affect her agency in determining her reproductive rights. RJF relates social inequalities to reproductive autonomy with an emphasis on the relationship between the present and the past as well as the community and the individual (Ross 2017). For example, Loretta Ross (2017), a reproductive justice pioneer, uses the framework to analyze the lasting impacts of reproductive violence against enslaved women on Black women's reproductive realities today. RJF is a feminist framework, not an anthropological framework. Therefore, it lacks the cultural emphasis that a study of Muslim, immigrant's reproductive health demands. The rich and complex religio-

cultural construct surrounding reproduction for Muslims from countries like Afghanistan requires a culture-oriented framework.

The cultural competency framework is a fruit of anthropology. It shares some similarities to reproductive justice in that it analyzes a wide spectrum of behaviors, attitudes, and politics but with the intent of maximizing effectiveness in cross-cultural situations and minimizing cultural barriers to healthcare (Cross 1989). In short, it acknowledges the cultural components of health. Terry Cross (1989) introduced the term in his seminal text "Towards a Culturally Competent System of Care" as a call to reduce health disparities through heightened understanding of patient circumstance. Cultural competency has since been integrated in medical curriculum and training. While cultural competency is the intersection of cultural pluralism and health, reproductive justice is the intersection of socio-cultural positionality and health.

Structural competency, a theoretical framework branched from CCF, seeks to transcend the bounds of culture and healthcare in centering social structures' production of health inequalities (Harvey et. al 2020). Structural competency aims to identify the modes by which structural inequalities are naturalized within health care, recognize the impact of social structures on the production and maintenance of health inequities, develop structural interventions for addressing global health inequities, and apply the concept of structural humility and collaboration between patients and healers (Harvey et. al 2020). Structural competency holds some of the cultural and positional awareness that cultural competency grants while expanding its scope to include social institutions. Additionally, structural competency and reproductive justice share bifunctionality as both an analytic lens and a political praxis.

What, then, is missing from the structural competency lens that still requires coalition with reproductive justice? Structural competency, as implied by the name, surveys the macrocosm and still holds the healthcare institution as the crux of health. The reproductive justice lens is dialectical in its analysis, weaving the individual, institutional, and socio-structural narratives, depolarizing health across nodes of wellbeing (Morison 2021). In bridging the discourses of reproductive justice, cultural competency, and structural competency, any analysis of healthcare must be multidimensional to identify the specific social factors and cultural forces which affect the reproductive health of Muslim Afghan women. Further, my analysis must dialectically analyze the network of individual narratives, community histories, cultural barriers, and socio-structural inequalities. This study identifies the ways in which life histories, cultural forces, and social inequities cause or compound each other, challenging the very distinctions between the three. It is important to note that I have loosely divided the results into components of cultural barriers and social and environmental factors for the sake of organization. The separation of these dimensions allows me to receive them in the context of our Western paradigm of health and wellness; however, the separation of these categories is nearly as arbitrary as the symbols on this page.

Afghan Refugee Crisis

Decades of conflict, political instability, and violence perpetrated by the Taliban have forced millions of Afghans to flee their homes and disperse across the world. In 2021, the number of Afghan immigrants in the United States skyrocketed. After twenty years of freedom from the Taliban's terrorist regime, Afghanistan was recaptured in August of 2021 following the withdrawal of American troops. As of the 31st of January 2022, the United States has accepted 68,000 Afghan refugees (PBS 2022). Refugees endure exceptional trauma at the hands of the terrorist organization before their escape, yet life after relocation presents new challenges. Refugees are initially housed in crowded military bases and camps then directed to refugee resettlement programs which aid in relocation to communities across the country. The women I interviewed had all arrived in the United States between August and September of 2021. They were initially housed in such refugee camps, before relocating to Winston Salem, North Carolina.

Methods

In *Writing Against Culture*, Abu-Lughod (1991) characterizes the position of the "halfie," which describes an individual with multiple cultural identities, whether by "migration, overseas education, or parentage" (466). I resent the term "halfie," because it reduces a cultural experience to a problematic dichotomy, a matter of matter wherefore each identity must be diminished to share space about the self. I resonate, instead, with Kiran Narayan's (1993) account of identity, "two halves cannot adequately account for the complexity of an identity in which multiple countries, regions, religions, and classes may come together" (673). However, Abu-Lughod's (1991) analysis of the positionality of "halfies" still has much to offer. I am one of these "halfies," half Persian and half American. About the dilemmas of halfie anthropologists, Abu-Lughod (1991) writes, "they position themselves within reference to two communities, but [also] when they present the Other they are presenting themselves, they speak with a complex awareness of and investment in reception" (469). Although Iran and Afghanistan are two distinct countries and cultures, the countries are intimately related and many Afghans, including the majority of my interlocutors, are considered ethnically Persian. Additionally, both countries are burdened by the same extremist theocracy and terroristic gender apartheid that produced the circumstances investigated in my research. When I first presented this research, my mom, my ever-supportive audience member, was deeply affected. The stories of Afghan women I reported echoed those of her mother's and her own. As I was explaining the women's social isolation and immobility, she could think only of my grandmother. Like the Afghan women, she cannot drive or speak English. Even after living in America for 20 years, she is still reliant on our family to take her to doctor appointments or social gatherings. In a non-walkable city, she is chained by immobility and largely socially isolated. It was these experiences of my family members' suspended lives post immigration which compelled me to study Muslim immigrants.

This emphasis on reflexivity imbues this study. Reflexivity is a post-modern anthropological movement intended to curb the bias inherent in any literature by taking the cloak off the ethnographer. Lila Abu-Lughod amends James Clifford (1986)'s characterization of ethnographic reports as "partial truths," by insisting the truths must be also acknowledged as "positional" truths (Fox 1991). I mark myself as the homodiegetic narrator of this ethnography to make clear the position of my interaction. Further, I mark the flaws in this ethnography, particularly in the disorganization of the focus group interview discussed above. This ethnography includes the entanglement of ethnographer and ethnography through honest inclusions of mistakes, emotions, and relationships with interlocutors for a non-estranged and non-subordinating ethnography.

I chose a case study of Afghan, refugee mothers because I came by the opportunity to work with them through a volunteer organization: World Relief. World Relief is a nonprofit, Christian, humanitarian organization which aims to help immigrants settle and assimilate in their new homes. Beyond helping the refugees with transportation, World Relief organizes weekly discussion groups with a cohort of Afghan, refugee mothers. The meetings ranged from helping the women sign up for ESL classes at a community college to recruiting reproductive health experts to lead discussions about contraceptive options. I registered as a volunteer and attended three of these meetings, conducting participant observation and a focus group interview with six of the refugee women.

Participant observation is regarded as the core 'tool' of the ethnographer (LeCompte and Schensul 1999). Russel Bernard (2018) describes it as both a "humanistic method and a scientific one" (272). Participant observation gave insight into the daily lives of the women and some of their recurring challenges which informed my results as well as my topics for a focus group interview. It allowed me to observe topics which evoked emotion and discomfort and topics which resurfaced repeatedly. It also allowed me to experience the social dynamics produced among members of the group. For example, the women trusted me much more readily than the other American students volunteering with me because I am Persian, and I could speak with them in Farsi. Dari is

regarded as a dialect of Farsi and is commonly referred to as "Eastern Persian" or "Afghan Persian." Because Farsi is my second language, it was much more difficult for me to interpret Dari than it was for them to interpret Farsi, so, often, our communication was lopsided. Still, the women and the World Relief coordinators appreciated the little boost in communication between the organization and the women from my language contribution. There was also social separation between the Dari speakers from urban backgrounds and the Pashto speaker from rural Afghanistan in the third meeting. During the focus group interview, all the Dari speakers crowded on one end of the long table together, and the Pashto speaker sat on the other end between World Relief volunteers.

The first meeting I attended was held at a park where we discussed the women's difficulties navigating the American school system for their children. In the second meeting, we helped the women register for ESL classes at a local community college. Before the third meeting I attended, I drafted a letter requesting a focus group interview. In the letter, I explained my research and the various topics we would cover. I included a translation of the informed consent letter in Dari. My preference was to conduct a semi-structured focus group interview, as I hoped the women would feel more comfortable in each other's presence and build on each other's ideas, sentiments, emotions, and insights (Bernard 2018). I could also get a better sense of which experiences are common or unique amongst the women. Knowing that some of the topics could be sensitive, I asked if they would prefer individual interviews or to interview together; they unanimously agreed on a focus group. I told the group I would brew *gole gov zabon* (borage tea) for the interview. In our culture, serving tea is a charged offering; it is an extension of gratitude and it projects the intention of creating a meaningful connection. The choice of tea was intentional, signaling my position as a cultural insider. Borage tea is a lesser-known tea to Westerners and, within Persian culture, it is believed to have a calming effect.

A coordinator of the discussion group allowed me one meeting to conduct the interview. Five women attended this meeting, four of whom spoke Dari and one of whom spoke Pashto. The five women in the interview cohort, Kaameh, Moska, Nahal, Shandana, and Hajira had immigrated to the United States over a year ago and they were all mothers between the ages of 30 to 39 with their families ranging from one to seven children. Because the meeting was coordinated by World Relief, I had no prior knowledge of the turnout. The focus group interview happened to be the first meeting Hajira, the Pashto speaker, attended. One translator was physically present, translating the responses from Dari, and one translator was on speakerphone translating Pashto. The introduction of another language into the group heavily disrupted the flow of the interview. The environment was chaotic with multiple conversations in multiple languages pin-balling between the translators, the women, and me. The women would deliberate at great lengths, and then I would receive a few sentences of summary from the translator. Lost information is always a limit of working with translators, and the focus group setting only increased the ratio of words spoken to words translated. Because I was coordinating two simultaneous conversations, asking follow-up questions and prodding for greater explanation was difficult.

Having women from two different regions revealed differences in the lives of women from urban Afghanistan (the Dari speakers) and rural Afghanistan (the Pashto speaker). On several occasions, the Dari women disagreed with the Pashto woman's accounts of life in Afghanistan, and vice versa, which allowed me some insight into the reliability, accuracy, and generality of my results. I was reminded Afghanistan, like any country, is not a monolith and has variability across locations and subcultures. Further, the focus group was fruitful for my study and for the women, who professed afterwards they found it therapeutic to speak about their challenges as a group. Despite the chaos, I maintain the focus group interview was the best method for this ethnography as it invoked unexpected conversational directions, it illuminated regional differences, and it was constructive for all parties involved. However, if I were to continue this study I would group by language and conduct two interviews, one for Dari speakers and one for Pashto speakers. I

would also meet outside of World Relief to have more control over attendance. There were, however, benefits of working with World Relief: they provided the translators as well as the transportation. Additionally, the women were in a familiar context with familiar people.

During the focus group interview I used my phone to record audio of the conversation, with the participants' permission, and I took notes of any visual cues and other observations. I transcribed the audio and overlaid my written observations. I then coded all my notes from the participant observations and the transcription of the focus group interview by hand using a hybrid of deductive and inductive codes, the majority of which were descriptive. These codes allowed me to identify themes such as challenges to wellbeing and barriers to healthcare. Accompanied by a literature review, I synthesize my fieldwork with existing studies to present a comprehensive image of women's health.

Social and Mental health

The relationship between stress and reproductive health

Medical anthropologists and reproductive justice advocates point to stress as a leading cause of reproductive illness disparities among minority women (Guido et al. 2019; Suglia et al. 2010). One proposed link between social-environmental health and reproductive health is the stress-induced adrenal hormone cortisol. This stress-cortisol relationship explains higher levels of prenatal birth and birth complications among minority women as compared to national averages (Mustillo et al. 2004). As of 2021, the rate of preterm birth among Black women in the United States was 50% higher than the rate of preterm birth among white or Hispanic women (CDC 2021). Unfortunately, few studies investigate the reproductive health of Middle Eastern women or refugee women.

Harakow et al. (2021) sought to conduct a literature review to understand refugee women's vulnerability to pregnancy complication but reported,

> The small number of articles eligible for inclusion in the review highlights the lack of research and knowledge on refugee health during pregnancy. Further research is required to understand and reduce disparities in pregnancy outcomes between refugee and non-refugee women (649).

With their dataset from 19 sources, Harakow et al. (2021) found refugees had increased risk of stillbirth and spontaneous abortion compared to native women. One study they reference, Badshah et. al. (2011), found Afghan refugees in Pakistan report low birth weight 2.6 times higher than Pakistani mothers. Without the capabilities to measure cortisol levels in Afghan refugee mothers and their children, I aim only to identify stress causing agents and employ the accompanying literature to suggest their relation to reproductive health. The primary 'stress causing,' or cortisol producing agents I identify are categorized by social isolation, emotional distress, and psychological trauma which can be summarized under the larger categories of social and mental health.

Afghan Refugee Mothers' Social and Mental Health

The focus group interview was a balancing act I was not prepared for. I walked into the conference room of the Forsyth Community Central library with 5 cups for tea, expecting the familiar faces of Kaameh, Moska, and Nahal, and our translator Shahla. Kaameh, Moska, and Nahal are Afghan and speak Dari. Although Shahla is Iranian and speaks Farsi, they all converse with no difficulty. I was surprised to find two unfamiliar faces joining the usual crowd. There was a new Dari speaker, Shandana, and a Pashto speaker, Hajira. Shahla was seated at one end of the table, flanked by the four Dari speakers. On the other end, Hajira and the accompanying members of World Relief leaned over the iPhone connected to a Pashto translator.

After serving the borage tea, I settled in the middle of the table between the Pashto and Dari sides and prepared for the ethnographic circus that was to follow. Throughout the interview, I exercised conversational acrobatics, bending backwards towards the iPhone speaker to tune into the Pashto translation while keeping an ear hooked on the Dari conversation, I juggled the appropriate follow

up questions, and I often made a clown of myself. A total of four languages whirled around this phonic sensorium. While tuned into the Dari conversation, Donna, a World Relief volunteer, tapped my shoulder, "this is important," she lassoed my attention back to the iPhone on the tabletop. The Pashto translated relayed a sentiment from Hajira that cut through the cacophony: her life in America was really no different than her life in Afghanistan. I probed for elaboration, and she explained, "I stay at home all day with my children while my husband goes out and works, just as I did in Afghanistan." I turned this sentiment to the Dari women, who disagreed, saying they felt their lives were different in America, but not in the way I expected. Despite immigrating from the country ranked 170th in gender inequality to the country ranked 15th, the women proclaim they are *more* isolated in America than they were in Afghanistan (UN data 2024). They point to three main causes of their social isolation and frustration in America: transportation, language, and underlying it all, a gendered division of labor.

Gendered division of labor and ability, language, and transportation

As of 2021, only 14.85% of women in Afghanistan are employed, capturing the cultural division of domestic and wage labor (TheGlobalEconomy.com 2021). This is a sharp decline from 2019 which reported 21.51% engagement in wage labor for women, reflecting the Taliban's influence on women's rights and social positionality (TheGlobalEconomy.com 2021). During Taliban rule from 1996 to 2001, women were restricted from working in public spaces, and women with children were prohibited from working altogether (PBS 2008). Though Afghanistan enjoyed freedom from Taliban rule between 2001 and 2021, these strict regulations had lasting imprints on the socio-cultural fabric of Afghanistan, imprinted in the shape of cultural taboos. Though women's employment increased steadily after the 2001 Taliban retreat, it never rose above 21.94%, and the economic sector itself remained heavily divided by gender (TheGlobalEconomy.com 2021).

Because different occupations engendered different abilities, this division of domestic and wage labor in Afghanistan causes unique challenges to the women that their husbands do not experience *after* immigration. The women will be the first to tell you immigrating is harder for them than it is for their spouses. When I asked, "what are the differences between your experiences and challenges and your husbands'?" they murmured for a moment and Shahla translated their response, "because they know the language, it is much easier for them than for us. It is more challenging [for the women]." The women hummed in agreement. Perplexed, I asked, "why are your husbands fluent in English, but you are not?" They explained that although they all learned English in high school, their husbands continued to use and practice English in Afghanistan in the workplace. Because of the American occupation, they explained, a lot of jobs required English proficiency, particularly those that worked with the government or American military. Most of their husbands' former jobs involved the military in some capacity and, as a result, most of their husbands came to the United States with high English proficiency. Meanwhile, the women either worked solely in the household or in jobs that did not require them to speak English — Shandana, for example, was a seamstress for an Afghan textile company.

The language barrier is no small adversity. I asked, "what are the greatest challenges in your day-to-day life?" Without hesitation, Nahal points to her open mouth, and responds "*zabon*," a homonym in Dari for tongue and language. I recalled the first group meeting I attended in Bolton Park where I first met Nahal and Moska. We pushed Nahal's son down the zipline and meandered to the other side to retrieve him. Attempting conversation, I asked Nahal if she was starting to feel settled here in Winston Salem. Her response, four weeks earlier, was the same: not really; this was because the language barrier was frustrating and debilitating. Now at the focus group interview, the other women had a chance to echo this sentiment. Shandana explained that she would like to work in the United States, just as she did in Afghanistan, but it is impossible without speaking much English. Despite

immigrating from a country with 14.85% women's labor force participation to a country with 57.4% women's labor force participation, most of these refugee households experience an increased wedge in division of labor between husband and wife (United States Department of Labor 2021). The barrier of social taboo was merely replaced by another, language proficiency. Further, comparing their employment opportunity to their husbands' reveals the first barrier induced the second. The language barrier impedes ability to work and, in conjunction with a transportation barrier, impedes socialization and enculturation.

A transportation deficit between husband and wife mirrors the language deficit; diverging occupations, cultural taboos, and Taliban influence in Afghanistan breed an enormous driving gap between men and women. Though no legislation directly outlawed women from driving before the Taliban's return in 2021, women drivers were perceived as subversive and were often subject to harassment. From 2005 to 2006, the license bureau of Kabul reported a total of over 17,000 licenses issued; of these 17,000, only 85 licenses, 0.5%, were awarded to women drivers (NBC 2006). Thankfully, mobility in urban areas is possible without a car. Kammeh, Moska, Nahal, and Shandana painted vibrantly populated illustrations of the streets of their hometowns. Merely walking out the door implants one in a social space. "When they go out [in Afghanistan], there's a lot going [on]. People are shopping, talking, all that. Versus here in this city, no one is out, no one is walking on the streets, no one is there to talk to them, no mingling," Shahla translates. The car-based infrastructure of Winston Salem leaves these unlicensed women stranded, physically and socially. Winston Salem has been listed among the least walkable cities in America (Thorn 2023). Without a license in Afghanistan, they could still walk to visit their friends, buy their groceries, or visit a doctor's office. in America, they are entirely immobile and reliant on their husbands. "Because the way here people live, they have to drive... For the ladies, because they don't drive, they are very, very dependent on their husband," Shahla translates.

While their husbands are at work, the women are bound to their houses. The language deficit compounds the mobility deficit, as the closest DMV which offers Dari translators for driving exams is forty minutes away, and drivers' education material in Dari is limited. The DMV in Winston Salem will permit a translator after the participant has failed the exam four or more times. Both options are highly inconvenient for the mothers who have the full-time responsibility of childcare. Additionally, they are entirely dependent on the schedule of their husbands or World Relief members to provide transportation to the DMV. En masse, the mobility deficit coupled with the language deficit has left these mothers feeling uncomfortably reliant on their husbands. In addition to mobility, these women have suffered a loss of independence and autonomy.

Another wrench complicates language proficiency and thus social integration: the responsibility of cultural preservation. While their children practice English at school, and their husbands practice English at work, the immobilized women have no opportunity to practice English unless the family speaks English at home. Moska tells the group she asks her husband and children to speak in English at home so that she, too, may practice, but her husband worries that if they do not speak Dari at home, the children will forget their native language, and their culture will be lost. Nahal and Kaameh echoed this experience. Learning a new culture while preserving an existing culture is a difficult balancing act and a heavily moral responsibility to bear. By nature of circumstance, the consequence of cultural preservation falls solely on the mothers, and the household is forced to privilege the preservation of Afghani culture over the mother's integration into American culture.

Motherhood—dual responsibility, dual experience

Motherhood is an integral component of these women's identities. Their emotional burden is twofold as they carry their children's tribulations as well as their own. The gendered division of domestic labor enlists the mothers as the primary caretakers of the children. As such, this disproportionately adds to their responsibility over their husbands for their childrens' integration. Language barriers add additional layers of frustration, impeding the

mothers' involvement in their childrens' new lives. During a weekly meeting at the park, Moska divulged, with a furrowed brow and worried eyes, that her son is performing poorly in school. She says she cannot get in touch with the teacher because of the language-based lapse in communication. Her fidgeting fingers, pushing playground turf in thoughtless clumps on the tabletop, betrayed the great deal of anxiety behind her admission. These World Relief meetings were designed to help these women integrate, not only by assisting in various stages of the process but also allowing a space to talk about problems they were facing. In the meetings, I observed that they brought up issues their children were facing as issues they themselves faced. The language barrier goes beyond occupational and social dissatisfaction, restricting their ability to help their children. The frustration and anxiety experienced by a loving mother feeling unable to help her children is inexpressible.

Trauma, Faith, and Counseling

"*It is important to understand the mental health of Afghans prior to their forced migration as their trauma is complex and multiple… Generations of Afghans have been born during the conflict and some have never known peace*."—Husna Safi

Near the end of the focus group interview, while I was deeply invested in Hajira's testimony, the Dari side conversed amongst themselves independently for a few minutes. Subconsciously detecting a change in the atmosphere, I shifted my attention back to the Dari-speaking women and noticed the dry eyes I left just a few minutes ago now glassy with tears. Sensing my confusion, Shahla relayed a synopsis of the conversation at hand,

> Prior to arrival to US, the experience they went through, the scenery they've seen of people being whipped by Taliban, being killed by Taliban, being tortured by Taliban, it's something that they can't forget. In the camp they were in a lot of stress, and they are still scared from that part… Still when they think about how they got out, and how horrible scenery they've seen, they are all in tears, even now, even now when they talk about it.

As the conversation continued, I learned the process of escaping the Taliban was just as harrowing as living with them. In the chaos of bodies clambering onto buses, Moska's daughter's little fingers slipped out of her husband's hands. "All of a sudden, they came to sit in a van, and they couldn't find their daughter." With their infant son and the threat of losing their spot on the bus, they were forced to make the decision to stay on the bus and leave without knowing where their daughter was. As Shahla was narrating her story, Moska wiped tears from her eyes. Thankfully, someone called them saying they had their daughter, and they were able to be reunited. These women were fortunate to make it on the bus with their families intact, but many Afghan refugee women are not. Some children were left orphaned in Afghanistan, some were separated from their parents and dispersed to different camps in the United States, and some were left dead, trampled by the swarm of frantic bodies seeking escape. Moska, attempting to illustrate the pure chaos of the affair, recalls children boarding the bus barefoot. Parents dragged their families through the turbulent crowds, weaving and jabbing their path to the bus. Their children's shoes would fall off in all the commotion, and there was no time to turn back for children who lost their parents' hands, let alone shoes who lost their children's feet. Those who secured a spot on the bus endured attacks from Taliban forces attempting to thwart the escape. The buses that successfully evaded Taliban attacks delivered those fearful, fortunate few to the airport where a US plane waited. An hour after the plane departed, Kabul international airport was bombed.

These near-death encounters, near-family losses, and exposure to the cruelest crimes against humanity weigh heavily on the mother's psyche, and in turn the women lean heavily on their faith. In the spirit of due diligence, I opened the interview by asking how they identified their religious beliefs. They unanimously responded, "we are all Muslim women" with a tone that practically inserted 'obviously,' as an introductory adverb. Their manner of response made me feel

embarrassed for even asking. Another anthropology student observing the interview asked Shahla to ask the women, "how important is their faith to them," and without hesitation, without relaying the question, she knew, and she responded, "their faith is everything." They made sure Shahla translated this distinction, "when the Taliban got to power, even though they are Muslim they are not true Muslim… They have their own rules and regulations that are not following our beliefs." The mothers' beliefs are not the same as those which persecuted and oppressed them, rather their belief empowers them in the wake of their many hardships. The women expressed that their faith has helped them through many of their endured traumas.

I asked if they would ever consider seeking counseling as an additional ally in processing trauma, but they rejected the notion on the grounds that God gives them strength, and they are now in a much better situation, so therapy is unnecessary. Mental healthcare seeking behavior varies by culture; reluctance to seek mental health care is common amongst Middle Eastern Muslims due to religious and cultural taboos. Many Muslims believe, if one is following the Islamic tenets dutifully, they cannot be depressed (Hammoud et al. 2005). This adds another level of complexity to the already complex mental health of Afghans who have endured decades of conflict and generational trauma. Husna Safi, an Afghan psychotherapist and social worker, addresses the Afghan mental health crisis, arguing that "generation of Afghans have been born during the conflict and some have never known peace" (Diwakar 2021). She explains Afghan's attitudes towards mental health care as inhibited by the normalization of their experiences, anxiety, and PTSD. "To Afghans, mental health is not just about mental well-being, it is a reflection of one's whole self. Most mental health experiences are normalized and viewed as everyday emotional experiences" (Diwakar 2021). This normalization of experience may explain why a study by Correa-Velez (2006) found that individuals from refugee backgrounds are 30% less likely to have mental or behavioral admissions than native born citizens.

Intersecting social and mental health with reproductive health

Medical anthropology informs us that stress causing factors in the social and political world manifest in the physiological world. In the context of reproductive justice frameworks, the merging of these domains involves investigation into the relationship between stress causing factors and reproductive illness. Studies suggest a pathophysiological relationship between maternal stress, elevated levels of cortisol, and increased risk of miscarriage and premature birth (Nepomnasch et al. 2006). Preterm birth is particularly dangerous as it is the most common cause of infant mortality in the United States. There is a significant body of literature which supports a relationship between elevated cortisol and preterm birth, such as Heckmann et al. (2005) who found postnatal plasma cortisol levels in preterm infants to be five to ten times higher than postnatal plasma cortisol levels of fetuses at the same gestational age.

Recent studies push further to suggest maternal stress prior to conception influences birth outcomes. A study by Wadhwa et. al (2011) postulates a cumulative pathway by which chronic exposure to stress results in elevated cortisol levels and dysregulated hypothalamic-pituitary-adrenal response to stressors. The hypothalamic-pituitary-adrenal axis, or HPA, is a key axis in homeostatic response, as it regulates physiological processes to mediate the body's response to stress. These processes include metabolism, immune response, and the autonomic nervous system. Therefore, elevated cortisol levels and loss of HPA regulation led to immune suppression and immune inflammatory dysregulation, all of which increase vulnerability to preterm birth. Wadhwa et. al (2011) thus suggest a comprehensive life-course model of reproductive health,

> The life-course perspective conceptualizes reproductive and birth outcomes as the product of not only the nine months of pregnancy, but of the entire life course of the mother from her own conception onward (or even before her own conception), and leading up to the index pregnancy. The suggestion

> that maternal health prior to pregnancy may have important bearing on pregnancy outcomes is not new, but a growing body of evidence is beginning to shed light on the mechanisms by which life-course factors, including stress, might influence birth outcomes such as preterm birth (17).

For our Afghani mothers, these life-course factors include social isolation, emotional distress, and trauma. Emotional distress produces cortisol in an unsurprising fashion, but studies prove social isolation produces cortisol as well.

Through testing urine samples, studies have found patients experiencing loneliness have higher levels of cortisol than patients who have social support networks (Kiecolt-Glaser et al. 1984). Additional studies find elevated levels of cortisol are found in saliva samples of students experiencing chronic loneliness (Cacioppo et al. 2000). Further, Serra et al. (2005) report that social isolation impairs the negative feedback regulation of the HPA, which results in overproduction of stress-hormones. A history of trauma likewise produces cortisol elevation which may affect pregnancy. Exposure to trauma through life has been associated with impaired cortisol activity, increased risk of preterm birth, and increased risk of reproductive tract infection (Wadhwa 2011).

Barriers to Reproductive Healthcare

The primary barriers to reproductive healthcare should look familiar: transportation, language, and gendered division of labor. The same agents which perpetuate social isolation present barriers to healthcare, but with one new accompaniment: gender provider preference. The women offer experiences with each obstacle alongside examples of culturally competent care that alleviated some of these obstacles. Language barriers restrict communication between patient and provider, though luckily these women reported that a translator was provided for the majority of their healthcare experiences; the translators usually communicated remotely through tablets. They found these translator systems highly effective, providing an excellent example of culturally competent care enacted. Transportation, however, is more difficult to come by. The women are restricted by the schedules of their husbands or World Relief volunteers. In considering reproductive health, reliance on others for transportation robs the women of reproductive privacy and autonomy. Additionally, childcare responsibilities restrict autonomous movement.

Hajira's testimony perfectly illustrates the barriers to healthcare experienced by these women. Hajira has seven children, and, like the other women, she cannot drive. Earlier in the year, she was experiencing extreme leg pain. Days went by and this pain did not subside. Hajira, unable to drive, waited at home for relief. Eventually, weeks passed, and the pain only worsened. At a certain point, the pain had become so severe that her caseworker wanted to take her to the emergency room, but Hajira had to refuse. There was no one else who could look after her young children at home if she went to the hospital. In this case, the ailment was non-reproductive, but the anecdote raises reproductive health concerns. Hajira had just had a baby, putting her at high risk for postpartum complications. In fact, death due to postpartum complications is growing in frequency in the United States and can occur up until a year after pregnancy (Berg 2023). Further, the CDC (2022) reports higher rates of complications and deaths for minority women. If Hajira were to experience postpartum complications, she would have been unable to seek care due to her lack of transportation and her childcare responsibilities.

Provider gender preference presents additional barriers to reproductive healthcare for Afghan women. When I asked the women if they would see a male gynecologist, the response was a resounding, emphatic, and unanimous "no." Moska raised her hand to her heart and made a sweeping gesture downward, "below here," she said, "I need a female doctor." This preference is so strong that the word preference feels a misrepresentation. For these women, it is a necessity. Hajira recounted her experiences with reproductive health care in America during her pregnancy and delivery of her seventh child. She said that they offered her the option of an all-female provider team, which she accepted. I asked her what she would

have done if they were not able to offer an all women team. She said, "I would turn around, go back home, and give birth by myself in my house."

This gender requirement is cultural and religious in origin. In Afghanistan, all the gynecologists are women in accordance with Islamic codes of appropriate conduct. There are several commandments within the ethical-legal structure of Islam that regulate conditions for reproductive healthcare; modesty is of great moral importance. According to Malik's *Muwatta*, a collection of The Prophet Muhammad's saying and deeds and a bedrock treatise of Islamic law, Muhammad stated, "every *dīn* [religion/way of life] has an innate character, the character of Islam is modesty" (Abd al-Haiy, Book 47, Hadith 9 1967). Modesty is governed by the concept of *'awrah*, which denotes the parts of the body that must be clothed in various circumstances. For men, regulation of *'awrah* asks for the covering of the navel to the knees and recommends the covering of the shoulders. For women the regulation of *'awrah* receives more explicit instruction. There are three contexts in which regulation of *'awrah* for women has defined terms relevant to healthcare. These three contexts are defined by the gender composition of the social setting. In the company of other Muslim women, the only area that a Muslim woman must have covered is the region from her navel to her knees. In the company of non-Muslim women, there are conflicting opinions. Many scholars will allot the same restrictions for the company of non-Muslim women and as for the company of Muslim woman; however, other scholars believe that a non-Muslim woman equates to a non-*mahram* man. A non-mahram man describes a man not related by blood, by marriage, or by virtue of sharing the same wet-nurse. In the company of a non-*mahram* man, everything must be covered save the face, hands, and feet (Padela & Pozo 2011). In addition to modesty of covering, situational and exclusionary modesty are relevant conditions.

Khalwah describes the prohibition of situations in which a man and woman are alone in a closed space (Padela & Curlin 2013). Related is the prohibition of physical contact between members of the opposite sex. Within this prohibition, there are rules for permissible physical contact that do not fall within the *'awrah* regions of the body (Padela & Pozo 2011). Of course, engagement with these religious commandments varies by individual. Moska, for example, said she has a male dentist and is comfortable with having male doctors for non-reproductive health encounters. Additionally, though they all generally wear headscarves in observance of *'awrah*, some of the women will remove the scarf in public on occasion. When I first met with the World Relief coordinator to discuss my study, she said that these women were generally "more progressive" than many other Afghan immigrants she has worked with. She postulated this to be in retaliation to the Taliban's viciously radical religious crusades. Though engagement with and interpretation of *khalwah* and *'awrah* differ across the women, one boundary remains clear across the board, reproductive health care must be conducted in the company of women only.

Discussion

Immigration: not everything is left behind

Gender inequality in Afghanistan begets a network of interconnected factors combining to amplify ability deficits between genders in America. The language deficit, mobility deficit, and division of labor interact reciprocally such that each deficit compounds the others and all deficits influence social health. Gendered division of labor in Afghanistan results in language and mobility deficits, which in turn prevent the women from entering the workforce in America. Low language proficiency inhibits mobility as it creates additional barriers to receiving a driver's license. Further, the gendered division of labor in America contributes to the language and integration deficit as the husbands practice English and learn cultural customs at work while the wives have no exposure to language learning and enculturation at home. This is augmented by the responsibility of cultural preservation, which prevents English practice from occurring in the household. The accumulation of these interactions propagates troubles in social health, mental health, physical health and integration unique to the wives. The following

flowchart illustrates the relationship between the nodes.

Figure 1 illustrates the causal relationships between gender inequality in Afghanistan and the resulting gender deficits in America experienced by Afghani refugee wives. The dotted rectangles indicate the contextual realm of the variables. The variables in the top rectangle act on the women in Afghanistan, whereas the variables in the bottom rectangle on the women in America.

Power: dispersion, maintenance, and amplification

Power, like ethnography, can be visualized as a line rather than a dot. Power and powerlessness are two effects of the same force. The force of power is the oppositional relationship between power and powerlessness. It is not that there is not one without the other, but that one is simultaneously the other. Where this framework identifies structures that infringe the women's autonomy and agency, it identifies structures of power. This analysis of power as dispersed rather than discrete stands on Foucauldian scaffolding (Foucault 1990, 94). Foucault (1990) radically innovated the conception of power, identifying it not as a force the ruling party, imposed on the ruled in sovereign and episodic acts, but rather as a bottom-up force exercised from "innumerable points, in the interplay of non-egalitarian and mobile relations" (94). The machinery promulgating force relations range from the institutional, social, and familial (Foucault 1990, 94). Taking this approach to power uncovers forces of power/powerlessness hidden in plain sight. Following the thread of stifled agency from Afghanistan to America reveals the seemingly neutral structures in America, like car -based infrastructure, which perpetuate the

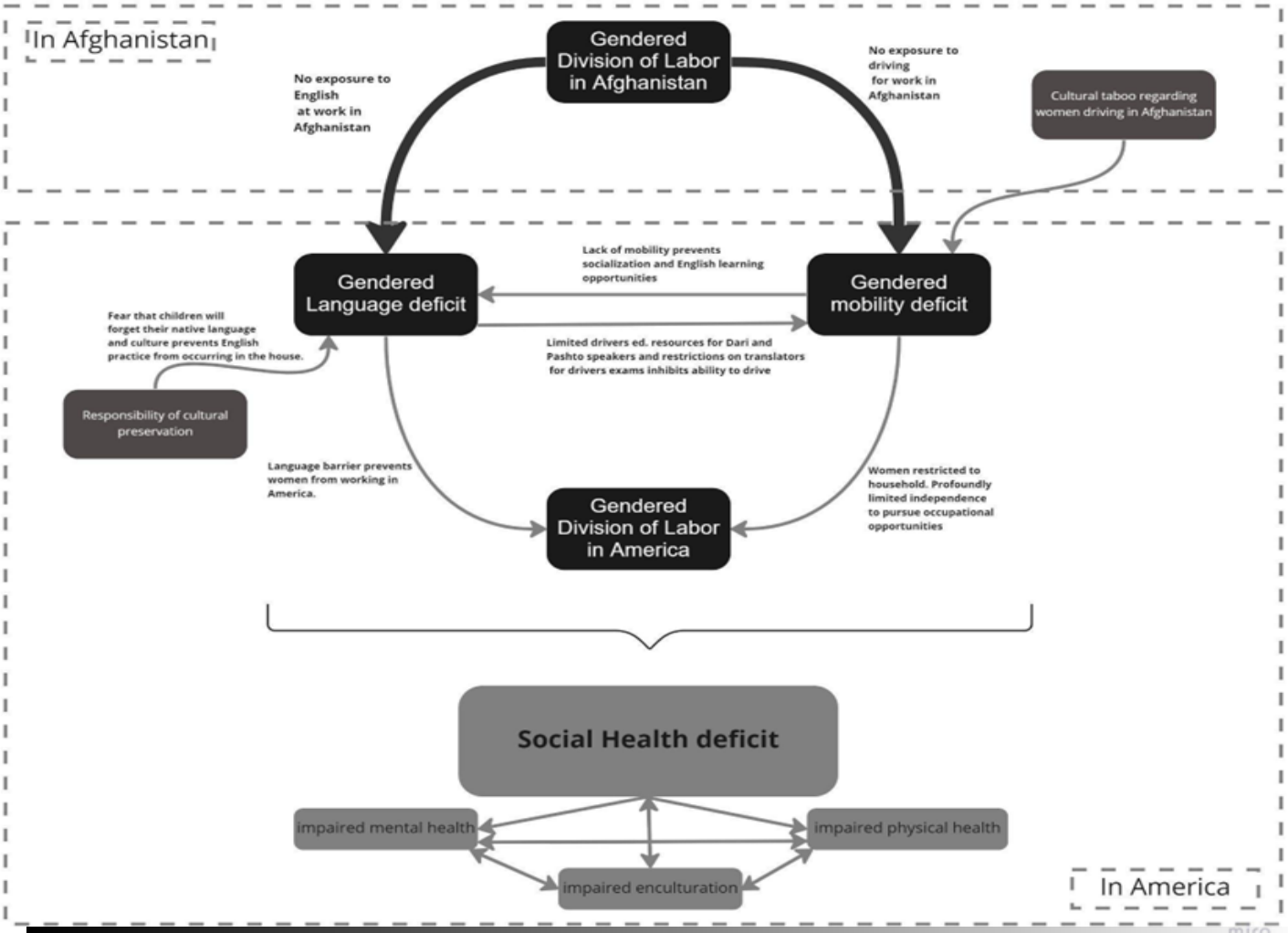

Figure 1: Matrix of factors affecting social wellbeing of Afghan Refugee Mothers

power/powerlessness force established by the gender-violent hegemony in Afghanistan.

Anthropology, particularly cultural anthropology, is often misunderstood as the study of human differences, but it is equally the study of human sameness. Although this is a case study specific to Afghan, refugee women, the study reveals the mechanisms by which power/powerlessness disperses to create global networks of women's subjugation and subordination. Many sociologists and anthropologists interrogate gendered division of labor as principal machinery by which global subordination of women is produced and maintained (Epstein 2007; Kelly 1981). The results of this study not only support this assessment, but also identify the mechanisms of power/powerlessness diffusion, maintenance, and amplification. Recall, most of the women stated they are more isolated in America than they were in Afghanistan. The composite framework identifies systems that transport power/powerlessness forces from the gender-violent hegemony from Afghanistan to America, and the systems within America which maintain and amplify power/powerlessness in America.

Gendered division of labor continued conditions of power/powerlessness after immigration, through opportunity deficit and restricted movement, but also amplified the force, namely by the English acquisition deficient. Simultaneously, America's car-based infrastructure not only buttresses the force of Afghanistan's hegemony in isolating women from society, but it also amplifies it. According to Foucault (1990), exercised power requires "a series of aims and objectives" (95). In Afghanistan, the Taliban aims to socially isolate women by restricting access to public spaces through banning participation in waged labor, education, use of public parks and gyms, and public speaking (United States Institute of Peace, n.d). They exercised their force through violence and institutions. In America, the women are similarly isolated, inhibited from access to those same public spaces. This force is exercised not by discrete violence but by infrastructure. A structural force is not necessarily a neutral force, and a nonviolent force can be oppressive. There is even an argument that the American, car-based infrastructure is violent as it is a physical force which produces physiological harm.

Success in Framework Synergy: public health utility

My findings support the adoption of a model that merges the reproductive justice framework; which investigates, political, social, and emotional dimensions of a woman's life, with the cultural competency framework; which investigates the cultural dimensions that present barriers to health care. Unique outcomes of each framework advocate the utility of adopting a composite framework. The RJF and CCF each revealed detriments to wellbeing that the other framework neglected. RJF uncovered the role of cultural preservation preventing language acquisition for the mothers as well as the additional responsibility of children's cultural integration as a stress causing agent. The CCF provided insight into the cultural norms and religious values which demand women providers for reproductive care. Simultaneously, major overlaps in RJF and CCF outcomes illuminate significant problem areas: gendered division of labor, language proficiency, and immobility.

The results from this composite framework identify keystone issues for public health initiatives to target to reconcile deficits in health for Muslim refugee women. In the realm of healthcare infrastructure, offering childcare at hospitals and increasing public transportation to hospitals could increase accessibility for mothers. Additionally, the women indicated that translation services and options for female providers greatly alleviated potential barriers, so healthcare facilities should ensure these options are available. Beyond healthcare infrastructure, job training and driver's education incorporated with ESL classes would greatly improve the quality of life for these women and allow them to overcome transportation, mobility, and occupational barriers which would increase enculturation and alleviate social isolation. The results contribute to the body of discourse advocating for public transportation and walkable city design.

Besides its utility for medical anthropological and public health research, the synthesized framework presents a holistic representation of

health that can illuminate the connections between seemingly unrelated outcomes. This framework was able to identify a matrix of interactions relating conditions in America to conditions in Afghanistan, relating conditions of mental to physical wellbeing, and relating all conditions to reproductive health. The nodes of the matrix can be analyzed to reveal the architecture of power, decloaking seemingly neutral structures and institutions.

Conclusion

I have always believed medical anthropology to be at the intersection of cultural, biological, and archaeological anthropology. Archaeology studies material artifacts to understand culture and history. The human body likewise captures lived experience, history, and culture and materializes them into physical matter which can be studied by anthropologists. Gender apartheid, violent terrorism, relocation, and family dynamics all manifest physiologically. The embodied experience exists internally and perpetuates these experiences long after they are externally removed. It is crucial that medicine adopts life course models that decategorize experience, body, and self; these connections are often only made longitudinally. As we move forward in medical anthropology, we must adopt frameworks which treat health as a nonsecular subject, and as a multidimensional web without boundaries segregating aspects of wellbeing, segregating a patient's present and past, and segregating extra-hospital and intrahospital circumstances. This model of health radically resituates and redefines forces of oppression and evidences the interplay of institutional, structural, and cultural forces of oppression.

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