Marking the Boundaries of Care in/and Definitions of Refugee Medical Encounters Author Names

Mais T. Al-Khateeb

Abstract: This essay brings together transnational feminist rhetorical studies and critical conversations in care with scholarship in the rhetoric of health and medicine (RHM) and technical and professional communication (TPC) to propose a methodological framework for reading and reimagining cultural interventions in transnational health contexts. This framework, what I term unexceptional logics of care, centers analyses of globalized power to interrogate the logics underlying the composition of cultural interventions intended to support refugees and health providers in health contexts. Using this framework to analyze the Centers for Disease Control and Prevention's (CDC) 2014-2017 "Refugee Health Profiles," I demonstrate how and why cultural interventions can become rhetorically entangled with logics of US exceptionalism that can limit the imaginaries of caregivers and foreclose possibilities for responsive care encounters. The analysis highlights three central logics (comparison, (re)victimization, and recognition of evidence) to consider in the construction of cultural interventions to challenge "non-performative" and/or violent forms of care in refugee health contexts.

Keywords: unexceptional logics of care, cultural interventions, colonialism of comparison, medical encounters, occlusion

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> "[T]o care about the body is to care about how we make meaning, to care about how we persuade and move ourselves and others."
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> —Jay T. Dolmage, Disability Rhetoric. (4)

A 2022 World Health Organization (WHO) report and recent empirical studies have documented health disparities in the care provided to refugees worldwide, attributed to diverse financial, logistical, systemic, cultural, and linguistic factors that hinder refugees' access to healthcare in host and asylum countries (Lamb and Smith; Matlin et al.; Ng; World Health Organization). Studies addressing cultural and linguistic barriers have focused not only on refugees' unfamiliarity with medical models in receiving countries but also on the cultural competence of health providers as a crucial factor that can (un)intentionally subject refugees to discriminatory practices in health contexts (Alizadeh and Chavan; Grant et al.; Koutsouradi et al.; Laverack; Newaz and Riediger). In the United States, for example, several studies conducted with refugees and other stakeholders, including health providers, practitioners, interpreters, and social workers, have identified health providers' cultural competence as an area needing critical attention (Alfeir; Balza et al.; Griswold et al.; Morris et al.; Njenga; Rashoka et al.; Reihani et al.; Worabo et al.). Stakeholders specifically continue to report

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challenges in delivering culturally appropriate care for refugees, despite the presence of interventions, such as guidelines, translations, and trainings (Getzin et al.; Teoh et al.). One problem these stakeholders recognize is the lack of clear and effective definitions of cultural competence, especially ones that move beyond emphasizing the importance of cultural sensitivity or equating this competency with providing translations (Dubus and Davis; Lau and Rodgers). The problem, as a group of community health centers explains, is not that health providers are not committed to acquiring the knowledge necessary for delivering culturally responsive care but that available interventions need to account for the complexity of care on the ground, especially with "an ever-changing refugee population" (Dubus and Davis 876). Collectively, these studies illuminate the need for examining and creating interventions that can support providers and refugees in health contexts. While cultural interventions are only one component of care within health contexts, I argue that they are nonetheless important sites of rhetorical inquiry because they mediate refugees' bodies and cultural knowledges based on assumptions, definitions, and intentions of *care* that can facilitate and/or hinder responsive care encounters. In other words, cultural interventions participate in marking and actualizing the boundaries of care for both refugees and health providers in health contexts.

This essay engages with the Centers for Disease Control and Prevention's (CDC) 2014-2017 Refugee Health Profiles (RHPs) as examples of cultural interventions circulated in refugee health contexts in the wake of what the UN Refugee Agency (UNHCR) characterized as the most massive refugee crisis since World War II. The RHPs are seven sets of cultural guidelines that introduce health providers and refugee resettlements agencies to US-bound refugees[1] from countries, including Bhutan, Burma, Iraq, Somalia, and Syria, and regions such as Central America. The CDC composed the RHPs in consultation with scientific and cultural research and through collaborations with local and global organizations, including the US Department of State, WHO, and UNHCR ("Refugee"). The RHPs have been disseminated to all US state-level health programs to assist health providers and resettlement agencies in "determin[ing] *appropriate* interventions and services for individuals of a specific refugee group" ("Refugee," emphasis mine). These guidelines are accessible to the public through the CDC's website and are continuously updated "as new information becomes available"—the latest update was on January 14, 2021 ("Refugee"). The RHPs are important not only because they were produced by a US federal agency but also because they evidence the complexity and problematics of constructing cultural interventions that can *both* amplify the voices, histories, and bodies of refugee populations *and* facilitate responsive care encounters. On the one hand, by providing information about the refugee groups' different conditions of displacement, languages, literacies, and cultural and religious practices, the RHPs reflect the CDC's commitments to implementing a cultural approach to care and challenging representational practices that homogenize refugees or demarcate them as, what Noor G. Aswad calls, "universal refugee subjects" (Aswad 363-65). On the other hand, through reverting to rhetorics of US exceptionalism to define care for refugees, the RHPs show how arguments about care can (un)intentionally (re)produce refugees and their bodies within the parameters of coloniality and colonial discourse in ways that might limit the imaginaries of caregivers and foreclose possibilities for responsive care encounters.

1 US-bound refugees are individuals who have been approved for resettlement and must undergo a medical examination before and after entry to the United States.

Bringing together transnational feminist rhetorical studies and critical conversations in care with scholarship in the rhetoric of health and medicine (RHM) and technical and professional communication (TPC), this essay advances a methodological framework to study, complicate, and reimagine cultural interventions in refugee health contexts. This framework, which I term *unexceptional logics of care* (ULCs), directs attention to the logics informing the composition of refugee care models with an emphasis on the politics of representation, inclusion, and care for the Other. I argue that those composing cultural health interventions must engage critically with the discursive and material entanglements of care and its rhetorics, especially in light of uncertainties brought by geopolitical exigencies such as a refugee crisis. Specifically, I argue that transnational feminist rhetorical orientations toward care are helpful to the critical engagement I am calling for because such orientations provide tools to highlight the possibilities, complexities, as well as limitations of care models through ULCs.

ULCs refer to arguments about care that gain appeal and credibility as a result of historical and contemporary relations rather than embodied, situated, and relational encounters. In a globalized world, these relations are normally facilitated by (neo)colonial, (neo)imperial, and global racial capitalist logics that, often in the name of care, can privilege and justify the (re)production and (re)circulation of ahistorical and disembodied care models for/about the Other. I use "unexceptional" to emphasize the persistence of particular composition logics, such as logics of US exceptionalism that (re)surface to inform new care rhetorics about marginalized populations. As a framework, ULCs center analyses of globalized power that inevitably inform the construction and design of cultural interventions and may mediate notions of care between health providers and refugees. Specifically, through a rhetorical analysis of the RHPs, this framework foregrounds questions about the logics of comparison, (re)victimization, and recognition of evidence about gendered violence within cultural interventions. As expressions of ULCs, the three logics and their concomitant rhetorics offer tools to unpack how care, its definitions, and practices can be/become rhetorically entangled with epistemically violent logics that can facilitate the production and circulation of "non-performative" (see Ahmed, *On* 17) and/or violent rhetorics of care in health contexts. Importantly, this framework offers ways to reimagine and rebuild cultural interventions intended to enhance health providers' cultural competence and honor and privilege refugees' bodily autonomy, agency, and the complexity of their identities and subjectivities.

Using ULCs, I rhetorically analyze the RHPs for the explicit and implicit argument(s) they make to represent refugees' cultural knowledges, mediate refugees' bodies to US health providers, and support health providers and refugees with dynamic definitions of care in medical encounters. My analysis reveals that rhetorics of care in refugee health contexts, in addition to moving beyond an emphasis on care as inclusion, must also attend to representations of care as *occlusion*. By occlusion I mean calling attention to what is hidden, assumed, or implied about cultural care in the RHPs, which must be considered in the construction of cultural interventions. This analysis builds on robust conversations within RHM and TPC that argue for critical analyses of medical and technical rhetorics to build relational, embodied, and situated models of care for marginalized populations in local and global contexts.

Care in (Transnational) Health Contexts: Possibilities, Complexities, and Occlusions

Scholarship in RHM and TPC has expectedly centered care and care ethics through advancing intersectional methods and methodologies that confront health injustices and bring about more accessible, inclusive, and equitable care discourses and practices within research and health contexts. An explicit emphasis on care is evident in works highlighting the rhetorical, material, and social possibilities of feminist and decolonial care-informed methodologies for fostering relational, reciprocal, and embodied encounters (Gagnon and Novotny; Novotny and Gagnon; Novotny and Opel; Scott and Melonçon; Teston).[2] This attention has also extended to articulating the complexities of care in intercultural and/or transnational health contexts (Bloom-Pojar; Bloom-Pojar and Devasto; Gonzales; Gonzales and Bloom-Pojar; Hopton and Walton; St.Amant; St.Amant and Angeli). RHM and TPC scholars have specifically argued that the construction and design of care in transnational health contexts must account for historical, contextual, social, political, economic, and linguistic differences, or what Kirk St.Amant calls "variables of care" (St.Amant 64). Considering these variables, Kirk St.Amant and Elizabeth Angeli argue, necessitates asking questions about the *when, who, what, why, where*, and *to/by whom* of care because such variables influence ways stakeholders understand the time/ing of care, objects of care, caregivers, access to care, and places of care in different cultural contexts (St.Amant and Angeli 1-4). To engage these complexities, RHM and TPC scholars have demonstrated how communicating care to communities requires developing and embodying simultaneously flexible and rigid rhetorical strategies (Hopton and Walton); considering communities' visual literacies (Bloom-Pojar and Devasto) and linguistic and cultural diversities (Gonzales and Bloom-Pojar); and emphasizing practices of localization, usability, and human-centered design (Acharya; Agboka; Melonçon; Walton; Walton and Jones). These complexities occasionally entail stepping "outside traditional concepts of medical care" to design and deliver care that is informed by relational and embodied interactions and that, thereby, truly serves communities in transnational health and research contexts (Hopton and Walton 5). Hence, these conversations have illustrated that evaluating and intervening in cultural approaches to care necessitates developing complex tools that challenge Euro-American notions of care while simultaneously centering communities' ways of being, knowing, and doing.

This line of inquiry about care also intersects, though implicitly, with conversations within RHM and TPC that have attended to ways medical and technical rhetorics can (in)advertently (re)produce violence and/or obstruct marginalized communities' access to relational, embodied, and situated care in local and global contexts. Through rhetorical analyses grounded in feminist, critical race, queer, disability, transnational, and decolonial theories, RHM and TPC scholars have illustrated how medical and technical rhetorics, embodying the appearance of objectivity, efficiency, and neutrality, have historically participated in dehumanizing, silencing, erasing, and objectifying marginalized populations (Agboka; Ding; Frost; Frost and Eble; Harper; Jones; Jones and Williams; Moeggenberg et al.; Molloy; Solomon). These forms

2 This robust body of RHM and TPC scholarship on care has added to an ongoing conversation within rhetoric and composition about the significance of an ethics of care for processes of knowledge production and the practice and the praxis of living with others in the world. For example, Jacqueline Royster and Gesa Kirsch make "an ethics of hope and care" one of the essential components of the inquiry model they propose for scholarship and research practices in feminist rhetorics.

of injustice and oppression necessitate analyses that, as Zarah C. Moeggenberg et al. state, reveal how such rhetorics "[mediate and] regulate bodies" and "mask the possibilities of social justice—even generate defeat, fear, and disengagement" (406). Therefore, this line of inquiry calls for analyses that expose and challenge the ideologies that facilitate the production and circulation of medical and technical rhetorics; trace how these rhetorics materialize on bodies of vulnerable populations; and reimagine and intervene in the construction and design of localized, usable, and human-centered communications in various contexts. Whether from a medical or technical rhetorical perspective, such interventions urge rhetoricians and other stakeholders to participate in creating communicative practices that promote "human dignity and human rights" (Walton 403) and "center […] the perspectives, experiences, and embodied realities of multiply marginalized communities" (Frost et al. 224). In the context of the refugee crisis, centering analyses of cultural approaches to care is not only a logical response but also an ethical imperative.

Conducting analyses of cultural interventions necessitates a critical engagement that highlights what care, its definitions, and practices make possible as well as limit in refugee health contexts. Accordingly, building on these conversations, I argue that rhetorical analyses of cultural interventions must also examine how arguments about care can (re)produce "non-performative" (see Ahmed, *On* 17) and/or violent forms of care for and about refugees. The attention here is to rhetorics framed and recognized as gestures of care that may fail their promises of supporting health providers and refugees or, worse yet, further "epistemic and [material] violence" against marginalized communities (see Spivak 282-3). Reflecting on their care framework, John T. Gagnon and Maria Novotny caution against research practices that, "even when highly participatory" can "re-traumatize the very research participants and communities our work seeks to empower" (487). To continue this inquiry in the context of the refugee crises, I argue the need for analyses of care rhetorics that reveal the role of globalized power in facilitating the production and circulation of health and medical discourses and practices, *including* ones that are relational, embodied, and situated. The next section demonstrates how critical conversations in care and transnational feminist rhetorics come together to augment rhetorical analyses of cultural health interventions with an emphasis on care as occlusion.

Transnational Feminist Rhetorical Orientations Toward Care

Turning to critiques of care directs attention to the patriarchal, colonial, ableist, and/or heteronormative frameworks that can inform the production and design of care models in research and health contexts. This engagement recognizes the importance of an ethic of care for social, political, and institutional transformation. However, informed by the work of feminist philosophers (Bartky; Gilligan; Held; Mol; Noddings; Tronto) and feminist, Black feminist, disability, and queer scholars (Ahmed, *Promise*; Kirsch and Ritchie; Piepzna-Samarasinha; Schell), this engagement also problematizes orientations toward care that overlook its embeddedness within power structures that have, often in the name of care, historically furthered conditions of violence and oppression against BIPOC and LGBTQ+ communities. Within such orientations, care can become the property or work of particular bodies (Schell); predetermine and therefore fix the shapes and forms of caregivers, care receivers, and caring outcomes (Ahmed, *Promise*); be used to "undermine, threaten,

or manipulate" caring relations in research contexts (Kirsch and Ritchie 22); and/or become a mechanism to oppress the bodies of the disabled and sick Black, brown, Indigenous, trans, and queer people (Piepzna-Samarasinha). Because care is often transmitted as one of the "innocent pleasures of everyday life" (Bartky 119), these critiques invite us to develop and embody analytics that constantly evaluate the frameworks informing caring relations, practices, and definitions in all contexts.

Engaging care frameworks in light of geopolitical exigencies such as the global refugee crisis also necessitates critical analyses of globalized power that expose how rhetorical productions such as the RHPs or other cultural interventions can become rhetorically entangled with colonial, imperial, and global racial capitalist logics. As transnational feminist scholars have demonstrated, analyses of globalized power can reveal ways the US nation-state and its apparatuses have (re)appropriated discourses of human rights and feminism (or discourses of care in the case of this project) to promote US exceptionalism and further the US's imperial and colonial reach (Dingo, *Networking*; Grewal; Hesford; McKinnon; Mohanty; Narayan; Riedner; Spivak; Wingard; Yam). Transnational feminist analyses challenge parochial conceptualizations of rhetorical studies, as put by Wendy Hesford and Eileen Schell, "around U.S.-centric narratives of nation, nationalism, and citizenship, including its focus on feminist and women's rhetorics only within the borders of the United States or Western Europe" (463). Importantly, by conducting "cogent analyses of globalized power" (Dingo et al. 518), transnational feminism engages rhetoricians in critical inquiries about "the relationship between on-the-ground action and global/local processes," especially processes facilitated by global neoliberal capitalism (Dingo and Riedner 416). In health contexts, transnational feminist analyses complement the work of RHM and TPC scholars by not only insisting on building non- Euro-American-centric care methodologies but also by evaluating how globalized power and its concomitant logics inevitably inform logics and conceptions of care in social, political, cultural, and medical contexts. These analyses allow us to identify sites for intervention that move from a mere emphasis on the inclusion of languages, literacies, and cultures to an examination of *how* inclusion is mediated through cultural interventions. Put differently, analyses of care in the wake of the refugee crises invite RHM and TPC to participate in "exposing all forms and mixes of globalized power through the identification and analysis of texts, spaces, and bodies upon which geopolitics are written" (Dingo et al. 525).

Brought together, conversations in care and transnational feminist studies inform my theorization of *unexceptional logics of care (ULCs)*, offering RHM and TPC scholarship analytical tools to engage more critically with the geopolitics of knowledge production and circulation, especially as geopolitics relates to the construction and design of care in refugee health contexts. ULCs demonstrate how arguments about the health of refugees can derive their rhetorical force from violent logics of composition rather than from embodied, relational, and situated encounters with refugees. Through this framework, I argue that what is determined or marked as *appropriate* care for refugees and other vulnerable populations cannot be read or consumed in a vacuum, but rather in the larger historical and political US context, more specifically in relation to the (ab)use of (health)care to medicalize and racialize the bodies of African Americans, Mexican immigrants, Asian immigrants, refugees, and Indigenous peoples (see Cisneros; Chavez; Flores; Harper;

Jennings; Molina, "Medicalizing"; Solomon).[3] ULCs intervene in health discourses and practices to examine how particular deployments of care might produce or (re)produce the violences they are designed to mitigate. In so doing, ULCs do not adopt an either/or approach to care that would limit questions/options to whether we should or should not care. Rather, it resonates with approaches to care that, as put by María Puig de la Bellacasa, think "*with* care in its transformative, noninnocent, disruptive ways" (71, emphasis mine). Simultaneously, however, this framework amplifies critical accounts of care to respond to geopolitical exigencies, particularly to the ubiquity of what is being produced, circulated, marked, and marketed as cultural care for refugees in health and other contexts. In this sense, ULCs echo theorizations of care maintaining that the immigration crisis demands critical engagements with care to identify what Miriam Ticktin calls "transnational regimes of care" (4). Ticktin argues that such analyses are important to understand how care about "[migrants' and refugees'] bodily integrity is mediated by social, political, cultural, [colonial, imperial] and economic contexts and histories" (4). While this framework does not give up on care because of its entanglements "with hegemonic regimes" (de la Bellacasa 9), it argues that thinking with care in the context of the refugee crisis necessitates unpacking how care is taken up, mediated, and enacted to justify the (re)production of hegemonic practices that can disadvantage immigrants and refugees. Because affect is not sufficient for a critical engagement with globalized power and its material effects (see Dingo, "Turning"; Kulbaga), we need transnational feminist rhetorical orientations toward care to investigate how care can become an emotion, action, and thought to not only escape responsibility but also to further discursive and material violence against marginalized communities across various contexts, if unintentionally.

In the following sections, I turn attention to the 2014-2017 CDC's Refugee Health Profiles (RHPs) as critical examples of cultural interventions that have circulated in refugee health contexts in the US and that aim to enhance the cultural competence of stakeholders working with refugee populations and reduce health disparities. Published as part of the larger discourses on screening (the health of) refugees entering the US in light of the 2011 refugee crisis, the RHPs are important because they show ways global mobility brings texts, technologies, and bodies together in new yet familiar ways that call for further exploration.[4] Therefore, my choice of the profiles was driven by an interest in these refugee screening discourses and questions about the politics of transnational rhetorical encounters (see Al-Khateeb).[5] This choice was also driven by two other factors: 1) observations about the continual (re)surfacing of the seven RHPs on websites of state health programs as guides for US providers and resettlement agencies to encounter the aforementioned refugee groups, and 2) an examination of "health rhetorics" that problematize the composition of existing cultural interventions in refugee health contexts. These rhetorics included recently published empirical studies in the US

3 For example, care has been historically invoked to commit violent acts, such as the 1932 Tuskegee Experiment that exploited the bodies of African Americans (see Solomon); the early 20th century eugenics projects in the US that entailed the sterilizations of thousands of people with mental illness; the medicalization of Mexican immigrants which, also in the name of care, justified actions like stripping Mexicans naked "for physical examination and then bath[ing] [them] in a mixture of soap, kerosene, and water" (Molina 28, "Medicalizing"). This violent history of care in health contexts repeats today in contemporary forms of care, such as the gynecological surgical procedures conducted at detention centers without the consent of Latina and Black women.

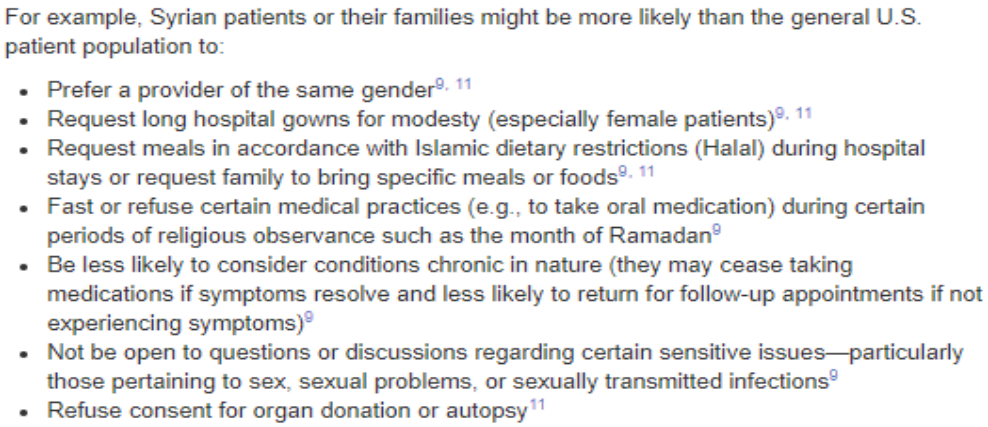
4 While this essay focuses on one profile, a larger in-progress project engages with the seven profiles.

5 Transnational rhetorical encounters refer to ways discursive and material entities travel and come together across different geopolitical contexts (Al-Khateeb 18).

highlighting an urgent need for more dynamic and responsive interventions that move beyond stressing the importance of cultural sensitivity and translations. These rhetorics also included texts that circulated globally and that reveal the impact of global racial capitalism on the health of refugee populations in host countries. Thus, my analysis of the profiles is "intercontextual" (see Hesford 9-11), linking together seemingly singular, distant, and disparate texts and contexts to reveal the role of globalized power and its concomitant logics in (re)producing and occluding particular forms of care composition. In this sense, this analysis is a critique with the end goal of ameliorating and intervening in health and medical rhetorics (Segal 16). This critique engages with the RHPs as one example of cultural interventions to argue for an intercontextual approach to evaluating and writing health guidelines in refugee contexts. However, this critique does not assume a direct causal relationship between the RHPs and well-documented cultural and linguistic inequities in refugee health contexts that I referenced in the introduction.

This essay focuses on the 2016 "Syrian Refugee Health Profile," which represents one of the CDC's responses to the increase in the number of Syrian refugees seeking asylum in the US following the 2011 'Syrian Civil War.' This profile was last updated on March 17, 2021. It draws from 64 sources of existing cultural and health research about Syrians, presenting 21 pages of information specifically intended for "resettlement agencies, clinicians, and providers" ("Syrian" 18). Based on a rhetorical intercontextual analysis, I have identified three important logics (comparison, (re)victimization, and recognition of evidence) to consider in the construction of cultural interventions, which can have implications for refugees and health providers in medical encounters. Centering the role of globalized power, my analysis questions what counts as effective marking for the boundaries of care for refugees in definitions of medical encounters and how a particular form of boundary marking can orient health providers toward a static mis/understanding of Syrian women, men, and children.

"Tips" and "Tropes"



For example, Syrian patients or their families might be more likely than the general U.S. patient population to:

- Prefer a provider of the same gender[9, 11]
- Request long hospital gowns for modesty (especially female patients)[9, 11]
- Request meals in accordance with Islamic dietary restrictions (Halal) during hospital stays or request family to bring specific meals or foods[9, 11]
- Fast or refuse certain medical practices (e.g., to take oral medication) during certain periods of religious observance such as the month of Ramadan[9]
- Be less likely to consider conditions chronic in nature (they may cease taking medications if symptoms resolve and less likely to return for follow-up appointments if not experiencing symptoms)[9]
- Not be open to questions or discussions regarding certain sensitive issues—particularly those pertaining to sex, sexual problems, or sexually transmitted infections[9]
- Refuse consent for organ donation or autopsy[11]

Figure 1: Screenshot of the "Tips for Clinicians" section (pages 4-5 of the profile).

The excerpted tips here are from a section of the "Syrian Refugee Health Profile" titled "Tips for Clinicians"— "Tips" henceforth. This section opens with a statement summarizing Syrian patients' relationship to the Western medical model: "Although most Syrians are familiar with Western medical practices, like most populations, they tend to have certain *care* preferences, attitudes, and expectations driven by cultural norms, particularly religious beliefs, and expectations" ("Syrian" 4, emphasis mine). The CDC then provides the intended audience with seven tips that compare "Syrian patients or their families" with what the CDC labels as "the general U.S. patient population" ("Syrian" 4). Each of the bullet points in the list is informed by cultural research, particularly from the Cultural Orientation Resources Center (COR) and a scholarly article on cultural competence in health care. The "Tips" specifically recommend providing Syrian patients with caregivers of the same gender, long hospital gowns for female patients, and food that follows Islamic dietary restrictions. The "Tips" also identify some practices that Syrians might decline to participate in or adhere to, such as eating or taking medications while fasting or observing Ramadan, returning to follow-up appointments when symptoms of diseases disappear, discussing sex-related issues and sexually transmitted diseases, and consenting to organ donation or autopsy. Finally, this section concludes with a recommendation to provide refugee patients with translators, preferably of the same ethnicities and genders.

Evidenced by the research cited, the "Tips" explicitly argue for definitions and practices of care that center Syrians' voices, bodies, literacies, and beliefs in medical encounters. Like any text that engages with cross-cultural communication, however, the "Tips" also highlight the complexity and problematics of representing comparative research, which inevitably informs transnational health interventions. Using ULCs, my reading of this section focuses on *how* and *why* certain comparisons gain rhetorical force in knowledge production about refugee care and how deployments of comparison can become entangled with logics of care that might (un)intentionally (re)produce and/or occlude colonial violence. To be clear, I am not arguing about the accuracy or inaccuracy of the information presented in the "Tips." These provisions may be in accordance with some Syrian refugees' care preferences and are, as previously stated, evidence-based and deployed to emphasize the specificity of the Syrian subject—or that Syrians are not "universal refugee subjects" (Aswad 363-65).[6] Rather, my argument is about representing comparative research to produce interventions that can support refugees and health providers in health contexts. This argument echoes the concerns of several stakeholders in recent studies about the need for improving cultural interventions including trainings, guidelines, and translations to facilitate responsive communication in refugee health contexts (Dubus and Davis; Lau and Rodgers). I argue specifically that this work requires probing questions about comparative logics and working *with* the ethical, epistemic, and political challenges these logics present to rhetorical studies at large (see Lyon; Mao and Wang; Wang) and to representations of comparative care specifically. While comparative logics are not problematic in and of themselves, comparison, as Arabella Lyon argues, is a tricky trope: "Comparison is not recognizing the other, but constructing the Other," and this entails "constructing ontologies and epistemologies" (246). Navigating the trickiness of comparison in the context of (cultural) care necessitates identifying and challenging how particular care constructions predetermine the goals,

6 For example, the scholarly article cited in this section is the result of qualitative interviews with 30 Syrian Muslims living in the Midwest about their cultural and religious beliefs about care and health care.

feelings, actions, and outcomes of care in ways that might limit modes of recognition at moments of encounter (see Ahmed, *Promise*).[7] This conception of comparative care makes visible the relations *re*imagined and *re*created by deployments of comparison as well as the relations that make them possible.

Reading cultural interventions from this perspective shifts attention from comparisons as gestures of inclusion to how deployments of comparison might mark boundaries and practices of care in medical encounters. Returning to the "Tips," this perspective can be useful for examining and reimagining the seven explicit comparisons drawn between the Syrian patient subject and the general US patient subject. Comparisons within this section are deployed as static categories that frame care as *invariant* processes for all US-bound Syrians. While this section of the profile includes a qualifying sentence acknowledging that care for Syrian refugees may vary on the ground ("Syrian" 4), these categories might fall short in providing guidance for health providers to inquire about the complexity of Syrians' identities and subjectivities, such as distinct languages and ethnic and religious differences within the Syrian context. The limitations of such framings of care extend beyond their homogenizing effects of refugees and into their implications for patient-provider encounters. As reported by several US health providers and refugees in recent empirical studies, such framings of cultural interventions have often resulted in ineffective practices, including the use of culturally inappropriate translation services, even when translators share the same ethnicities and genders as refugees (Morris et al.; Reihani et al.; Teoh et al.; Worabo et al.); misrecognition of refugees' experiences of trauma and genocide, especially when cultural interventions highlight histories of geopolitical conflicts and refugee displacement without providing trauma-informed guidance to inquire about these experiences (Alfeir; Dubus and Davis; Getzin et al.; Griswold et al.; Reihani et al.; Teoh et al.); and, relatedly, the use of generalizations and stereotypes that can lead to cultivating negative attitudes toward refugees, undermining refugees' trust in health providers, and discouraging them from sharing critical information due to fears of stigma and discrimination (Njenga; Rashoka et al.)[8]. These examples illustrate how deployments of comparison and comparative research, even when intended to *include* refugees and stakeholders, can materialize as rhetorics of fixation that can limit stakeholders' effective engagement in care encounters.[9]

While the solution does not lie in creating interventions that (re)produce refugees' complex differences as new static and essentializing categories, health providers highlight the necessity for strategies that promote *dynamic* communication with refugees in health contexts (Alfeir; Griswold et al.; Lau and Rodgers; Njenga; Reihani et al.; Teoh et al.). These strategies would enable providers to elicit input from refugees, such as asking open-ended questions that position refugees as experts during these interactions and that avoid relying on preconceived and limited/ing notions of cultural care (Griswold et al.). Accordingly, *re*framing the seven comparative constructions in the "Tips" would offer strategies to inquire about Syrian

7 Sara Ahmed calls this type of care "a hap care" because it does not foreclose "possibilities to become possible" (Ahmed 218, *Promise*).

8 For example, due to generalized and stereotypical representations prevalent in cultural interventions, Somali refugee women reported that "some of the health care providers believed that all Somali women and girls had undergone FGC [Female-Genital Cutting]" (Njenga 10).

9 In the words of Arabella Lyon, comparison in such cases can become a mechanism to perpetuate rather than challenge "the colonialism of comparative work" (245).

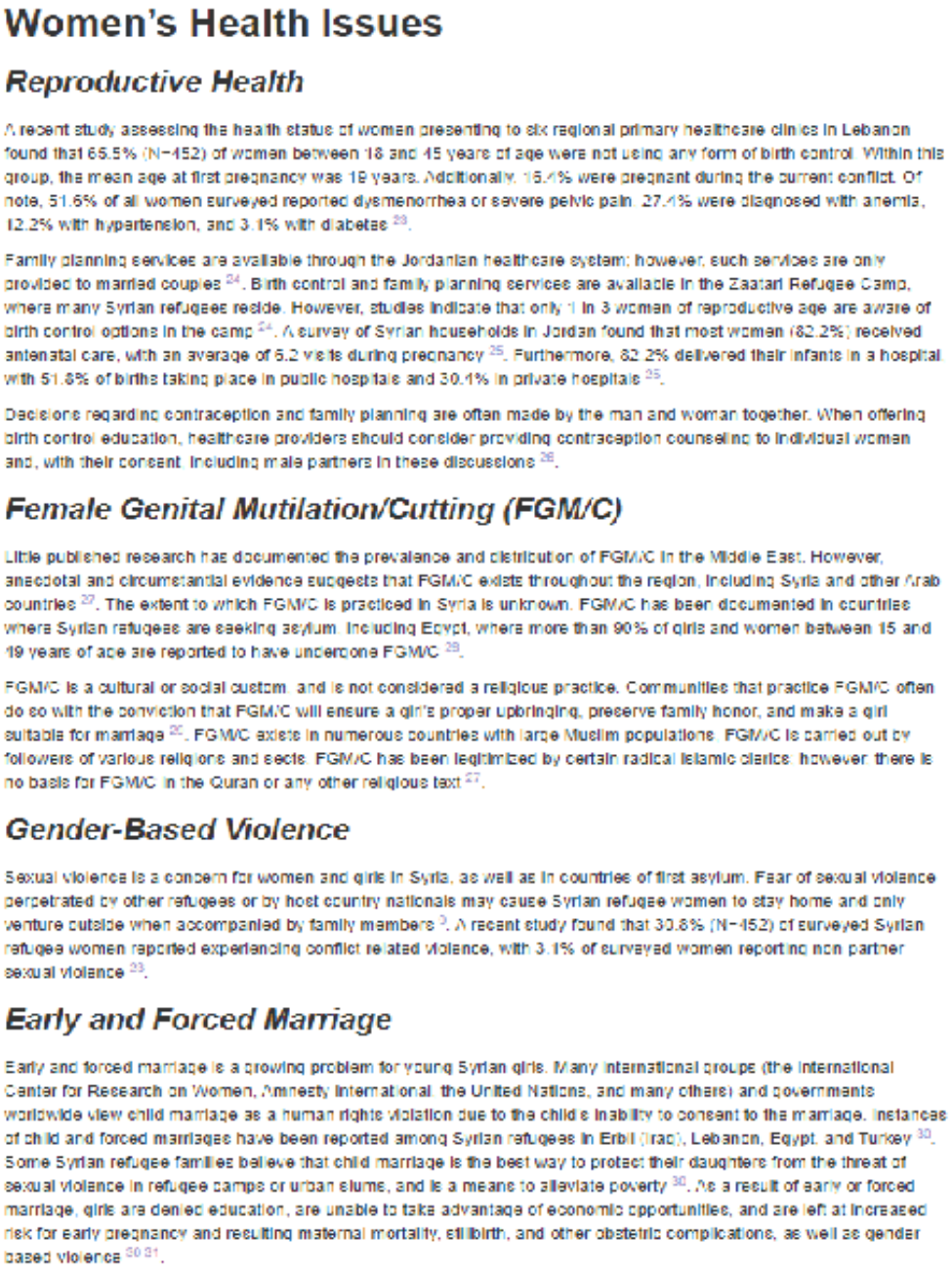
refugees' self-defined and self-identified needs as well as their understanding of their bodily autonomy. Such strategies relate not only to inquiring about Syrians' care preferences about organ donation, autopsies, and their preferred genders of health providers but also to defining the medical encounter in ways that address emergent problems in light of the 2011 'Syrian Civil War'[10] while avoiding the (re)production of tropes and topoi about Muslim women, particularly regarding openness to discussions about sex and sexually transmitted diseases.

While it is fairly common for medical and technical rhetorics to embody *efficiency*, it is crucial to examine how particular deployments of comparison can lead to "non-performative" (see Ahmed, *On* 17) and/or violent frames of care in refugee health contexts. Simultaneously, given how efficiency has been historically used to silence, oppress, and limit the agency of marginalized populations in various contexts (Frost; Ornatowski), it is also imperative to continually interrogate the logics that make efficient definitions of comparative care im/possible. In the context of cultural interventions and, more specifically, the CDC's "Tips," ULCs examine how efficiency can be/become rhetorically entangled with colonial logics that (un)intentionally normalize and perpetuate inequitable rhetorics and practices of care about/for refugees. Even when cultural interventions are evidence-based, this attention to comparative care logics means framing efficient comparisons in ways that engage stakeholders in dialectical, dialogical, and open-ended processes of (re)construction[11] and that also account for the geopolitics of knowledge production and circulation.[12] This transnational feminist rhetorical orientation toward care shifts attention from comparison and its constructions as categories to understanding how globalized power has brought such categories into being (see Dingo et al.; Wang). Similar to social-justice frameworks in RHM and TPC emphasizing human-centered and usable communication in local and global contexts (Acharya; Agboka; Melonçon; Walton; Walton and Jones), ULCs center comparative research with refugees and other stakeholders while calling for representational practices that provide dynamic understandings of comparative care and its definitions in transnational health context. This means leveraging the rhetorical power of comparative logics to design interventions that not only stress the importance of cultural sensitivity or that provide qualifying statements about translations and diversity but that also continually draw upon refugees' insights and care preferences, allowing for the emergence of bodies, subjectivities, and identities in medical encounters.

10 In light of the 2011 'Syrian Civil War,' millions of women and children have suffered rape and sexual assault at the hands of the regime forces of Syrian President Bashar al-Assad. The Assad regime has used "rape as a tactic" (Forestier) to silence, oppress, and torture Syrians who opposed the government, especially Syrian women and children during house raids, in prisons, and at checkpoints (Andrzejewski and Minano; Mattar; Thomas-Johnson).

11 Arabella Lyon call this "a performative understanding of comparison" (245).

12 Bo Wang calls this "a geopolitical approach to rhetoric" (235) and Rebecca Dingo et al. refer to this as "cogent analyses of globalized power" (518).



Women's Health Issues

Reproductive Health

A recent study assessing the health status of women presenting to six regional primary healthcare clinics in Lebanon found that 65.5% (N=452) of women between 18 and 45 years of age were not using any form of birth control. Within this group, the mean age at first pregnancy was 19 years. Additionally, 16.4% were pregnant during the current conflict. Of note, 51.6% of all women surveyed reported dysmenorrhea or severe pelvic pain, 27.4% were diagnosed with anemia, 12.2% with hypertension, and 3.1% with diabetes [23].

Family planning services are available through the Jordanian healthcare system; however, such services are only provided to married couples [24]. Birth control and family planning services are available in the Zaatari Refugee Camp, where many Syrian refugees reside. However, studies indicate that only 1 in 3 women of reproductive age are aware of birth control options in the camp [24]. A survey of Syrian households in Jordan found that most women (82.2%) received antenatal care, with an average of 5.2 visits during pregnancy [25]. Furthermore, 82.2% delivered their infants in a hospital with 51.8% of births taking place in public hospitals and 30.4% in private hospitals [25].

Decisions regarding contraception and family planning are often made by the man and woman together. When offering birth control education, healthcare providers should consider providing contraception counseling to individual women and, with their consent, including male partners in these discussions [26].

Female Genital Mutilation/Cutting (FGM/C)

Little published research has documented the prevalence and distribution of FGM/C in the Middle East. However, anecdotal and circumstantial evidence suggests that FGM/C exists throughout the region, including Syria and other Arab countries [27]. The extent to which FGM/C is practiced in Syria is unknown. FGM/C has been documented in countries where Syrian refugees are seeking asylum, including Egypt, where more than 90% of girls and women between 15 and 19 years of age are reported to have undergone FGM/C [28].

FGM/C is a cultural or social custom, and is not considered a religious practice. Communities that practice FGM/C often do so with the conviction that FGM/C will ensure a girl's proper upbringing, preserve family honor, and make a girl suitable for marriage [27]. FGM/C exists in numerous countries with large Muslim populations. FGM/C is carried out by followers of various religions and sects. FGM/C has been legitimized by certain radical Islamic clerics; however, there is no basis for FGM/C in the Quran or any other religious text [27].

Gender-Based Violence

Sexual violence is a concern for women and girls in Syria, as well as in countries of first asylum. Fear of sexual violence perpetrated by other refugees or by host country nationals may cause Syrian refugee women to stay home and only venture outside when accompanied by family members [3]. A recent study found that 30.8% (N=452) of surveyed Syrian refugee women reported experiencing conflict related violence, with 3.1% of surveyed women reporting non-partner sexual violence [23].

Early and Forced Marriage

Early and forced marriage is a growing problem for young Syrian girls. Many international groups (the International Center for Research on Women, Amnesty International, the United Nations, and many others) and governments worldwide view child marriage as a human rights violation due to the child's inability to consent to the marriage. Instances of child and forced marriages have been reported among Syrian refugees in Erbil (Iraq), Lebanon, Egypt, and Turkey [30]. Some Syrian refugee families believe that child marriage is the best way to protect their daughters from the threat of sexual violence in refugee camps or urban slums, and is a means to alleviate poverty [30]. As a result of early or forced marriage, girls are denied education, are unable to take advantage of economic opportunities, and are left at increased risk for early pregnancy and resulting maternal mortality, stillbirth, and other obstetric complications, as well as gender based violence [30,31].

Figure 2: Screenshot of the subsection "Women's Health Issues" (pages 8-9 of the profile) from the larger section "Healthcare Access and Health Concerns among Syrian Refugees Living in Camps or Urban Settings Overseas."

This excerpt is a subsection from "The Syrian Refugee Health Profile" titled "Women's Health Issues," which includes a lengthy discussion of concerns framed as specific to Arab and Syrian women. Specifically, this subsection provides definitions and statistics about violent practices, attributing this violence

predominantly to the patriarchal nature of Syria and other Arab countries ("Syrian" 4). Read through ULCs, this subsection reverts to familiar rhetorical strategies deployed historically in the form of US exceptionalism together with rhetorics of victimization, repeatedly (re)producing the colonial trope of the brown woman in need of rescue (Alhayek; Dingo, *Networking*; Grewal and Kaplan; Hamzeh; Hesford; McKinnon; Mohanty; Narayan; Spivak).[13] Additionally, ULCs add to these critiques by examining how the depiction and amplification, indeed the centering, of gender-based violence (GBV) can serve colonial racial capitalist logics that have had detrimental effects on the health and well-being of Syrian women and children since 2011. This aspect of ULCs specifically attends to how local encounters (those between US health providers and Syrian refugee women) are inextricably connected to global encounters (those between health providers and Syrian women across the globe) and, therefore, must inform the construction of cultural interventions in refugee health contexts. My reading of this subsection focuses explicitly on the material violence the US nation-state has committed and justified against Syrian women and children in refugee camp contexts. For example, on April 3, 2017, the US, under the Trump administration, cut all its funds to the United Nations Population Fund (UNFPA), which is commonly defined as "the United Nations sexual and reproductive health agency" ("About"). These cuts were an extension of the Trump administration's attacks on reproductive rights that limited women's access to abortion, contraception, and other screenings related to reproductive health in the US and around the world. For Syrian refugee women and children, withdrawing the UNFPA funds meant cutting 80% of the budget of a maternity clinic located at the Za'atari refugee camp in Jordan. The clinic, named The Women's and Girl's Comprehensive Center, supported Syrian refugee women and children, providing them not only with resources to deliver babies and vaccinate children but also with routine health screenings, counseling services for mental health issues due to the War, and outreach programs to spread awareness about GBV and early and forced marriages (Alabaster; Dehnert; Ibrahim; "Safe"). In an Aljazeera report, the clinic's leading gynecologist, Dr. Rima Diab, describes the clinic as "the cradle of the whole camp" that carries the souls "of the mother and baby" (Ibrahim). Although the Biden administration reinstated the UNFPA funds in 2021, the four-year period of fund suspension has put thousands of Syrian women and children at the risk of death, violence, and disability at a critical time for displaced Syrians in Jordan, especially during the COVID-19 pandemic (Ibrahim; UNFPA, "Statement," 2021). Reflecting on the impact of the cuts, UNFPA Jordan Representative Laila Baker explains that the US's decision will inevitably result in the closing of numerous refugee health centers in Jordan and a significant reduction in the health services and outreach programs provided by the Women's and Girl's Comprehensive Center (Dehnert).

Since its founding in 1969, the UNFPA has promoted the health and wellness of women and girls worldwide, especially in countries affected by wars, famines, and natural disasters. In a letter to the Committee on Foreign Relations Chairman, the US State Department invoked the Kemp-Kasten Amendment to justify the $32.5 million budget cut from the UNFPA. In an enclosed memorandum of justification (dated March 20, 2017) that fails to supply evidence, the US State Department claims that the UNFPA "supports, or

13 Such strategies have not only historically rationalized US's colonial and imperial legacies worldwide but have also erased two-thirds world women's agency and the resilient, relational, contextual, and creative acts of resistance they are performing to counteract patriarchal and political violence.

participates in the management of, a program of coercive abortion or involuntary sterilization [in China]" (United States Department of State). Following the US's decision, the UNFPA released numerous statements over four consecutive years (2017-2020) denying these accusations, seeking evidence as to the veracity of these claims, and inviting the US government to reconsider its decision and visit the UNFPA office in China for an open dialogue (UNFPA, "Statement," 2017; 2018; 2019; 2020; 2021). In all these statements, the UNFPA also reiterated its mission, which is "to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled" ("About"). The resulting material violence against Syrian women and children from cutting such vital funds, especially in the name of safe childbirth and fulfilled potentials, demonstrates how global racial capitalist logics have organized and shaped medical encounters in global and local contexts since the 2011 escalation of the refugee crisis.

Constructing cultural interventions that facilitate responsive encounters with refugee women necessitates analyses of globalized power that name and identify all sources of GBV as well as the connections between localized and globalized violences. Such analyses equip stakeholders (health providers, policymakers, health organizations, and technical writers) with critical strategies to compose definitions of care that bear witness to violence without revering to unexceptional logics that justify and insist on depicting violence as something alien to and distant from the US, violence that is the property of "particular geographies and particular women's bodies" (McKinnon 10). Identifying and naming these connections acknowledges not only how the amplification of GBV furthers (neo)imperialist and (neo)colonialist interventions globally but also how this amplification can obscure and divert attention from the violence perpetrated against the very same women and children the US claims to protect and care for. For example, the "Syrian Refugee Health Profile" attributes GBV to the "patriarchal" nature of the Syrian society that limits the Syrian woman's rights to control her reproductive rights or consent to marriage ("Syrian" 4; 9). This depiction detaches GBV from the global racial capitalist and heteropatriarchal logics that have organized care encounters for refugee women and children in global contexts and (re)attaches this violence to the brown man's body being the synecdoche of patriarchy. Here, ULCs make visible the occlusion of macro relations and processes that have enabled and exacerbated these violences in the first place. Thus, accounting for this critique in cultural interventions means considering and naming the operation of globalized power and its concomitant logics in making health care (im)possible for refugees in global contexts. This consideration raises health providers' awareness of ways to read, negotiate, and respond to GBV in cultural interventions, such as health guidelines.

"Evidence" about GBV

Besides connections to health encounters across the globe, ULCs attend to how definitions of care in cultural interventions recognize, legitimize, and manage evidence about GBV. Because of its historical entrenchment in colonial and imperial logics, evidence about gendered violence in the Global South must be carefully examined and negotiated in the construction of cultural interventions. Specifically, in addition to the (re)production of colonial topoi and tropes, ULCs invite us to examine what counts as evidence about

GBV before making claims about its existence. This point becomes clear when examining the management of evidence cited under "Female Genital Mutilation/Cutting (FGM/C)," which is derived from information from international health and human rights organizations. The CDC acknowledges the dearth of research on FGM/C in Syria in this section. What is available, according to the CDC, is limited to anecdotal and circumstantial evidence of this practice within the Arab region ("Syrian" 9). While this passage defines FGM/C as "a cultural or social custom [that is] not considered a religious practice," it contradicts this claim by asserting that this practice "exists in numerous countries with large Muslim populations [and is] carried out by followers of various religions and sects" ("Syrian" 9). The section then adds that "FGM/C has been legitimized by certain radical Islamic clerics; however, there is no basis for FGM/C in the Quran or any other religious text" ("Syrian" 9). The claims in this section are not only based on anecdotal and contradictory evidence riddled with misunderstandings of culture and religion, but they also legitimize and normalize the lack of evidence about gendered violence as evidence. Based on these statements, evidence about GBV does not seem to matter, given what is assumed to be known about Syrian and Arab women. These statements show how care in cultural interventions can derive its rhetorical force from deeply entrenched colonial and imperial relations and evidential misperceptions as well as Islamophobic sentiments rather than from available, relevant, and verifiable evidence. This (mis)management of evidence calls for an examination of what counts as evidence, and importantly, it directs attention to relations and processes that warrant the inclusion of particular pieces of evidence in cultural interventions. Therefore, using ULCs to read the management of evidence in (transnational) health contexts invites questions about the politics of mattering and politics of recognition: *what, how*, and *why* does a particular piece of evidence *surface* and another *recede* (see Ahmed, *On* 185) when it comes to the construction of care models for vulnerable populations?

In her work, Christa Teston studies biomedical practices and scientific methods that medical professionals use to respond to uncertainty about bodies in "perpetual flux" (1). Teston poses questions about ways biomedical evidence becomes rhetorical or "comes to matter" when stakeholders make decisions about diagnoses and prognoses while responding to uncertainty about such evidence (125). Teston also argues for an ethic of care that recognizes bodies' "perpetual flux" (1), which is the result of continuous intra-actions and entanglements between human and nonhuman actors, insisting that "possibilities for future action [must be] the result of coconstructed evidences" (167). Although Teston's argument is about care ethics in a different context, her questions can be useful to engage with how health organizations and policymakers use and legitimatize evidence to construct two-thirds world women in general and the Syrian woman subject in particular. In this sense, ULCs invite stakeholders to negotiate evidence about GBV in two ways: 1) it necessitates evaluating the logics informing the production and circulation of evidence in transnational health contexts that (re)produce rhetorics of US exceptionalism, victimization, and erasure; and 2) following Teston, this framework calls for negotiating the uncertainty that the refugee crisis has brought with definitions of care and meaning-making practices that privilege the co-construction of evidence in rather than *before* the encounter. This co-construction insists on foregrounding rather than backgrounding refugees' narratives and counternarratives about their health and embodied experiences as the basis for negotiating and including evidence and providing care.

The subsection "Women's Health Issues" illustrates how rhetorics of cultural competence and care can (un)intentionally fail refugee women by reverting to rhetorical strategies that silence women's voices and bodies. Bearing witness to violence, however, necessitates critical analyses of globalized power that uncover how and why cultural interventions deploy GBV and, in the case of this project, how evidence about GBV matters in definitions of care and refugee medical encounters. These analyses direct attention to how the depiction and amplification of GBV might limit engagement with *what* is recognized as evidence and *who* and *what* is presenting evidence to inform the composition of cultural interventions: is it the refugee and her body or organizations that have historically appropriated human rights discourses to (re)produce two-thirds world women through tropes and topoi that extend the colonial and imperial reach of the US worldwide (see Hesford)? Importantly, attention to ULCs necessitates engaging and tracing ways such depictions can impact how policymakers may use the lack of real evidence as evidence when writing refugee health policy. These questions resonate with the work of RHM and TPC scholars (Harper; Frost; Molloy) who have conducted feminist analyses of medical and technical rhetorics to reveal and intervene in the ways medical discourse constructs women and gender-nonconforming people, especially from marginalized populations (see also Moeggenberg et al.). ULCs extend these analyses by turning to the geopolitical production and circulation of care, including care that is recognized as cultural but that (re)produces logics and rhetorics of US exceptionalism, victimization, and erasure.

Marking the Boundaries of (Health)Care Encounters

Building on the work of RHM and TPC scholars, this essay proposes ULCs as a methodological framework for reading and reimagining the construction of cultural interventions intended to support refugees and health providers in health contexts. Through attention to the possibilities, complexities, and occlusions of care, ULCs disrupt the either/or approach to care that asks whether we should or should not care and moves instead to questions of how we care and mediate care in ways that unsettle asymmetrical power relations between recipients and receivers of care. Similar to what Natalia Molina, in the context US immigration, calls "racial scripts" (Molina, *How* 7),[14] ULCs provide tools that illuminate how care rhetorics are related, implicated, and imbricated in asymmetrical power relations that can reinforce the *fixation* rather than *emergence* of bodies and relations in medical encounters. In the case of the "Syrian Refugee Health Profile," this framework has engaged with questions about the rhetorical force and function of the logics of comparison, (re)victimization, and recognition of evidence about GBV, particularly how and why particular tropes, topoi, and pieces of evidence are recognized and come to matter in transnational health contexts. Through analyses centering the role of globalized power and its logics of composition, ULCs can be useful for stakeholders to evaluate and create health and medical guidelines attuned to historical and contempo-

14 Racial scripts show how "once cultural stereotypes, attitudes, practices, customs, policies, and laws are directed at one group, they are more readily available and hence easily applied to other groups" (Molina, *How* 7).

rary entanglements of care in local and global contexts. This engagement makes apparent how certain logics of composition can persist over time and (re)surface to inform the production of care rhetorics about/for marginalized populations. In this regard, ULCs direct attention to how textual productions circulate within racial and colonial ecologies that have long pathologized and medicalized bodies of migrants and refugees and that can participate in (re)producing care as/through occlusion. This consideration invites stakeholders to create cultural health interventions including guidelines that look with and beyond inclusion and toward representational practices that emphasize epistemologically and ontologically emergent rhetorics of care. Because of its emphasis on intercontextuality, ULCs also urge stakeholders to create health guidelines that link so-called local encounters to global micro and macro encounters. In other words, creating care rhetorics attuned to the politics of representation, care, and occlusion necessitates an engagement with the geopolitical and material conditions constantly shaping the health and well-being of refugees and migrants living across and crossing transnational borders.

In this sense, ULCs emphasize the relationship between cultural interventions as meaning-making practices and the well-being of patients, particularly those from historically marginalized communities. Jay T. Dolmage articulates this relationship to meaning-making in a different context *as* care for the body, "care about how we persuade and move ourselves and others [toward bodies]" (4). While an examination of how cultural interventions constitute and mediate refugee bodies cannot rectify the complex web of health inequities faced by refugee populations today (Lamb and Smith; Matlin et al.; Ng; World Health Organization), these inquiries help identify and mitigate some of these inequities and their potential effects on refugees and health providers in care encounters. This objective is in line with the overarching goals of recent empirical studies that advocate for an ecological framework aimed at dismantling barriers to equitable healthcare for refugees at *all* levels (Alfeir; Rashoka et al.; Reihani et al.; Teoh et al.; Worabo et al.). Transnational feminist rhetorical analyses represent a critical step toward reducing such barriers through an emphasis on the (geo) politics of care, representation, and inclusion that can obstruct refugees' access to embodied, situated, and relational care, if unintentionally.

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