Midwifery (2009) **25**, 181–186

midwifery

www.elsevier.com/locate/midw

Somali women's experience of childbirth in the UK: Perspectives from Somali health workers

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Received 11 October 2006; received in revised form 7 February 2007; accepted 8 February 2007

Abstract
Objective: to conduct a qualitative study of perceptions of experiences of childbirth from Somali health workers in the UK.
Design & setting: in depth narrative interviews at community centres and places of work in London.
Participants: eight Somali women aged between 23 and 57 years. The interviewees worked within the health sector in the UK and/or as nurses or gynaecologists in Somalia. Six of the women had also given birth in the UK.
Key findings: mismanagement of care of female circumcision provided during pregnancy and labour leads to problems at birth for many Somali women. The importance of Somalia's oral culture is not recognised when addressing communication barriers and continuity of care is lacking but important. Somali women also felt that midwives held stereotyped and negative attitudes towards them. Existing pressures as a consequence of migration were compounded by these experiences of childbirth in the UK.
Key conclusions: issues concerning female circumcision, verbal communication, cultural aspects of care and pressures that were a consequence of migration play a part in the experience of childbirth in the UK for Somali women.
Implications for practice: midwives need to possess the necessary clinical knowledge and skills to deal with women who have been circumcised and the issue needs to be raised early in the pregnancy. Attention needs to be paid to ensure continuity of care, maximising verbal communications and challenging stereotypical views of Somali women.

Keywords Somali; Circumcision; Female; Pregnancy; Childbirth

Introduction

Somalis have been one of the largest groups of refugees to the UK over the last ten years (Refugee Council, 2005) yet there is little available literature regarding their health needs. It is estimated that in 2001 there were 43,000 Somalis living in the UK; 79% (34,000) of whom resided in London (National Statistics Office, 2001). Women made up 54% of the 2001 Somali population in the UK and 44% were under 39 years old (National Statistics Office, 2001). However, these numbers are likely to be an underestimate as asylum seekers are not included in census data and there are problems with collecting accurate information from ethnic minority groups (Elam et al., 2003).

0266-6138/$ - see front matter
doi:10.1016/j.midw.2007.02.002

Specific health needs of refugees and asylum seekers, such as those from Somalia have previously been identified, including issues of: language and communication (Davies and Bath, 2001; Harper-Bulman and McCourt, 2002; Bischoff et al., 2003), access to health services (Burnett and Fassill, 2002) and mental health service provision (Aldous et al., 1999; Watters, 2001). These needs can become more acute for female refugees during pregnancy and childbirth (McLeish, 2002); additionally, a significant part of the maternity experience is determined by cultural and social aspects of care (Kitzinger, 1982; Jordan, 1997).

The aim of this study was to use a narrative approach to examine cultural and social aspects of childbirth, and to determine how they intersect with the needs and experiences of Somali women in the UK. Somali health professionals were interviewed in order to draw upon the wealth of experience they have in assisting in childbirth both in the UK and in Somalia.

Methods

This study took an ethnographic approach and used in-depth interviews with eight Somali women who had been health professionals in Somalia and/or were practising in the UK. The participants ranged from 23 to 57 years of age and were all currently living in the UK. These participants were able to provide personal perspectives of their experiences of childbirth in the UK, both as mothers and as health professionals with a clinical perspective on the experiences of other Somali women (see Table 1).

Participants were recruited through the researcher attending two community Somali womens' groups in London, over a period of six weeks. Participants either attended these groups or were found through snowballing. In-depth individual interviews were held and an interpreter, who was a friend of the participant, was used on one occasion. Interviews were semi-structured and there were no definite research questions as it was felt that this would allow issues that were most pressing for the participants, rather than those defined by the researcher, to be presented. Interviews were recorded, transcribed and then analysed using a thematic analysis. The transcripts were read through and initial topics were identified. The transcripts were then re-read and labelled with these initial topic codes. Each topic was then looked at in more depth and sub-themes emerged. These identified sub-themes, from each topic, where then applied to the whole text, irrespective of the topic they emerged from. Once the themes and sub-themes had been defined, the narratives were read again to ensure that all the material had been identified and reflected in the themes.

Approval for this research was granted by the ethics committee of the Anthropology Department, University College London and deemed not to require further ethical consideration. Consent for interviews was obtained verbally and recorded.

Findings

Circumcision

Female circumcision, often referred to as female genital mutilation (FGM), is still practised in many parts of Africa and the Middle East and is widespread in Somalia. It is estimated that 95% of Somali women have undergone FGM (UNICEF, 2004); and 80% of Somali women in Britain (Black and Debelle, 1998).

There are several forms of circumcision including pricking or excision of the prepuce of the clitoris

Table 1 Professions and maternity history of the participants.

Participant	Profession prior to the UK	Profession in the UK	Given birth in the UK?
1	Unknown	Health advocate/interpreter	Yes
2	Civil servant	Interpreter/co-ordinator of Somali women's group (inc. health promotion)	Yes
3	Gynaecologist	Community health advisor	No
4	Medically trained midwife	Health promotion worker	Yes
5	Unknown	Sure Start worker	Yes
6	Student	Health advocate	Yes
7	Nurse	Not working	Yes
8	Unknown	HIV/AIDS promotion worker	No

(Type I, also known as Sunna circumcision), partial or total removal of the clitoris and the minor labia (Type II) and circumcision which removes all of the clitoris, labia minora and inner parts of the labia majora before stitching the edges of the wound together to leave a small opening (Type III, also known as infibulation or Pharaonic circumcision) (Arbesman et al., 1993). Pharaonic circumcision leads to a hard scar forming that needs to be cut either before or at birth, to allow the baby's head to exit. If this intervention is not made it can lead to complications such as perineal lacerations, haemorrhaging, anterior or posterior vaginal prolapse, vesicovaginal and rectovaginal fistulas, infection, excess pain and difficulties for the mother and baby (Baker et al., 1993). Furthermore, due to pressure caused by intercourse while the scar is still intact, the perineum of a woman who has undergone infibulation is likely to be relaxed and shortened; this makes the perineum easy to rupture during childbirth. Many stories were recounted regarding problems that Somali women have had with this aspect of their childbirth.

> When she is pregnant for the first time, all she will be thinking is how am I going to have my baby, do they know how to cut it?... the scar has to be cut before birth.

Many midwives and doctors in the UK are not trained or familiar with this required intervention, and many deliveries were reported as being excessively traumatising for Somali women. This was further compounded by the reluctance of health professional staff to accept the knowledge of Somali women in this medical procedure.

> I told her [midwife], even if you've had a baby, you need an epistomy, to be cut. It was my fourth child; I even wrote it down for her... She was afraid to cut a vein... I got a laceration.

There was also a feeling amongst the Somali women interviewed that caesareans were unnecessarily encouraged because they had been circumcised and health professionals felt that they were unable to have a normal birth.

> I didn't want a caesarean but felt pressure to have one... I was not in control, not because of the language but because of not knowing the system.

Communication

Lack of interpreters and notably a lack of what was described as ''suitable'' ones were mentioned as a difficulty. It was further highlighted from the interviews was that there were many other aspects of communication barriers that cannot be overcome by providing interpreters.

> Communication is a very big problem, you know, just speaking the language is not a good communication if you do not know the terminology.

Many of the women interviewed were able to speak limited English, yet felt removed from the management of the birth process due to their inability to communicate effectively back to health professional staff. This process was also made more challenging by the use of 'complicated' language and medical terminology.

A theme that was also apparent was the role of non-verbal communication in health encounters between Somali people that does not occur with UK health practioners. This included an emphasis on listening and physical contact between patient and clinician. Lack of these elements of communication was interpreted as bad practice.

> Nobody will touch the patient ... they ask about the symptoms, they write them down, but there isn't any listening, there is no communication between doctor and clients.

Perhaps the most important aspect of communication that is very rarely addressed for the Somali women interviewed, and the most significant difference between UK and Somali culture is that of the oral tradition.

> I have all the leaflets here, I translated them, but they are no use at all... it's oral in our culture..., that's why in my clinic I have to talk to them and talk, talk, talk, talk.
>
> When someone gives me a letter, book, reading, no, I don't want to read it, I want to see and I want to hear it.

Cultural aspects of care

Many of the women commented that when they had been pregnant in Somalia they would have only seen one person related to their maternity care throughout their whole pregnancy and birth. In rural areas and small towns this is likely to have been a traditional birth attendant. In some cases there will have been an established government health centre, with a trained public midwife. However, even in larger towns or cities, with hospital maternity services, women often elect to have home births, with a midwife or traditional birth attendant.

> Each time I go for a check-up I've seen a different midwife.

The consequence of having multiple health professionals involved in pregnancy, as in the UK, is that the familiarity and trust that is developed from a relationship with only one person over nine months is much harder to achieve. This difficulty was also sometimes compounded by the asylum seeking status that many of the women had, in that they were required to move accommodation, GPs and hospitals due to dispersal policies or changes in their accommodation.

Encounters with health professionals including doctors, nurses, midwives and health visitors were often cited as being met with stereotyped judgements that led to women feeling patronised and not in control of their birth. These stereotypes revolved around ideas that Somali women were unintelligent, lacking in knowledge about pregnancy or childbirth and were unaware of family planning, due to the number of children they have.

> The midwife—she thinks that you have the babies under the tree and they have a low expectation, 'how can these people afford this? Why are they complaining if they receive this?'

Pressures arising from migration experience

In discussing childbirth in the UK, a major theme was how the distressing experiences of maternity care were increased by pressures arising from the experience of being a refugee. These pressures included social and psychological problems such as

- Isolation and depression,

  > Nobody talks to you…it's very rare for Somalian to get mad there [in Somalia] but here all become crazy because of the isolation.

- family difficulties such as lack of family support and marital breakdown,

  > We came from a country where you have a lot of extended family.
  >
  > Back home always men were supposed to be the leader of the family, here, no… we become, to not understand each other, the values and things between us were vanishing… and we divorced at last… A lot of divorce happened here.

- insecurity of personal identity,

  > I don't pray for anyone, the way we have it. You lose whole country, whole identity collapses and then you come someplace to a country, it's something very very hard.

These pressures contribute to feelings of vulnerability and anguish, and are a significant part of the distress experienced whilst pregnant in the UK in addition to fears for the future welfare of the baby.

Discussion

A strength of this research is that it adopted a narrative approach in which themes emerged from the subjects' accounts and, in doing so, did not have a rigid set of pre-defined questions. However, interviews were conducted in English, by an English person and therefore could create cultural and communication difficulties. Attempts to reduce these barriers were made by researching Somali culture, both in the UK and internationally and several weeks were spent with participants and other Somali women prior to interviews to gain a better understanding of potential communication limitations. The findings presented in this paper are also based on accounts from Somali health workers in London only. However, the themes presented were common across all the Somali women interviewed and came from women who had and had not given birth in the UK and therefore will be of useful insight to all health professionals working with Somali women.

Problems due to female circumcision, a procedure carried out on many women from Africa and the Middle East, were very significant to the maternity experience. Although the practice is illegal in the UK the majority of Somali women of child-bearing age in the UK will be circumcised and therefore care and attention is needed when treating Somali women. As has been shown by the findings, the mismanagement of care for women who have been circumcised can cause great physical and mental distress for the mother. The lack of appropriate attention to addressing circumcision by health professionals before the birth can lead to problems at birth and a bias towards conducting caesareans. It is recommended that deinfibulation is carried out prior to birth for women who have suffered from FGM, (Baker et al., 1993; McCaffrey et al., 1995) but it seems from the narrative accounts that this is not part of routine clinical practice. This may be because clinicians are unaware that their patient has been circumcised, or become aware too late in the pregnancy for the procedure to take place. It is argued that doctors and midwives should directly enquire if Somali women have been circumcised as

women may be uncomfortable about offering the information voluntarily (Momoh et al., 2001) and that early acknowledgement of the circumcision may help the management of the pregnancy (Widmark et al., 2002).

The interviews also revealed that there are several barriers to effective communication between midwifery staff and Somali women. It is argued that, for Somali women, language barriers are the biggest hurdle for contact with maternity services in the UK (Harper Bulman and McCourt, 2002). Fifty three percent of Somalis in London have limited or no access to interpretation services (Islington Somali Community, 2000). Even if access was improved, reliance solely on interpretation as the method of overcoming communication barriers fails to acknowledge that many Somali women are reluctant to use interpreters for fear of misinterpretation and lack of confidentiality (Davies and Bath, 2001). A further finding from this study was the importance of Somalia's 'oral culture'; information among Somali people is generally transmitted verbally rather than in literate form (Olden, 1999). Furthermore, this emphasis on health communication verbally rather than in writing means that 'gossip' may be a far more trusted source of information amongst Somali women (Manderson and Allotey, 2003). As well as written and spoken aspects of communication, the findings highlight that non-verbal forms of communication such as touching and gesturing were important to Somali women yet noticeably lacking in the UK health setting. These aspects of communication may have implications for conventional forms of information such as leaflets, doctor's/hospital letters and appointment cards. Information given verbally, and by trusted persons may lead to better communication and care for Somali women. These aspects of communication may also apply to women from other ethnic minority groups, especially those which also follow an oral tradition, or for women who do not speak English.

The cultural practice of health professionals, including midwives, was a further difficulty recounted by the women interviewed, including lack of continuity of care from a single practitioner and stereotyped judgements. It is more likely that women from ethnic minority communities have less access to continuity of care (McCourt and Pearce, 2000) and findings from this research suggest that continuity of care may actually be more important for ethnic minority communities. Stereotyping of non white-British patients by midwives can discriminate the care and treatment of patients (Bowler, 1993) and was something encountered by the participants. In terms of both developing communication and continuity of care, partnership caseload practice may be of benefit. This model of midwifery care enables a strong relationship to be built with one midwife, increases continuity of care by much higher levels than standard practice and leads to less interventions at birth (Walsh, 1999; Page et al., 1999; Benjamin et al., 2001).

A further finding suggested that feelings and pressures caused by migration, such as lack of family support, loneliness, depression, isolation and identity insecurities have a significant impact on Somali women in the UK. Maternity care only extends so far and does not fill the gaps of support customarily filled by Somali family and community (Kennedy and Murphy-Lawless, 2003). Although it may not be possible to alleviate these pressures through the maternity care that Somali women receive, awareness of these pressures may contribute to better understanding of the individual woman.

Conclusions and implications for practice

The aim of this study was to explore the experiences and needs of Somali women in the UK during pregnancy and childbirth. The findings demonstrate that there are major concerns around: the mismanagement of care for women who have been circumcised, aspects of communication, continuity of care and attitudes of health professionals.

These difficulties may also be experienced by women of other ethnic minority groups in the UK. In order to overcome some of these difficulties a greater awareness of, and early approach to, the topic of female circumcision could aid the care of women and reduce complications in birth. Secondly, communication with women could be improved by explaining information verbally rather than relying on written (even if translated) material and being aware that information delivered verbally by a trusted person will be treated with more authority. Thirdly, efforts to maintain the same midwife, interpreter and other health professionals may lead to more favourable experiences for the client. Lastly, an awareness of the difficulties encountered by many women, due to consequences of migration, may help midwifery staff to understand and relate to the client better.

In order to improve the care of women who have been circumcised, including Somali women, further research and the construction of clear guidelines are needed. This could include further discussion with women who have been circumcised, a review

of current policies and practices, and discussion with staff involved in maternity care.

Acknowledgements

The authors would like to acknowledge the help of the West Hampstead Women's Group, the Somali Community Association (Haringey) and the women that took part in this study. The advice and support of Dr. Alex Argenti-Pillen is also gratefully acknowledged.

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