

Facing the Healthcare System as a Refugee: The Plight of Somali Women

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Abstract This study uses a qualitative approach to examine how biopolitics and medical dominance affect the lives of refugee women of Somali origin. The focus is specifically on looking at the challenges which they face in negotiating the healthcare system of a Western city in the United States. The study utilizes the context of prenatal care and delivery to examine the way this subordinate group is treated, their reaction to this treatment, and the perceptions which are in turn engendered by their reaction to this treatment. Biopolitics in this context is a conceptual collaborator in illuminating the body as a source of transcendental identity. It will be particularized by illuminating U.S. health care providers within the context of providing prenatal services to Somali women refugee patients. Within this context Somali women are representative of particular ideological identities that are conveyed within biomedical interactions.

Keywords Biopolitics, Medical Dominance, Somali Women, Refugees, Interprofessional Collaboration

Introduction

As a result of the Siad Barre Coup of 1990 over 1 million Somalis fled Somalia to seek asylum in other countries. In the aftermath of such upheavals many persons from Somalia sought and received refugee status in America. They came as refugees from camps in countries such as Kenya, or as asylum seekers and still others were sponsored by families. Approximately 100,000 arrived in the U.S. between 1991 and 2000 (Carroll, Epstein, Fiscella, Gipson, Volpe, & Pascal, 2007). Refugee status presents challenges to many refugees in terms of redefining their identities in the new country and interacting with institutions that may have been completely foreign. Frequently, new refugees experience multiple stressors, which are exacerbated by the immediate challenges they face in trying to navigate complicated service delivery systems in their host countries, systems that are often ill equipped to deal with the scope of issues that

refugees present (Karakashian, 1998; Mooren & Kleber, 1999; Morris Popper, Rodwell, Brodine, & Brouer, 2009).

Although Somali refugees in general comprise a vulnerable population, Somali women of childbearing age are a particularly vulnerable refugee subgroup because they have lost the support of extended family and community to assist them during pregnancy, childbirth and childrearing (Hill, Hunt, & Hykas, 2012). Frequently, these women must deal with post migration stressors that are the result of torture, famine and witnessing the violent death of family members (Hill et al., 2012). In the absence of these supports health care providers play an important role, particularly during pregnancy. However, challenges arise as Somali women struggle to maintain their prenatal traditions and customs while seeking unfamiliar western medical services.

Health care providers have often been unwilling to accept or understand how Somali women's cultural practices impact their understanding of obstetrical care (Pavlish, Noor, & Brandt, 2011). Instead they have asserted their knowledge of western medical care in a non-negotiable manner leaving little, if any, opportunity to collaborate with their Somali patients. Conflict ensues as both patient and provider struggle to assert cultural primacy. Although research has been conducted to understand these problematic interactions (Ameresekere, Borg, Frederick, Wagovic, Said, & Raj, 2011; Herrel, Olevitch, DuBois, Terry, Thorp, Kind, & Said, 2004) few have explored the epistemological and ideological dynamics that inform these interactions. This study will examine the antenatal experiences of Somali refugee women and the U.S. healthcare system from a biopolitical perspective. The unique experiences of refugees, particularly women, often go unnoticed in the traditional medical interview. Biopolitics describes the way in which social policy is asserted through "the strategic uses of knowledge which invest bodies and populations with properties making them amenable to various technologies of control" (Ong, 1995, p. 1243). The study employs a grounded theory qualitative method using a non-representative sample to explore the question: *What factors shape Somali women's perceptions of pregnancy within the context of health care service delivery and access*

issues they face in the U.S? It will be argued that increased understanding of such interactions will facilitate ways of training health care providers and social workers to work more effectively with Somali patients.

Literature Review

Global conflict has led to mass migration of populations to the U.S. where it is estimated that approximately 10% of the population is comprised of refugees and immigrants (Carroll et al., 2007). By the time many refugees, including Somali women, present to prenatal health care providers, the physical, mental, and spiritual effects of their pre-immigration losses, refugee camp experiences, post-immigration stressors, and cumulative traumas have often increased exponentially (Ishisaka, Nguyen, & Okimoto, 1985). Many Somali women, due to these experiences, are considered at risk for experiencing an overall decline in their ability to function optimally on a daily basis. In addition, linguistic barriers frequently make it even more challenging for perinatal providers to understand the complex and stressful contexts in which Somali women patients are engaging their services. Providers who are unable to understand what it means to attempt to adapt to a new environment given the numerous stressors refugees face run the risk of further contributing to Somali women's increasing load of stressful experiences. These realities represent opportunities for social workers to play a critical role in co-creating spaces within which encounters between Somali women and perinatal providers are infused with sufficient understandings regarding patients' background experiences, and mutual expectations for optimal perinatal care. The treatment received by patients at the hands of insensitive or ill-informed practitioners militates against such collaboration. It is difficult to tell the story of one's life and how one may construct those experiences when it is evident even to newcomers that such information is unwelcome, or likely to be discounted when shared.

Within the context of the biopolitical perspective to which refugees are subject when they interact with powerful institutions in the host country, professional dominance which, although weakened since it was brought to scrutiny in the 1970s, is still a lingering feature of doctor-patient interactions (Coburn, 2006, Padela & Rodriquiz del Pozo, P., 2011). We examine the challenges faced by Somali women refugees, as they interact with the healthcare system in America in the process of prenatal care and delivery. These challenges reflect the biopolitical perspective of a country which extends courtesies to refugees within its territory, and the professional dominance which exists within the healthcare profession in the United States.

Biopolitics is carrying out a political agenda of subordination through the way the bodies of subordinate group persons are treated, or more specifically, playing politics with the bodies of subordinate group persons (Bassel, 2008). In the discourse of bio-politics, diseased versus

healthy bodies are not only defined on the basis of biological processes, but are also shaped within socio-cultural, political, and economic contexts. Consequently, patients, for example refugees, are socialized to accept subject identities that produce compliance to health care practices. However, refugees, as well as other subordinate populations, often resist becoming willing and docile subjects of such constructions and their attendant socializing processes. This is especially the case when acceptance hinders their ability to achieve their health care goals and fulfill their health care expectations regarding control of their bodies and minds. Consequently refugees attract the biomedical scrutiny that leads to struggles during health care interactions with providers. Practitioners and patients are drawn into complex webs of power that involve negotiation, deception, resistance, assertion, and biopolitical experiences for refugees regarding what it means to be socialized into a subject deserving of health care provision in the U.S.

Biopolitics and the Role of Social Work

A discussion of biopolitics and its presence, or absence, in the interactions between healthcare providers and refugees must also include a discussion of the role of the social worker in either facilitating or problematizing these interactions. By virtue of their training as culturally competent advocates of social justice it could be assumed that social workers as a whole are able to identify the problematic nature of biopolitical interactions and appropriately intervene on behalf of refugee patients in particular. However, there is a paucity of literature available to either confirm or refute the nature of social work involvement in biopolitical interactions.

Professional Dominance and Negotiating the Healthcare System

Social institutions often experience what sociologist Ogburn (1922) in his classic work called cultural lag. This phenomenon can be described as a situation where one part of a culture or institution changes without a corresponding change in the other part with which it is correlated, thus causing the two parts to be out of sync. This may well be the case with the American health care system and professional dominance. Some social science research has argued that by 1920 the medical doctor had become the most revered example of a professional (Parsons 1951). This prominence has come to be known as professional dominance, as evidenced by the profession's autonomy, its hold on highly specialized knowledge, and the trust placed on it by the American society at large (Freidson, 1970, 1994; Reich, 2012).

While the level of medical dominance of physicians as a professional group has declined it has not completely disappeared (Freidson 1994, Light & Levine 1988; Pilnick & Dingwall, 2011). Reasons for this decline include the rise in stature of nursing as a profession, and the change in the very

nature of nursing and medical education whereby the boundaries between doctors as diagnosticians and prescribers of treatment and nurses as obeyers of orders and dispensers of treatment, have become less clear (Fagin & Garelick, 2004; Stein et al. 1990). The professional dominance of physicians in their interaction with patients has also declined. This decline is attributed to the general rise in educational levels, and public access to the internet, whereby patients are armed with more knowledge which enables them to challenge their doctors' diagnoses and decisions about care (Haug, 1988; Shah & Robinson 2011). Changes in physician autonomy have also been attributed to the rise in interprofessional collaboration that include social workers, resulting from rising healthcare costs and efforts to improve the quality of care for patients as well as staff retention (MacNaughton, Chreim, & Bourgeault, 2013). This has also meant that the rising status of nursing has occurred within a collaborative model where they are required to work more closely with respiratory therapists, occupational therapists, discharge planners, social workers and other health care professionals (Miller, Reeves, Zwarenstein, Beales, Kenaszchuk, & Conn, 2008)

We however argue that while the stature of nurses has risen within the interprofessional model, thus causing a decline in the professional dominance of physicians, there is still cultural lag (Ogburn, 1922) in American medicine, whereby physicians still maintain a great deal of professional dominance. In addition, the dominance of physicians' interaction with patients may not only apply to interaction between the American physician and the general American public. Within their refugee status, Somali women are not considered to be in the same category of well-educated U.S. health care consumers. The Somali woman refugee may be seen as undeserving of the empathy and courtesies normally extended to patients under the care of the American healthcare system in which social work reflects an aspect of the system. Since these perceptions are diffused throughout the American society, it is reasonable to believe that treatment as a second-class human being may be meted out to Somali refugee women from not only the higher echelons of the healthcare system, but from the rank and file health workers such as nurses and technicians, and to some extent social workers.

Although the U.S. is a nation of immigrants those who arrived when the nation was young put protections in place that would ensure their descendants would enjoy a privileged status over newer immigrants (Simon 1985). This type of negative attitude towards newer immigrants has persisted despite the passing of the Immigration Act of 1965, and may have even become more prominent since the national tragedy known as "9/11", and the focus on illegal immigrants coming over the southern border of the U.S. Drawing national opinion data from a 2003 public opinion survey, researchers found that 25% of the American public disagreed or strongly disagreed that immigrants are generally good for the U.S. economy, and 27% believe that immigrants increase the

crime rate of the country (Simon & Sikich 2007).

Somali women might be seen as "strangers" who are reaping undeserved benefits from the American society such as food stamps or health care services. Sobczak (2010) explains that in metro areas, white suburbanites indirectly hold higher levels of anti-immigrant attitudes as a result of their significantly higher levels of negative stereotypes towards blacks resulting in unequal or negative treatment.

Theoretical Perspectives

Other theoretical approaches found in social science literature tend to support the notion of unequal or negative treatment. For example, social identification theory (Bastian & Haslam, 2008; Colic-Peisker & Walker, 2003; Tajfel, 1982;) indicates that as people self-identify as members of an in-group, they tend to act negatively towards persons perceived as members of the out-group. Cultural affinity theory proposes that as observable individual differences between people increase, the potential for negative stereotyping and discrimination increases (Anker 1997; Fourie & Santana Gallego, 2011). The segmented assimilation theory as explained by Portes and Rumbaut (2001) argues that one of the modes of incorporation which determines the quality of life of immigrants in their host community is the attitudes of the general population. If the native population of the host community welcomes the immigrants warmly and openly, the quality of life of the immigrants would reflect a trajectory of upward social mobility, and their assimilation into that society would be smooth.

It is recognized that after 9/11, negative attitudes towards Muslim persons have increased (Moor 2002; Stadlbauer, 2012). The theoretical perspectives alluded to above would suggest that Somali refugee women are prime targets for negative stereotyping, discrimination, and less than courteous treatment by the American healthcare system; many wear flowing robes distinctive of Muslims, and most speak less than fluent English. In addition, the stereotyping to which they might be exposed can have far-reaching effects on their quality of life in the host community. The existence of Somali refugee women in America leaves open the possibility that they would be treated negatively by the American society in general and the healthcare system in particular (Herrel, Olivetich, DuBois, Terry, Thorp, Kind, and Said, 2004). They would be treated negatively by the American society in general because the perspectives of host societies have traditionally inclined towards the biopolitics of investing bodies and populations under their control, with properties which make them more amenable to control (Ong 1995). This negative treatment extends to the healthcare system in particular because firstly, the traditional medical dominance of physicians has not disappeared, and secondly because the negative views in the American society towards immigrants are very diffused, and these attitudes may be strongly directed towards refugees who seem to reap benefits

like health care, at the expense of the American taxpayer. Despite the presence of negative treatment social workers in the healthcare system hold the power to counteract these effects as agents of change working to illuminate the problematic nature of the treatment received by refugees and immigrants. Social workers in this role find themselves uniquely positioned to take action because of their understanding of institutional and interpersonal dynamics in healthcare settings.

This study uses a qualitative approach to examine how biopolitics and medical dominance affect the lives of refugee women of Somali origin. The focus is specifically on looking at the challenges which they face in negotiating the healthcare system of a Western city in the United States. The study utilizes the context of prenatal care and delivery to examine the way this subordinate group is treated, their reaction to this treatment, and the perceptions which are in turn engendered by their reaction to this treatment.

Methodology

This is an exploratory study designed to address the question: *What factors shape Somali women's perceptions of pregnancy within the context of health care service delivery and access issues they face in the U.S.?* According to Borum (2012) when there is a lack of information regarding a particular research area an exploratory approach is most appropriate to conduct a research study.

Sample

Participants were recruited using an informant. No incentive was given and each participant was initially contacted by phone. Criteria for participation included being a Somali woman, living in a city in the Pacific Northwest, who had given birth in the U.S. within three years of the time of the study and who spoke fluent English. Three Somali women, whose names have been changed to Farhiya, Zaynab, and Saafi, were recruited and all three agreed to be interviewed in their homes. Their ages ranged from 25 to 35 and all three women were married and had worked as medical interpreters in two hospitals in a city in the Pacific Northwest. Each woman had been living in the U.S. with her family for at least 3 years. Each woman entered prenatal services early in their first trimester and had regular visits either with a physician or a nurse midwife. All three women were interviewed based on a semi-structured 90-minute interview. The interview guide was constructed using mainly open-ended questions in order to facilitate in depth responses that would provide a richer pool of data.

Data Analysis

The study utilized grounded theory. Grounded theory is a quasi-qualitative approach that facilitated the establishment of themes through repeated reading of the transcribed

interviews and analysis of discussions in which meaning units were identified and coded. Glasser (2002) along with Strauss, were able to design and legitimate a model for research practice that addressed some of the limitations inherent in more strictly positivist research approaches to the examination of people in their environments. In addition to its application in social work research (Erera, 1997), grounded theory has also been documented to be useful in disciplines such as nursing (Engward, 2013), and health education (Mullen & Reynolds, 1978). However, its value in the social sciences continues to be challenged (Wells, 1995), as well as its validity as an actual qualitative method.

In applying grounded theory, content analysis was used to examine the transcribed interview data and identify themes pertaining to participants' prenatal experiences of health care access and utilization that were similar across all three interviews (Miles & Huberman, 1994). All three interviews were conducted by one of the authors. The interview guide included 19 open ended questions in addition to 5 demographic questions such as "How long have you lived in the U.S.?" and "How many times have you been pregnant?". Two of the three interviews were recorded. The third participant did not want to be recorded but gave the interviewer permission to take notes during the interview. In designing a thematic structure, the sentence clause was used as the unit of analysis to identify similar recurring themes among the interviews (Labov & Waletzky, 1967). Open coding was used to categorize thematic data while trying to preserve its contextual relevance.

Results

The study employed a grounded theory qualitative method using a non-representative sample to explore the question: *What factors shape Somali women's perceptions of pregnancy within the context of health care service delivery and access issues they face in the U.S.?* The findings yielded useful results; first, the participants' prenatal experiences reflected the meanings they attributed to cultural practices from their unique perspectives as Somali women refugees. Second, the participants' relationships with other Somali women, who had experienced pregnancy and childbirth in the U.S., appeared to influence their level of prenatal preparedness and their recollections of their experiences of being pregnant, going into labor, and delivering their babies within the health care setting. Third, each woman also identified at least one relationship with a health care provider during her pregnancy that influenced how she recalled her prenatal experience. Results indicate that biopolitical challenges did not occur for the women during pregnancy; however they were present during labor and delivery

The Influence of Cultural Practices on Prenatal Experiences

All three women had migrated to the U.S. by way of

Europe and had either given birth in a European country or witnessed birthing practices in the country where they temporarily resided. As a result, their expectations for service delivery reflected their knowledge of Somali beliefs and customs regarding pregnancy and birth as well as their acquisition of transcultural knowledge regarding western medical practices. This enabled them to navigate through the U.S. health care system and advocate for the kind of health care services they preferred.

Relationships with Other Somali Women and Prenatal Preparedness

Each woman asserted that she had a sense of community where she was currently living and could seek out advice from Somali lay midwives or Somali women who had delivered in the U.S. One of the issues of particular concern for all three women was having what was considered in their Somali communities, unnecessary caesarean sections. According to Farhiya many Somali women believe that health care providers perform C-sections prematurely, without letting Somali women labor a sufficient amount of time:

To be honest Somali they prefer to have it normal. But c-section, although women they scared but most of the Somali women including me when I was having my son I stay home and till I am sure that the baby is almost coming because I didn't want to have a c-section. And a lot of Somali women they believe that too. They don't go, when they're having labor, they don't just go to the hospital. They wait until the last minute. That's what I did. When I went to the hospital...I was open for like 6. And then after a couple hours, like 2 hours, I had him.

Despite her background as a medical interpreter, Farhiya's decision to wait to go to the hospital until she was ready to deliver was strongly influenced by the advice she had received from other Somali women in her community, some of whom had had bad experiences with laboring that resulted in C-sections in the past. This sharing of knowledge demonstrated the strength of the relationships that Somali women in Farhiya's community were able to form and how Somali beliefs and customs were not only maintained but strengthened in regards to pregnancy and birthing practices in the U.S.

Experience with a Health Care Provider during Pregnancy

Farhiya, Zaynab and Saafidid not discuss their health care experiences with providers in terms of simply good or bad. They described relationships that involved collaborations based on their knowledge of the healthcare system. Saafi described supportive pregnancy and delivery experiences that did not include C-sections, even in her experience of how she gave birth to her stillborn daughter:

"I think a month and a half I have a mis- the child die

inside of my, you know, stomach. And then I went to the university and they put me in labor and I was having like two days, and I just deliver, you know. I didn't have any C-section or anything. But that was good. I appreciated...yeah, it was very good."

In this description Saafire calls a painful experience within the context of a relatively positive outcome that occurred in a U.S. health care setting. She included in her story the fact that her delivery experience, although occurring under sad circumstances, was mitigated by the support she received in having a delivery that was not impacted by a C-section.

In contrast Zaynab described her experience of birthing in Germany "where they have to put you C-section if you don't deliver within two hours, or three hours". Zaynab's experience of childbirth in Germany was one where women were not able to negotiate their birthing plans to include extensive laboring, something which was an issue for Zaynab and which influenced her experience of her relationship with her German health care provider and birth experience.

Discussions

This qualitative study explored factors that influenced Somali women's perceptions of pregnancy and service delivery within the U.S. among 3 Somali women who had given birth in hospitals in a city in the Pacific Northwest with a fairly significant Somali population. Within the context of in depth interviews the following themes emerged: (1) the influence of cultural practices on prenatal experiences, (2) the influence of relationships with other Somali women on prenatal preparedness, and (3) experience with a health care provider during pregnancy

Since the focus of the questions was on access and utilization experiences during pregnancy the assumption was that information would be unearthed regarding the gap between each woman's cultural expectations regarding access and utilization of prenatal services and her actual experience in the U.S. health care setting, specific to outpatient prenatal services. Farhiya, Zaynab and Saafi did discuss some Somali traditions and beliefs around pregnancy, as well as what they heard from Somali mothers and lay midwives in their communities. They also expressed varying degrees of satisfaction with prenatal experiences; however the majority of their responses focused on their labor and delivery experiences. The women discussed strategies they used to assert their preferences for not having a C-section as an option that included waiting to go to the hospital until they were almost ready to deliver. In each instance they were met by health care providers' disapproval.

In Farhiya's description of her experience of laboring she made it clear that she was aware of approximately where she was in the birthing process by referencing the number of centimeters she was dilated when she went to the hospital

“When I went to the hospital...I was open for like 6”. She made her decision to go when she was approximately 6 centimeters based on her understanding of C-sections and not wanting to have one and the knowledge she acquired within the Somali community about how to avoid what was often considered an unnecessary procedure “ although women they scared but most of the Somali women including me when I was having my son I stay home and till I am sure that the baby is almost coming because I didn’t want to have a c-section.”

Farhiya’s, Zaynab’s, and Saafi’s discussions of their laboring experiences illuminated their bodies as the site of epistemological and ideological conflicts in which attempts have been, and continue, to be made within the health care setting to reconstruct subject identities for Somali mothers as docile and compliant patients. In each woman’s description of her labor and delivery she was able to assert an agenda that problematized a concept of critical prenatal knowledge that only exists within the domain of institutional health care. Instead their responses reflected an argument for the existence of opportunities to re-construct the way in which prenatal knowledge is privileged so that the process of service provision is informed as much by Somali women’s wisdom and experience as it is by biomedical exigencies.

Conclusions

The importance of these interactions warrants further study utilizing a larger and more diverse sample of Somali women. Both English speaking and non-English speaking Somali women of childbearing ages with experience with western medical practices would fill a major gap in the literature. It would be equally important to include the perceptions of health care providers and particularly social workers who work with Somali women and examine their experience of their interactions and assumptions that underlie those interactions. Doing so would illuminate the nature of problematic interactions and provide opportunities for providers to improve, or establish, culturally competent practices. It would additionally facilitate opportunities for social workers to work with providers on ways to establish culturally competent practices.

The findings of this study are applicable to three areas of perinatal service provision with culturally diverse patient populations. First, is the manner in which interprofessional collaborations are created and managed in relation to facilitating versus discouraging patients’ access and usage of services. It seems clear that such teams would benefit from the inclusion of specialists, that include social workers, who can provide much needed consultation in regards to diverse life ways, patients’ own constructions of their medical needs, and how better to interact with communities toward collaborative help-giving and help-receiving. Second, mainstream training programs in professional health related schools continue to struggle to identify, define, and implement an appropriate model for culturally competent

practices. Progress can be made, however, if administrators and educators are willing to examine critically their assumptions regarding medical dominance and cultural competence as meaningful and productive content needed for teaching effective health care practices. Without such educational reform, health care seems doomed to reproducing the values, attitudes, and behaviors that have led to problematic patient- provider interactions, which in many instances may threaten the wellbeing of women in need of perinatal care. Third, mainstream perinatal research practices continue to be informed by a western medical paradigm that values assimilationism cloaked as good liberal multicultural practices. Both practitioners and researchers in the arena of perinatal services must adopt a more reflexive posture regarding their roles in bio-political subjectivation and question whether these normalizing efforts are either ethical or advantageous to our increasingly heterogeneous population, especially to those refugees who come seeking freedom from oppression, and the opportunity to freely traverse the borderlands in which they find themselves.

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