

# Facing the Healthcare System as a Refugee: An Examination of Somali Women's Prenatal Experiences

Rachel Robinson<sup>1,\*</sup>, Malcolm Cort<sup>2</sup>

<sup>1</sup>Alabama A&M University P.O. Box 1417 Normal, AL 35762

<sup>2</sup>Athens State University 300 N Beaty St. Athens, AL 35611

\*Corresponding Author: rachel.robinson@aamu.edu

**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 on examining interactions between Somali women and healthcare providers in a Northwestern city in the United States. These interactions create spaces of contestation and negotiation in which Somali women's meanings of prenatal experiences are illuminated. 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, Dimensions of Disturbance

---

## Introduction

When subordinate groups live within the territory of a host country, and under the aegis of powerful institutions within that country, those groups often face challenges which the normal population may not face. We focus here on two such challenges. One is embedded within the collective perspective of the host country, and the other within one institution with which such subordinate groups must interact as they live within the host country. These perspectives are 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 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). To state this simply, 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; Clarkson Freema, P., Penney, D., Bettman, J and Lecy, N. 2013). 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, especially when acceptance hinders their ability to achieve their health care goals and fulfill their health care expectations of control of their bodies and minds. 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 of what it means to be socialized into a subject deserving of health care provision in the U.S.

Within the context of the biopolitical perspective to which refugees are subject when they interact with powerful institutions in the host country, and given the 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, A.I. and Rodriquez 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.

## Biopolitics and the Refugee

Many refugee families arriving in countries of asylum experience post-migration stressors as multi-layered as their

pre-immigration losses. Trying to obtain employment, settling children into new schools, learning new cultural habits, and dealing with numerous acculturative stressors create severe post-immigration challenges (Gagnon, A.; Tuck, J., 2004; Dow, H., 2011). These challenges include unemployment, family conflict, cultural anomie and mental health problems (Hauff&Vaglum, 1993). Frequently refugees' experiences of multiple stressors are also 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 (Mooren&Kleber, 1999; Karakashian, 1998; Morris, M., Popper, S., Rodwell, T., Brodine, S., and Brouer, K., 2009).

One important challenge which refugees, specifically Somali refugee women in America face is the biopolitical perspective of the American society. The stress which this perspective presents is combined with the continued pain of their own disadvantaged past. Many had suffered checkered post-colonial experiences, going from being subjugated on their home soil, to being manipulated on another. War, starvation, famine, and natural disasters in their home countries all impact their transition and acculturation into their host societies (McMorran 2008).

Refugee status is delineated within the semi-mutable theoretical and physical borders between and within nation states. It is within this transitory space that refugee status is created through covert and overt forms of socialization. This status of refugee, implanted within subjects occurs following, and/or during times of great upheaval. Despite their circumstances refugees create opportunities to assert and reassert their claims to their physical, social, political, and cultural identities as citizens of the countries they have fled. They do so by resisting messages they receive as they are examined to determine their fitness as the subject of a host country (Turner, 2009). Their suitability, represented by the outcome of physical and psychological exams conducted in refugee camps, gives them permission to begin the process of acculturation through biomedical manipulations of the host country. It is upon reaching their host country, crossing the border from citizen to biopolitical subject that the status of refugee becomes situated on and within the body of the individual.

Often, in their efforts to maintain their identities as citizens of the countries which they have fled, refugees find themselves in the psychological state of transnationalism (Crag, Jackson and Dwyer 2004; Lim, Soh-Leong, 2009). This phenomenon is described as a psychological state wherein "many contemporary migrants maintain various kinds of ties to their homelands at the same time that they are incorporated into the countries that receive them" (Levitt and Jaworski 2007, p. 129). While this mindset may be the only way by which refugees can cope with the biopolitical perspective of their host societies, it may be interpreted as a type of oppositional culture, which may convey lack of gratitude to their hosts, or worse, a sense of resentment of the culture of their host society.

### **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, A., 2012). Historically the reverence with which the doctor was held could be seen in this quote from an article written at the turn of the century by a nurse, describing her interaction with her physician supervisor: "The first and most helpful criticism I ever received from a doctor was when he told me I was supposed to be simply an intelligent machine for the purpose of carrying out his orders". (Sarah Dock, 1917).

Without a doubt this level of medical dominance of physicians as a professional group has declined but not completely disappeared (Freidson 1994, Light and Levine 1988; Pilnick, A and Dingwall, R, 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 (Stein et al. 1990; Fagin and Garelick 2004; Reich, A., 2012). 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 and Robinson 2011).

The physician regards the American public as generally more educated than before, and very adept at using the internet, the great source of public information. However, 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 is perceived as an immigrant; a Muslim immigrant; and a Muslim immigrant who because of her refugee status is living off the largess of the American citizenry. Consequently we feel that with these perceived characteristics, 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. 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.

Somali refugee women may be treated negatively in the American society for a number of reasons. As explained above these persons might be seen as “strangers” who are reaping undeserved benefits from the American society. Moreover, the Somali community in general in the metropolitan area where this study was done may have even been victims of racial stereotyping to the extent that the health care providers were white. 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.

Other theoretical approaches found in social science literature tend to support the notion of unequal or negative treatment. For example, social identification theory (Tajfel 1982; Colic-Peisker, V. and Walker, I., 2003; Bastian, B. and Haslam, N., 2008) 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, J. and Santana Gallego, M., 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 native 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.

Moreover, it is recognized that after 9/11, negative attitudes towards Muslim persons have increased (Moore 2002; Stadlbauer, S., 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. We are inclined to feel therefore that the context of 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, N; Olivetich, L. DuBois, D; Terry, P.; Thorp, D; Kind, E.; and Said, A., 2004) 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). By 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.

In this study we make a qualitative examination of the way biopolitics and medical dominance affect the lives of refugee women of Somali origin. We look specifically at the challenges which they face in negotiating the healthcare system of a Western city in the United States. We use 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

### Pilot Study

The current study was conducted by one of the authors and was informed by a pilot study designed to explore the following research 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 from this grounded theory study would be used as the foundation for designing a more extensive examination involving a larger sample of Somali women and health care providers who work with them. Primary data for the current study and the pilot study came from interviews with three Somali women, Farhiya, Saafi, and Zaynab, and analysis of the data was based on a grounded theory perspective. Each woman was recruited by an informant. Their ages ranged from 25- 35 and each spoke fluent English. Additionally, each woman had given birth within three years of the start of the study and was not pregnant at the time of the interview. The interview guide was semi-structured to elicit narratives and the interviews lasted approximately ninety minutes.

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 quality of their various types of relationships played a significant role in how each woman experienced her pregnancy. Third, 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. Fourth, each woman also identified at least one relationship with a health care provider during her pregnancy that influenced how she recalled her prenatal experience. Despite the usefulness of the above findings they also indicated the presence of important meanings that that each woman associated with her prenatal experiences that were strongly connected to their labor and delivery processes. The researcher believed that these missed meanings warranted further examination before proceeding to the larger study.

**Table 1.** First Dimension of Disturbances

Expected Results	Actual Results
Participants would limit responses to prenatal issues	Overall responses focused on labor and strategic timing of admission for delivery based primarily on avoidance of c-section
Participants' cultural expectations for service would be primarily informed by historical Somali prenatal practices	Expectations reflected transcultural experiences integrated into historical Somali practices
Participants would have problems relating to any prenatal providers	Transcultural experiences and professional experiences as medical interpreters helped them to anticipate their relationships with providers
Participants' prenatal experiences would either be positive or negative	Each participant reported both, not allowing for an either/or conclusion to be drawn.

In re-examining the pilot study, the researcher used narrative analysis to unearth multiple layers of meanings that, like the issue of labor and delivery, had been missed and which provided a better understanding of the participants' experiences of the health care system. These meanings were located in sites of epistemological and ideological differences between interviewer and interviewee. These meanings were illuminated when the researcher a) recognized significant discrepancies between the expected outcomes to emerge from the analysis of the pilot study data and the actual outcomes, and b) considered the discrepancies to be significant enough to warrant closer examination. The researcher subsequently refers to these instances as points of disturbance and where they occurred at each layer of re-examination, they were conceptualized as dimensions of disturbance (see table 1).

### Locating the Speaking "I"

Although this examination is informed by data collected from the pilot study it was conducted by the same researcher/author thus providing an opportunity for the researcher and author to speak fairly univocally with regards to the interpretive process. Research that is analyzed within this postmodern perspective identifies the salience of the researcher's voice as much as that of the participant (Mishler, 1986). This is particularly important when examining a study from a biopolitical perspective wherein the voice of the researcher is implicated in how the voice of the participant is expressed. For this reason in subsequent discussion the author will utilize the first person "I" which effectively locates the researcher/author as a co-participant in the interviews.

### The Re-Examination

I used the points of disturbance discovered in the first dimension of disturbances as guides, striving to discover whether or not they were linked by a common theme. I discovered two. First, I discovered that each point of disturbance indicated that the meaning of participants' experiences resided within their community and institutional relationships with key individuals. Second, I discovered that my expectations represented cultural stereotypes of Somali

people as one homogenous group and of Somali women as a culturally homogenous subgroup.

Narrative analysis was used to explore the meanings yielded from the pilot study. The current study explored the following questions: 1) What are the turning points in the narratives where ideologically different perspectives were illuminated during each interview between the Somali woman and the health care researcher? And 2) What were the narrative strategies used by the Somali women during the interviews to assert their agendas? In revisiting the pilot study, I saw it in part as a comprehensive story or meta-story in which the transcribed interactions between me, the interviewer, and each interviewee constituted ideological and epistemological spaces that illuminated the conversations as narrative units of analysis.

## Narrative Analysis

Since the context within which the narratives occur is as important as their content, this examination uses narrative analysis that explores the representative and transactional process involved in reading narratives as a form of data (Riessman, 1993) and the intentional and strategic construction of the narrative questions and responses within an interview structure informed by the biomedical perspective (Sharf, 1991; Kalitzukus, V, and Mattiessen, P, 2009). This approach facilitates the construction of a methodological space that illuminates the narratives as signifiers of complex ideological embodiments.

### The Function of Narratives

Although narratives within health related interviews are often fraught with differing ideological perspectives, health care providers and researchers have been known to miss such differences by privileging an essentialized interpretation of the meaning the interviewee is believed to ascribe to her narrative (Scharf, 1990; Hunter, 1991; Reissman, 1993; Mishler, 1986; Pavlish, CL, Noor, S and Brandt, J, 2010 ) thus situating the meanings the health care providers and researchers attribute to these narratives within a fairly

superficial understanding of the interviewee. Biomedical challenges ensue as scientific conclusions are drawn and recommendations are disseminated based on profoundly myopic meanings health care providers and researchers attribute to the essentialized subjects of examination. Narrative analysis was employed as a means of providing an opportunity to critically examine the interviews as sites of biopolitical dynamics between interviewer and interviewee.

I employed Riessman's (1993) five levels of representation to analyze the interviews as a critical source of data. Reissman identified the following levels of representation as key to narrative analysis : 1) attending, recognizing and addressing overt and covert messages of the participant, 2) telling, representing both the dialogue that occurred and the situation within which the narratives were constructed, 3) transcribing, the style of transcription that is adopted and whether it privileges verbal or non-verbal narration or grammatical and temporal structure over non sequential approaches, 4) analyzing, the transcripts are analyzed for a particular research issue and are often articulated in the form of a question or set of questions and 5) reading, confronting the data, keeping in mind it is open to multiple sources of interpretation.

### Second Dimension of Disturbances

As a result of the re-examination I discovered in the conversations that the meanings interviewees constructed were situated within the conversational interactions between me and the interviewee. These conversations contained deeper meanings that each participant ascribed to her experiences with health care providers and which had not been recognized in the analysis of the interviews. I redirected my focus to include the question or comment I made to which the participant had responded. This redirection lead to the emergence of three points of disturbance: 1) the meanings each participant ascribed to her prenatal

experiences were constructed within those of labor and delivery.2) Prenatal expectations were informed by culturally diverse experiences, 3) In situating their responses outside of such a limited binary I was encouraged to rework my understanding of health care interactions involving Somali women as much more than simply problematic. In re-examining the biopolitical nature of health care interactions I recognized in this disturbance the enactment of the health care setting within the interview structure itself. (see table 2).

As I completed my re-examination and construction of a second dimension of disturbances I realized that in the process I had generated additional disturbances that, like the previous iterations, demanded my attention. Yet there was something different about my experience of these disturbances. They were not predicated primarily on the prior dimensions of disturbance, but instead seemed to emerge within my re- reading of the transcribed interviews. These were disturbances that emerged through my cognitive and emotional experiences of segments of text I read and that evoked yet another dimension of meaning for me.

### The Third Dimension of Disturbance

In the third dimension of disturbance I recognized in my interactions with the participants a particular regulatory ideological and epistemological paradigm which I had not fully addressed in the second dimension of disturbance. Re-examining the data revealed biopolitical interactions that conflicted with the ideological and epistemological positions of the participants. This finding lead to the illumination of three points of disturbance which make up the third and final dimension of disturbances: 1) transmission of biomedical assumptions, 2) being "othered" by the other, 3) transitioning into embodied meaning.

**Table 2.** Second Dimension of Disturbances

Points of Disturbance [D1] Pilot study 2001		Points of Disturbance [D2] Review of pilot study
Expected Results	Actual Results	
Participants would limit responses to prenatal issues	Overall responses focused on labor and strategic timing of admission for delivery based primarily on avoidance of c-section	Recollections of pregnancy experiences were informed by a comprehensive and interconnected process
Participants' cultural expectations for service would be primarily informed by Somali prenatal practices	Expectations reflected transcultural experiences integrated into Somali practices	Prenatal expectations informed by culturally diverse experiences
Participants would have problems relating to any prenatal providers	Transcultural experiences and professional experiences as medical interpreters helped them to anticipate their relationships with providers	Key health care relationships informed recollections of quality of services received
Participants' prenatal experiences would either be positive or negative	Each participant reported both, not allowing for an either/or conclusion to be drawn.	

**Table 3.** Third Dimension of Disturbances

Points of Disturbance [D1] Pilot study 2001		Points of Disturbance	Points of Disturbance
Expected Results	Actual Results	[D2] Review of pilot study	[D3] Results of re-examination
Participants would limit responses to prenatal issues	Overall responses focused on labor and strategic timing of admission for delivery based primarily on avoidance of c-section	Recollections of pregnancy experiences were informed by a comprehensive and interconnected process	Transmission of biomedical assumptions
Participants' cultural expectations for service would be primarily informed by Somali prenatal practices	Expectations reflected trans cultural experiences integrated into Somali practices	Prenatal expectations informed by culturally diverse experiences	Being "othered" by the "Other"
Participants would have problems relating to any prenatal providers	Transcultural experiences and professional experiences as medical interpreters helped them to anticipate their relationships with providers	Key health care relationships informed recollections of quality of services received	Transitioning to an embodied meaning
Participants' prenatal experiences would either be positive or negative	Each participant reported both, not allowing for an either/or conclusion to be drawn.		

**Transmission of Biomedical Assumptions**

Philosophically, many health care researchers and practitioners would contest the assumption that they view individuals who are the focus of their examinations as mere objects. This is not considered a socially acceptable or politically correct ideology to identify with or enact in this day and age. However, it is through the actions of health care professionals that the philosophical becomes realized.

**Being "Othered" by the "Other"**

I need to preface discussion of this finding with an explanation of the "Other," a term that has been, and continues to be, used to delineate the colonized from the colonizer, and oppressed from oppressor. Socializing agents have been responsible for implementing this "Othering" practice through attempts to deny individuals within colonized or oppressed populations their sociopolitical, cultural, physical, spiritual, economic, and emotional identities (Bhabha, 1994; Spivak, 1988) for the purpose of insuring social regulation and control. The "Other" is a term that effectively denotes the body as the ideological site of a particular construction of subjectivity (Foucault, 1976):

This point of disturbance occurred in reading Farhiya's response to my inquiry regarding how U.S birth experiences compared to those in Somalia. Farhiya's response illuminated the ideological assumption that I held which asserted an essentializing narrative that devalued the transcultural nature of her migration to the U.S. My question constructed Farhiya's refugee experience within a simple

binary of Somali versus U.S. cultures. Had Farhiya responded to my question as it was stated, the ideological assumption implied by my question would have been privileged and thus gone unchallenged. Instead, I read in her response her assertion of a contesting narrative containing a much richer and more complex meaning of normalcy as a Somali mother in the U.S.

F: 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.

My question conveyed my assumption that I considered the participant to be a subject of biomedical examination and I considered myself a regulatory agent of health care practices. I read in this interaction the blatant theme of "Us versus Them," in which I assumed the societal identity of the collective Us, and Farhiya was viewed as the essentialized Them, culturally different, problematic, the "Other."

As I re read the transcribed interview I remember sitting and staring at Farhiya, whose identity reflected her surroundings, situated in Somali customs and beliefs that she referenced in the multiple transnational knowledges she had acquired through her migratory experiences. I saw in my interpretation of the interview and my notes a temporal and

figurative space in which I became the “Other” given my limited geocultural and educational experiences of childbirth. In that space, I no longer envisioned myself within the role of health care professional, but instead accepted a role in which I was seen as representative of stereotypical western cultural practices.

### **Transitioning to an Embodied Meaning**

Although I was familiar with the term embodiment, I only recognized it objectively as a critical theoretical concept. Writings by Csordas (1994), Bourdieu (1987), and Hall (1987) provided words and images that helped to articulate for me some of the nuances of embodied practices. However, Waquant’s (1999) work crystallized for me how meaning is signified within lived experiences that are always inclusive of emotions, regardless of our conscious awareness of their presence.

From this perspective my pilot study’s limitations as a conceptual framework seemed glaring to me and also clearly was associated with the objectifying tone of my research activities. With this reflection, I finally began to recognize my whole being as an embodiment of critical theory, not defined within the liminality of the written word, but infused with powerful meanings situated in lived experiences

## **Discussions and Conclusions**

We have argued that Somali refugee women in America face many challenges in negotiating the American health care system. These challenges include the biopolitical perspective of not only caregivers within this institution, but the American public in general, since this perspective is diffused throughout the society. The importance of this concept is that it explains the hegemonic ambitions and actions of powerful societies as they proceed to control less powerful groups within its borders. This process of control may be conscious or unconscious. However, it becomes more overpowering for the victims when it is combined with other psychological forces such as the medical dominance that exists in an institution that these less powerful groups must negotiate as their lives within the borders of their host societies.

Moreover, the status of “refugee” carries its own cluster of stresses. When this status accompanies the classification of an ethnic group regarded with suspicion, the stress of daily living is severely exacerbated. Most Somali women refugees in America are Muslims, hence they are members of a group which is regarded with a great deal of suspicion by the American public. (Moore 2002). The fact that they make efforts to preserve their cultural and national identities leave them confined to a space of transnationalism (Crang, Jackson and Dwyer 2004), which causes them to be regarded as a group with an oppositional culture, not appreciative of the culture of their hosts, or worse, resenting it.

These concepts merely serve as a backdrop for understanding and appreciating the larger disadvantage, that of the negative health outcomes which may arise from these aspects of the lived experience of these Somali refugee women in America. The clash of cultures causes them to be misunderstood by members of the American health care institution. They are considered non-compliant when they do not cooperate with the advice given by their caregivers. They are often reluctant to take optimum advantage of prenatal care, not because they are willfully negligent of their own health, but because their culture is often not respected. Issues like the gender of the examining gynecologist or the choice of natural birth over a C-section, which may not be accompanied with any stress by the average American female, to them looms large. Such issues may cause them to temporarily abandon the health care system and wait until they are very close to delivery before re-introducing themselves to the system for perinatal attention.

The impact of sociocultural factors such as race and ethnicity on clinical care is widely acknowledged (Institute of Medicine 2003). The challenge of delivering culturally competent care has resulted in major educational efforts, through training and corporate development, as to how better to “manage” diversity at the workplace and business/service relations (Chin 2000). This presence of Somali refugee women in America makes more evident the need for cultural competence among healthcare workers. “When sociocultural differences between patient and provider aren’t appreciated, explored, understood, or communicated in the medical encounter, the result is patient dissatisfaction, poor adherence, poorer health outcomes, and racial/ethnic disparities in care” (Institute of Medicine 2003, p. 200).

Having assumed the responsibility of caring for refugees; people who have had to flee violence, economic disparity, repression, natural disasters, and other harsh living and working conditions (McMorran 2003), the American nation has automatically made itself responsible for avoiding a replication of any of the conditions which those refugees have been forced to flee. In order to become a “kinder and gentler nation”, America and more specifically the American health care system must find the will and method to understand the culture of Somali refugee women, and to care for them in a way that would maximize the health outcomes for them and their infants.

---

## **REFERENCES**

- Ahmed, S. (1999). Islam and development: Opportunities and constraints for Somali women. *Gender & Development*, 7(1), 69-72
- Anker, R. 1997. Theories of occupational segregation by sex: An overview. *International Labor Review*.136(3).1-14.
- Bantz, C. R. (1993). Ethnographic analysis of organizational cultures. In S. L. Herndon &G. L.107-119). Cresskill: Hampton

Press.

Bassel, L. (2008). Citizenship as interpellation: refugee women and the state. *Government and Opposition*, 43(2) 293-314.

Bastian, B. and Haslam, N. (2008). Immigration from the perspective of hosts and immigrants: Roles of psychological essentialism and social identity. *Journal of Social Psychology*, 11, 127-140.

Chin, J.L. (2000) Culturally competent health care. *Public Health Reports*, 115:25-33.

Clarkson Freema, P, Penney, D., Bettman, J. and Lecy, N.(2013).The intersection of health beliefs and religion among Somali refugees: A qualitative study. *Journal of Religion and Spirituality in Social Work*.32.1-13.

Coburn, D. (2006) Medical dominance then and now: Critical reflections. *Health Sociology Review*, 15:432-443.

Colic-Peisker and Walker, I. (2003 Sep/Oct). Human capital, acculturation and society: Bosnian refugees in Australia. *Journal of Community and Applied Social Psychology*, 13(5), 337-360.

Crang, P. Jackson, P. and Dwyer C.( 2004) *Transnational Spaces* London: Routledge.

Data, A. 2012. The 'Other' in sociological canons: Reading the trinity through critical postcolonial lens. *Journal of Intercultural Studies*.33(6).657-673.

Dirie M. A. &Lindmark G. (1991).Female circumcision in Somalia and women's motives. *Acta Obstet Gynecol Scand*, 70, 581-585.

Dock, S. 1917. The relation of the nurse to the doctor and the doctor to the nurse. *American Journal of Nursing*, 17, 394.

Dow, H. (2011). An overview of stressors faced by immigrants and refugees: A guide for mental health practitioners. *Home Health Care Management*, 23(3), 210-217.

Fagin, L. and A. Garelick. 2004. The doctor-nurse relationship.

*Advances in Psychiatric Treatment*, 10, 277-286.

Friedman, T. (2005).Globalization 3.0.*Blueprint Magazine*, 2.Freidson, Eliot. 1970. *Professional Dominance: The Social Structure of Medical Care*. New York: Atherton.

Friedson, Eliot. 1994. *Professionalism Reborn*. Chicago: University of Chicago Press.

Gagnon, A. and Tuck, J. 2004. A systematic review of questionnaires measuring the health of resettling refugee women. *Healthcare for Women International*, 25(4)111-149.

Greider, W. (1997).One world ready or not. The manic logic of global capitalism. New York:Simon and Schuster.

Gyekye, K. 1997. *Tradition and modernity: philosophical reflections on the African experience*. New York: Oxford University Press.

Hauff, E., &Vaglum, P. (1993). Vietnamese boat refugees: the influence of war and flight traumatization on mental health on arrival in the country of resettlement. A community cohort study of Vietnamese refugees in Norway. *Acta Psychiatr Scand*, 88, 162-168.

Haug, M. 1988. A re-examination of the hypothesis of physician deprofessionalization. *Milbank Quarterly* 66(supplement 2): 48 –

56.

Herrel, N., Olevitch,L., DuBois, D., Terry, P., Thorp, D., Kind, E.,

Abdi, S. (July-Aug.,2004).Somali refugee women speak out about their needs for care during pregnancy and delivery. *The Journal of Midwifery and Womens Health*.49(4).345-349.

Hicks, E. K. (1993). *Infibulation: Female genital mutilation in Islamic Northeastern Africa*.New Brunswick, NJ: Transaction.

Kalitzukus, V, Matthiessen, P. 2009. Narrative-based medicine: Potential, pitfalls, and practice. *Permanente Journal*, 13(1), 80-86.

Karakashian, M. (1998). Armenia: A country's history of challenge. *Journal of Social Issues*, 54(2), 381-392.

Institute of Medicine (2003) *Unequal Treatment: Confronting racial and ethnic Disparities in healthcare*. The National Academies Press.

Levitt, P. and Jaworsky, N. (2007). Transnational Migration Studies: Past Developments and Future Trends. *Annual Review of Sociology*, 33(1), 129-156.

Light, Donald W., and Sol Levine. 1988. Changing character of the medical profession: A theoretical overview. *Milbank Quarterly* 66 (supplement 2): 10-32.

Lim, SL(2009). "Loss of connections is death": Transnational families resettling in the U.S. *Journal of Cross-Cultural Psychology*, 40(5), 1028-1040.

Martin, J., Hamilton, B. Sutton, P.D., Ventura, S.J., Menacker, F., and Munson, M.L.(2005). *Births: final data for 2003*.

*National Vital Statistics Report*, 54, 1-116.McMorran, C.

Biopolitics.

Availableat:<http://www.beyondintractability.org/essay/refugees/2003>. Last updated 2008.

Moore, K.M. 2002. 'United we stand': American attitudes toward (Muslim) immigration post-September 11th. *Muslim World*, 92, issue ½.

Mooren, G., &Kleber, R. (1999). *War, Trauma, and society:*

*Consequences of the Disintegration of former Yugoslavia*. In K. Nader, N. Dubrow, & B. Stamm (Eds.), *Honoring Differences: Cultural Issues in the Treatment of Trauma and Loss* (pp. 179-210). Ann Arbor: Taylor & Francis.

Mollica, R., &Wyshak, G., & Lavelle, J. (1987). The psychological impact of war trauma and torture on Southeast Asian refugees. *American Journal of Psychiatry*, 144 1567-1572.

Ogburn, W. (1922).*Social Change*. New York: B.W. Huebsch Inc.

Ong, A. 1995, Making the biopolitical subject: Cambodian immigrants, refugee medicine and cultural citizenship in California. *Social Science and Medicine*, 40(9), 124-1257.

Padela, A.I. and Rodriguez delPozo, P. (2011).Muslim patients and cross-gender interactions in medicine: An Islamic bioethical perspective. *Journal of Medical Ethics*, 37, 40-44.

P Parsons, Talcott. 1951. *The Social System*. New York: Free Press.

Pavlish, CL, Noor, S. and Brandt, J. 2010. Somali immigrant women and the American healthcare system: Discordant beliefs, divergent expectations, silent worries. *Social Science and*



Medicine.71(2).353-361.

Pilnick, A. and Dingwall, R.(2011). On the remarkable persistence of asymmetry in doctor/patient interaction: A critical review. *Social Science and Medicine*. 72(8)

Portes, A. and R. Rumbaut. (2001). *Legacies: the story of the immigrant second-generation*. Berkley: University of California Press.

Reich, A. (2012). Disciplined doctors: The electronic medical record and physician's changing relationship to medical knowledge. *Social Science and Medicine*.74(7).

Shah, S. and Robinson, I. (2011). Patients' perspectives on self-testing of oral anticoagulation therapy: Content analysis of patients' internet blogs. *BMC Health Services Research*, 11(1), 25-37.

Simon, R.J. 1985. *Public opinion and the immigrant*. Print Media Coverage 1880-1980. Lexington, MA: Lexington.

Simon, R.J. and K. Sikich 2007. Public attitudes toward immigrants and immigration policies across seven nations. *International Migration Review*, 41(4) 956-962.

Sobczak, Michael. (2010) *American attitudes towards immigrants and immigration policy*. LFB Scholarly Publishing LLC, El Paso, TX.

Stadlbauer, S. (2012). A journey to "pure Islam": Time, space, and the resignification of critical in post 9/11 faith testimonies of Muslim women. *Narrative Inquiry*. 22 (2), 348-365.

Stein, L, Watts, D.T. and Howell, T. 1990. The doctor-nurse game revisited. *New England Journal of Medicine*, 322, 546-549.

Tajfel, H. 1982. Social Psychology of intergroup relations. *Annual Review of Psychology*.33: 1-39