"I now see operation after operation…. and they never asked me what I want". Caesarean section fear, anxiety and mental wellbeing among Somali migrants in Johannesburg, South Africa.

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Abstract. There is a close relationship between maternal health and psychological health. Pregnancy can accentuate the vulnerability migrants and refugee women often experience in the host society impacting their mental health. However not many studies have sort to establish the relationship between reproductive health and mental health. Drawing from qualitative in-depth interviews conducted with Somali migrant community on their experiences of undergoing Cesarean section in the city of Johannesburg, South Africa, findings point that separation from the traditional and familiar environment complicates the unde rstanding and acceptance of Cesarean birth. It is worth highlighting that maternal health, particularly caesarean birth, is always contested, always infested with both healthcare providers' influence and emotive forces.

Keywords: C-section; mental health; refugees; asylum seekers; Somalis; Johannesburg; South Africa.

Introduction

Migration flows are increasing globally (Agunwamba et al., 2022; Pineteh, 2017) and migrants contribute substantially to the total number of births in host countries. Refugee women, who account for nearly 47 percent of all those displaced across borders (UNHCR, 2020; Yeo et al., 2023), are particularly at higher risk during pregnancy and childbirth. According to Yeo et al (2023) on a global scale refugee women continue to face higher maternity-related risks from preventable complications during pregnancy and childbirth, to some extent due to high health care costs, unfamiliarity with the healthcare system, language barriers, and discrimination. Migrants' health is often compartmentalized, and, in this paper, I will look at how events in reproductive health impact on mental health. Migrant and refugee pregnant women constitute a highly vulnerable group to mental disorders (Iliadou et al., 2019). The rates of mental illness of migrants and refugees are higher than those of host populations, with migrant women being more likely to suffer from prenatal depression (Iliadou et al., 2019). Drawing from research conducted as part of a larger multi-sited project (including Johannesburg and Nairobi), which explores the relationship between displacement, gendered violence, and mental ill-health for internally displaced persons (IDPs), refugees, and asylum seekers who face multiple barriers to accessing healthcare (see also Walker et al 2023). This paper focuses on Somali migrant community on their experiences of undergoing Cesarean section in the city of Johannesburg, South Africa. I argue that fear and anxiety provide a mechanism, in understanding mental conditions anchored in a sense of disempowerment and limited voice or choice, by which migrant women manage and encounter childbirth. Childbirth through cesarean section has been outstanding in the narratives of the

Somali migrants both women and men as a topical issue that is discussed within the community and as a cause of worry and mental stress. In this paper the aspect of cesarean birth is viewed as both a trigger of mental ill health and lens to understanding perpetual psychological stress among Somali women post child delivery and that affects future reproductive hope and confidence.

In several studies cesarean birth has been recognized as central in understanding of fear and anxiety among pregnant women, which includes feelings of worry or fear over things that might happen. These lived stressors impact on the psychological well-being and preparedness of migrant women during pregnancy and the process of childbirth. Such feelings might either be imagined or real encounters with medical procedures during childbirth (Sinatra & Feitell, 1985; Wrześniewski & Sosnowski, 1987; Latendresse, 2009; Makandwa & Vearey, 2017; Lowe, 2019). In this paper, I will use the terms migrants, refuges and asylum seekers indistinctively. I highlight that there is a close relationship between maternal health and psychological health in the context of lack of reproductive rights. Refugee mental wellbeing can be further and better understood through focusing on the psychological perspectives on maternal health specifically the child delivery process and postpartum period. In this case how Somalis feel and express they have control and feel satisfied on their encounters with the health care providers.

Insights into Cesarean birth

Somali culture can be broadly described as pronatal, that is, they commonly desire frequent childbearing and large families (Gee et al., 2019; Lowe, 2019). Somalia has one of the highest fertility rates in the world, and although religion plays an intrinsic role in shaping reproductive beliefs and practices, it is by no means the only factor. In the context of Somalis in Dadaab refugee camp in Kenya, Gee et al (2019) note that having more children is a source of pride and prestige as women will receive more praise and respect from the community. In Eastleigh in the same context of Kenya Lowe (2019) found out that producing many children was described as a religious requirement, a symbol of wealth, and a continuation of the patrilineal clan and extension of the Somali nation. This responsibility to reproduce the nation physically and socially was felt acutely by the women and men coming from what was often perceived as a "failed state." Early and frequent motherhood was praised, while contraceptives were publicly rejected on cultural and religious grounds, although secretly used by many women, and abortion was rarely spoken of, except to condemn it (Lowe, 2019). In South Africa Pursell (2005) notes that Somali women have diverse health needs. Some of these needs are like those of the local citizens. But they also encounter distinct reproductive health challenges. Pursell (2005) argued that firstly, they originate from a nation where family planning is not widely practiced. This ultimately hints that many women have children in quick succession which place a strain upon their bodies. Also, stronger gender relations means that many Somali women are unable to negotiate or control sexual relations with their partners - thus to many Somali women when to fall pregnant is rarely a choice. It is also important to point that Somalia is a country where female genital mutilation (FGM) is widely practiced. As a result of this, many women are unable to have a natural birth. Often times, delivery is more complex than that of South African women (Pursell, 2005).

Maternal and child health is a key public health concerns in South Africa (Solanki et al., 2020). Yet there is an ever increasing local and global concern over the appropriateness and safety of the increasing numbers of Cesarean section births (Solanki et al., 2020). According to the World Health Organization (WHO) (2015) caesarean section refers to the surgical procedure

used to deliver babies through an opening in the mother's lower abdomen rather than through the vaginal canal. Some pregnant women choose to have the procedure done but many caesareans happen because of complications during pregnancy or labour (Sung & Mahdy, 2023). WHO (2015) points that C-sections can be lifesaving in cases where vaginal birth would be dangerous for mother and child or should be done when there are medically stated reasons such as there being signs of distress that necessitate a quick birth or in circumstances where vaginal birth is improbable (WHO 2015).

In some studies, conducted worldwide about C-section point to refusal or fear in some cases by Somali mothers to embrace cesarean delivery. For example, Borkan (2010) studied Somali resistance of c-section in Ohio, United State of America (USA), in Kenya, Lowe (2019) notes that rejecting cesarean delivery among Somali women is an avenue to protect their future reproductive capacities. She argues that in a context of displacement and insecurity, women's reproductive bodies can be crucial to their security and strategies for onward migration (Lowe, 2019), and Brown et al (2010) researched on Somali women's fears of obstetrical intervention in the USA. The refusal of Cesarean section is not only a Somalis phenomenon several studies globally have indicated that there is resistance to this biomedical procedure of child delivery. However not many studies have sort to establish the relationship between reproductive health in this case the experience of C-section and mental health, which this study seeks to do. Based on the interviews conducted with Somalis in the city of Johannesburg I argue that separation from the traditional and familiar environment complicates the understanding and acceptance of Cesarean birth.

Mental health in South Africa

South Africa is widely regarded as a sick society and there is urgent need to fully understand the social determinants of health and the need for mental health services (South African College of Applied Psychology (SACAP), 2019; Pillay, 2019). Pillay (2019) points that there is a lack of prioritization of mental health globally and in South Africa in particular. Reflecting on the bad mental health situation of South Africa, SACAP (2019) noted that in 2018, one in six South Africans suffer from anxiety, depression, or substance-use disorders, 41% of pregnant women are depressed and only 27% of South Africans with severe mental disorders receive treatment. The prevalence of anxiety disorders among South African pregnant women is 23% (Brown et al., 2020). The post-apartheid socioeconomic and xenophobic context, combined with the 30% HIV prevalence in pregnant women, high prevalence of food insecurity and an increasing burden in non-communicable diseases such as high blood pressure and diabetes, increases the risk of poor mental health (Jack et al., 2014). This state of the mental health situation in South Africa is troubling and require urgent action (Pillay, 2019).

South African government's attention in terms of government investment and development assistance for mental health remain very low. The South Africa Human Rights Commission (2019) and Pillay (2019) points to neglect, mismanagement, as well as under-funding of mental health services in South Africa. The lack of political will has left the public health system severely compromised in its ability to respond to the needs of citizens and non-citizens in South Africa (Walker & Vearey, 2022). Consequently, those struggling with mental health problems are not only left without support but living in contexts in which these issues are exposed and further amplified (Walker, 2021; Walker et al., 2023). In most cases women carry the huge burden of

mental illness in society (Iliadou et al., 2019). Lliadou et al (2019) point that when a mother experiences depression, anxiety, or stress during pregnancy, she may expose both herself and her infant to multiple psychological risks, including impaired bonding with the fetus and the newborn, increased risk of poor psychological postnatal adjustment and postnatal depression. Anderson et al (2017) identified the risk factors for depression in migrant pregnant women as lack of social support, lack of marital support, time in host country, socioeconomic difficulty, stress, low acculturation level, not working or attending school in pregnancy and precarious legal status. Drawing from the findings, themes of high costs of maternity services, language and miscommunication, limited decision power and lack of acceptance of the services were outstanding.

Methodology

Mayfair, the context of this study in the City of Johannesburg, is known as the heart of Somalis living in South Africa and is popularly referred to as the 'Little Mogadishu' (Jhazbhay & Mahomed, 2020). This presented a relevant site for this research. The fieldwork for this research was conducted between 2020 and 2022, which also coincided with the outbreak of the COVID-19 pandemic (See also Walker et al, 2023). The Research was conducted as part of a larger multi-sited project (including Johannesburg and Nairobi), which explores the relationship between displacement, gendered violence, and mental ill-health for internally displaced persons (IDPs), refugees, and asylum seekers who face multiple barriers to accessing healthcare. Although the focus of the project was not intended to delve into pregnancy and giving birth, this thematic area was continuously raised as a stressor and became a topic of interest.

The focus on Somali refugees and asylum-seekers was aimed at better understanding the interrelationship of migration and health, including mental health as determined by the broader context of xenophobic violence.

Interviews were conducted both online and through face-to-face. The realities of the COVID-19 lockdown restriction forced the fieldwork to be conducted largely online through platforms such as Zoom and WhatsApp calls and when the lockdown restriction were relaxed, I then shifted to face-to-face physical interviews with the participants. The face-to-face interviews gave room to interactions with the community and observing the local environment. They also opened an avenue to observe and have a better feel of the emotional component of the topic under research by observing the changes in expression from the participants. A subsample of interviews relevant for this paper was drawn from a total of 40 interviews which were conducted with adults from the Somali community in Mayfair (25 males and 15 females). Snowballing was very crucial as the researcher was referred to other Somali members in the community.

Most of the interviews were conducted through the assistance of a translator from the Somali community who helped to translate from English to Somali language and from Somali back to English language. Transcription of the interviews was done through the services of professional transcribers, and data analysis was done through thematic content analysis. During the interviews most women expressed fear and anxiety of giving birth as Muslim migrants in the city, fearing the encounter and pressure of delivering through cesarean section, so often perceived by the same community to be done among Somalis more than among any other communities. Based on data on fear and anxieties it was also emphasized by the community leaders that it's an issue always under discussion among the community.

Findings and Discussion

Demand for maternity fees and identity documents

Access to healthcare is a fundamental right to everyone at a global context. In the South African context migrants are regarded as a drain to the healthcare system (Makandwa & Vearey, 2017; Vanyoro, 2019). Narratives from the Somali refugee community highlights serious barriers in accessing maternal care. In the context of this study the demand for different maternal charges and identity documents (refugee status permits and asylum papers) are major concerns reflected upon. In the context of South Africa maternal health remains a widespread and growing concern among migrant communities. Pointing to the challenge Mother J who has been residing in Mayfair for the past six years and still using an asylum paper has this to say:

> *"Ja. Ja I have been having a thyroid problem, and they take the blood sample [……] they said I cannot get a baby because of that diagnosis. Now when I went to the public hospital, they said I am supposed to pay forty thousand rand (Zar 40,000.00) if I want to have a baby and it was supposed to be C-section, I immediately felt it's a big stab with a sharp weapon in my mind (….), I was having a problem of the thyroid, they removed it. (Mother J, interviewed, Oct 2021)*

The mental health shocks among migrants in the city of Johannesburg can be read through maternal health. The narration by Mother J provides a window to the understanding of the weight imposed by health costs on mental wellbeing. Although detailing her struggles with thyroid problem the main worry for Mother J was the news of her delivering that was going to be through caesarean section. The feelings of being stabbed by a "sharp weapon" accurately captures the degree of the pain and harsh psychological struggles thereafter, which impacts on the mental wellbeing and the same time is a vivid metaphor for the actual operation.

The pain of isolation and loneliness after giving birth in the city is also one of the mental challenges that exacerbate the fragile situation of the Somali migrant women. Somali women described life in South Africa as scary and stressful, thus life in the city of Johannesburg brought in a host of new fears and anxieties in contrast to the war and violence in Somali. Amiya a 28-year-old undocumented Somali migrant, staying with her husband, and has been in the city of Johannesburg since 2019 details the fears and struggles in the following exchange:

> *"The people are fearing to deliver in a public hospital because of the money, and putting birth through caesarean section, it's a matter of life and death and if you survive it, the pain and stress of recovering alone without anyone taking care of you, it's very depressing, when I think of all this, I miss my people home especially my mom and sisters". (Amiya, interviewed, Oct 2021)*

This rich exchange with Amiya highlights major concerns with serious psychological consequences on the mental state of migrants linked to giving birth. The monetary component generates fear as most of the Somali refugees are self-employed and work informally as shop keepers in Spazza shops (these are small informal stores in townships, often run from a private home) and this does not generate enough revenue to cater for extra medical costs. These Spaza shops exposes Somali operators to violent attacks from the local communities in South Africa.

However intimately linked to the costs involved in accessing healthcare is the possibility of having a Caesarean delivery, which on its own besides attracting higher costs, is viewed as a "matter of life and death", which reflects chances of survival being at stake. Recovering from the scars of caesarean birth is pictured in the exchange as associated with huge mental stress and depression. Moreover, what is critical in all this is the separation from support which is made a reality by migration and being a refugee as Amiya reflects on being lonely and missing her mother and sisters in Somalia.

Other participants like Asha gave a different impression about the medical costs of caesarean birth in public hospitals, as she narrates her daily struggles with fear and the stress of being constantly reminded of putting to birth through the procedure:

> *"I was always fearful and stressed they always told me you, you are going to give birth through c-section,……. If I could have money I prefer to go to the private hospital….. the other day when I was admitted at coronation hospital they cut my skin to remove the drip it was painful the nurse was fighting with me, from there now I just go to private hospital especially when pregnant". (Asha, Somali Woman, interviewed, Oct 2021)*

Limited by funds, the sentiments by Asha portray her desire to seek private care. She backed her claim by digging deeper into the abuse that she experienced at one of the public hospitals. The findings highlight how public healthcare spaces are viewed as both spaces of mental and physical pain and they generate fear and ressentiment. The level of poor relations with healthcare providers especially nurses in public healthcare facilities is a cause of concern here. Jewkes et al (1998) and Kruger and Schoombe (2010) note that although nursing discourse usually emphasises "caring" and giving hope in times of need, nursing practice in some public healthcare facilities in South Africa is often quite different and may be characterised by humiliation of patients and physical abuse as reflected by Asha in her narration.

Most of the participants in this study shared accounts of a perceived loss of hope and power to access proper healthcare during pregnancy and child delivery due to lack of proper documentation. For undocumented migrants they survived in perpetual fear as Hawa reflects on how this compromise health and wellbeing:

> *"The other thing is sometimes they say if somebody doesn't have a permit here at the moment, she can't deliver at the hospitals because she doesn't have medical aid, it's so confusing and it always make us live in fear always and think of home, and when it's about delivering through C-section it becomes hell you can even think of delivering secretly". (Hawa, Somali women, Interviewed Nov 2021)*

Detailing the nightmares of not being only a migrant but an undocumented migrant complicates life and feelings of not belonging becomes amplified. Studie have reflected on how migrants in South Africa are perceived and highlights dishonest especially regarding documentation (Vanyoro, 2019; Makandwa 2022). The most significant obstacle for the respondents was the issue of documentation in accessing maternal health services, and it affected confidence regarding access to healthcare. The confusion and fear have a great impact on mental

stability of the migrants in the host community. Living with this perpetual confusion and fear and the potential of giving birth through Caesarean section which requires specialized care becomes a torment.

Forced against their wishes

Somali women that I interviewed shared their sentiments on how caesarean delivery has become fashionable and they feel its forced on them against their desires. The moment of giving birth connects healthcare providers with women of different ethnic backgrounds who bring along with them heterogeneous cultural and religious beliefs into the maternity and child delivery spaces. Resultantly the women's expectations are not met, and this negatively affect future healthcare seeking (Mantula et al., 2023) and gave rise to bad memories of giving birth. One participant recounts her past experiences with giving birth in Somali before she moved to South Africa points:

> *"Before my kids were normal deliveries… I delivered normally last time, and it was very nice at that time. But nowadays everything has changed. And it was one thing that we always discuss in our community… that here in South Africa it is not good that when you get into labour some of the people start, starting straight take you for 'Caesar', we were three we were sharing the information. People are discussing about it……". (Mama, Somali woman, interviewed Oct, 2020)*

These sentiments expressed by Mama hinted on sudden change in practice towards giving birth and this issue was of great concern among the Somali community. The expression highlights shock on the unprecedent change on birth practices and the increasing practices of delivering women through C-section in the city of Johannesburg.

Some women in this study were adamant that the experience of childbirth and motherhood in South Africa have changed considerably from previous experiences in Somalia, largely because of the loss of traditional community support during pregnancy, childbirth and post-delivery. Cawo in her narrative below was convinced that:

> "*There is a big difference. There in Somalia, there are people who can wait for you for almost three days, four days, five days until your labour comes but here, they said you are alone, after two hours, three hours they say no you can sign here then you are going to get the caesar. There in Somalia is very nice to deliver. People are always making you happy, speaking with you in your language, speaking to you about normal and good things. Until you deliver normally, but here it is very difficult". (Cawo, Somali woman, interviewed October 2021)*

It is interesting to note the recounting of how in South Africa the Somali women are shocked by the limited patience in waiting for women to experience the process of natural labour, waiting even taking several days for the baby to come. However, in South Africa few hours of waiting are not afforded, as the process is rushed. This can be attributed to the over reliance on technological interventions on giving birth which results in negative encounters with the process of birth and motherhood. It also hints the real reason behind negative encounter as in her narrative she pointed to the issue of language, and failure to speak to the women giving birth in their

language complicates the whole encounter, hinting to how communication can smoothen or complicates the entire process. Implying midwives' lack of cultural sensitivity in their provision of care (Mantula et al., 2023). Cultural sensitivity is a set of skills that allow understanding and learning about people whose cultural background is different from one's own, and the ability to modify behavior to accommodate other people's cultural beliefs (Hamidzay, 2018). In this study this is perceived as a total lack of cultural sensitivity and has been captured by Tesa as she said:

> "*Yeah, actually there is something going on within our community, they [Somali leaders] are also in a meeting of, all the community leaders and Muslim elders, they meet them [government officials] once, they said they want a hospital that we find only women who are there are Muslim women, but we never got it". (Tesa, Somali woman, interviewed Nov 2021)*

Most Somali women I interviewed in this study have delivered through C-section either because of their compromised health as mothers or because of the underdevelopment on the part of the child to be born. Caesarean birth became a motif of maternity among most of the participants in this study. It's depth and magnitude equated to the fear and anxiety it generated among women. Some women devised strategies to avoid the procedure and its associated nightmares by trying to push for normal delivery. Here, the clash between biomedical knowledge, or the knowledge of experts, with women's own understanding and wishes, became a point of debate:

> *"The things that we never had in Somalia is that inside the womb the child's water is finished…….and the baby is tired, we never had that back home, something like that. Then they say sign it you are going to get the caesar. That is the things we have here in South Africa". (Tesa, Somali woman, interviewed Nov 2021)*

From Tesa's sentiments above there is a general feeling that the issue of giving birth is going against the Somali religion and they feel powerless to voice their concern. This was further expressed by Hawy a Somali man below:

> *" …and still it's very difficult for us, to interfere with the Government things…and we are all proposing that it's very wrong what they're doing for the women, Muslim's women….we have never seen a lot of women in Somalia who have Caesar, it's like twenty women delivering, half of it is through a Caesar here in South Africa, and then, in Somalia, you see a hundred of them you going to see one Caesar only, so it's very difficult. Some of them they're scared of getting babies here." (Hawy, Somali man, interviewed Nov 2021)*

Comparing the experience of womanhood and giving birth in Somali and in South Africa with figures paints a picture of how bad the situation is in the host nation of South Africa. This also is a captured as a big trigger of mental stress and fear as explained by Fatima below:

> *"If I think of giving birth here in South Africa I became stressed and very fearful because you know you need someone you trust, and for me the closest friend I*

have are men, so when I am sick as a woman I can't explain that to a man, and I feel stressed and depressed because I need a female figure to share with my problem…..if you tell a man that I have menstrual problems they laugh at you, and if you deliver through operation you need a female figure to help you during the healing process you see…." (Fatima, Somali woman, interviewed Oct 2021)

This quotation from Fatima details how the uprooting of migrants from familiar environment to a new environment is a recipe for a chain of psychological challenges as most women encounter the lack of familiar support structures mostly to do with their reproductive health needs. Finding themselves in a male dominated environment without women who share similar cultural background according to Fatima above is a big source of stress and depression, was the concern that if as a woman one delivers through C-section this requires a female figure to assist during the healing and recovery process, yet in most cases they are left to battle it as lonely figures. This lack of support and family structures impacts the physical healing and the psychological adjustments associated with childbirth.

Fatty, a Somali man interviewed in Mayfair expressed how Caesarian birth generates frustration and worry even among men in families among the Somali migrants. For him it's a direct attack on Somali masculinity and their desire for big families as he says:

"I am worried because of my wife here she has given birth through operation, but in Somalia she had given birth normally, I am very worried because this Caesarian may limit the number of kids as the doctors recommended, but it's against our tradition as Somali people we are always for big families". (Fatty Somali Man, Interviewed Oct 2021)

The reality of limiting the number of deliveries a woman who put to birth through the procedure is described here as a direct slap on the traditional dictates of having big families.

The narration by Fundi however shades light to the genesis of the root cause of the problem of caesarean delivery among the Somali migrants, which emanates from the traditional Somali cultural practices as he says:

"This problem of the Cesarean birth its caused by the Somali traditional practices done to women, which is believed as a way to protect them again sexual practices were they had to seal the female vagina through sawing the area and leaving a small opening for them to pass urine and the husband on marriage has to cut and open that and some of the men they don't know or do that hence when it comes to deliver the women will have problems and here automatically it's a caesarean delivery".

The illustration above debunks the myth among the Somali refugee community interviewed in this study that the South African maternal healthcare system is infested with Cesarean deliveries because of some underlying agendas against the Muslim community. It is interesting how he fingers the causes to be associated with the Somali traditional practices of female circumcision (see Pursell 2005), in which external flesh, including the labia minora and

majora and the clitoris, are removed and the remaining skin is sewn together, and how the modern Somali men lack knowledge on how to help their woman with their sexuality and reproductive health when they get married. This is believed to have a direct contribution to delivering through the procedure. Cultural insensitivity is intimately linked to the aspect of language and communication theme and the attitudes it potential generates. Some of the women I discussed with highlights that women born in the 90s and before were frequently than now subjected to the more severe form of circumcision and they have problems when it comes to childbirth, and it must be through C-section. With some also having challenges even during menstrual period.

Interpersonal miscommunication

What follows are excerpts of stories shared by the Somali migrants on what effects interpersonal miscommunication has on their relationships with the healthcare providers and their eventual satisfaction with the services rendered. The centrality of language in healthcare provision has adverse effects on treatment that is language-insensitive and unaware (Peled, 2018). Most of the participants were never educated and could only speak Somali language, surprisingly those who speak English claim to have learnt it on their own either at their small shops through interacting with customers or at the clinics as they interact with the nurses and other healthcare users, however some have learnt and perfected their English through watching movies or through attending English language classes. Most believed that language was used as a tool to block them from understanding what was being shared among the nurses which created uncertainty and confusion among most migrant users. In this case building negative feelings as healthcare was not dialogical or based on mutual understanding, and this created fear, hesitation, uncertainty and ultimately silences the patients' voices (Parry, 2008; Prosen & Tavčar Krajnc, 2013). Hani a 36-year-old who never went to school and was staying with her family in Mayfair since 2009, said:

> *"I never learned English in my home country; I have a problem with both my kids here in South Africa. I married here, then I became pregnant. They took me to the hospital, but they refused to let my husband go inside with me. The first doctor I saw told me that I am going to deliver normal, I showed signs to deliver normally, I became very happy. So, another nurse came to me and gave me an injection when the doctor left……When she left, she dropped that injection next to the bin, and then we took that injection with those bottles, everything, and wait for the next nurse to come and showed those things. They said, what is this? This means that somebody gave you this injection and you will not deliver normally. You are going to get a cesarean……...I did not understand that person, then I called my husband. They would not allow my husband to come inside. So, the next person came, and I showed that person the things and then the lady said, after six hours they will make a cesarean of my first baby. If the doctor were Somali, then we could understand each other, that time I felt lonely in this country, I am not happy. They just gave me a cesarean without any consent from my husband or myself." (Hani, Somali woman, interview Nov 2021)*

This emotive response exposes how language is a pre-requisite in healthcare provision, source of happiness and confidence in meaning making. It contributes to certainty or uncertainty

in the management of health conditions and illnesses. This interview points to the expanding multilingual landscape of inner-city Johannesburg and how healthcare encounters can be comforting or stressful to both healthcare providers and healthcare users due to the inability to engage and understand each other.

Asha a woman in her late twenties who was working as a community health worker in Mayfair, described her feeling of marginalization, exclusion, and loneliness because of language complication – with the experience being horrible from even her days of attending antenatal care (ANC).

> *"ANC was very horrible it was not good they were talking in their language and I could not get help most of the time….at the hospital it was very bad I started swelling all over the body and the nurses could not help and I was very young, I was 19 years by then, I delivered through C-section, If the doctor was Somali or nurse Somali, we could have understood each other…." (Asha Somali woman, interviewed Oct 2021)*

As the above quote suggests, language has the potential to alienate and exclude the migrant healthcare user from accessing care. Linguistic proficiency here can be argued as a determinant of health (Zhang et al., 2021; Pandey et al., 2021) as it results in medical isolation and mental stress and feelings of loneliness. Zhang et al (2021) points to how language isolation during critical health seeking moments is known to be associated with adverse health outcomes. Asha here even feels disappointed that the doctor was not Somali or any of the nurses as this could have served her situation and improved understanding, which eventually resulted in her delivering through C-section.

Bravo points to the lack of proper communication and the barrier posed by lack of English proficiency on the trust on healthcare provision:

> *"What I know in Somalia If there is going to be Casear, they were going inform the mother of the pregnant woman, the mother of the child, the father then everybody is prepared that, this time is Caesar time, but these people they do not understand English, they know their Arabic language I remember, two weeks ago, they said they let somebody call to say your wife is supposed to go to theatre for, a Caesar, and they did reach that guy. But when he went, they were already there doing it……Caesar, Caesar, Caesar, too many Caesars, too little babies". (Bravo, Somali elder, interviewed Nov 2021)*

The sentiments by Bravo a Somali elder points on how Improving communication and allowing migrant women to preserve some of their traditions may increase their mental wellbeing and positive feelings (Fassaert et al., 2011).

Limited decision power/Consent

> "I now see operation after operation….and they never asked me what I want." (Amigos, Somali woman, interviewed Nov 2021)

This study highlights how caesarean births have become rife and fashionable in recent years. Chadwick and Foster (2013) views C-section as resulting from biomedical construction of risk in the medical setting, which views the pregnant body as vulnerable. This led Amigos to argue that she is now a victim of forced caesarean birth, as this was done on her without her consenting to it. When I posed the question to Somali migrant women about their fears in the city of Johannesburg, most of them constantly raised the fear of Caesarean birth and its associated risks. Timo and Amiya both in their late twenties cited how they have limited consent on what happens to their bodies during delivery as their narratives detail:

> *"What they do nowadays, before even you are going to see much of your labour and the coming out of the baby, you have just to go straight to see Caesar, I cannot trust them, they are just talking about Caesar. I never consented to the Caesar, I just signed……because of the language barrier…" (Timo, interview Somali woman Oct 2021)*

> *"We deliver without consent, because these people they use their languages, we do not understand any of their languages, same as our husbands, before these people, they said okay, come with your husband inside until you deliver, but nowadays, you go there alone, they only ask your husband to bring the documents and go back until the baby is delivered and then without consent, everything they can do it. They give us injections for family planning, and they give us Caesar without our consent". (Amiya, Interview Somali woman, Oct 2021)*

Language and lack of consent are portrayed as inseparable siemens twins that Somali migrants in this study grapple with, in the maternity spaces. What is very distinctive about Timo's and Amiya's narratives is the illustration on lack of consent and how they feel powerless. A lack of voice and choice in deciding on caesarean birth was always emphasized by most of the participants who gave birth through C-section. This confirms the analysis by Panda et al (2018), that Obstetricians and midwives are directly involved in decisions to perform Caesarean sections, hence they exercise medical power and knowledge over human life (Solanki et al., 2020). The narratives delve deeper into the heart of anxieties around Caesarean sections in the city. They point to a lack of communication in the maternity ward, where everything goes by paperwork and language complexity silences them.

The practicalities of a caesarean birth generate substantial fear among pregnant women. This could be either when biomedical caesarean procedure went haywire, and for some participants like Kamiler, the scariest part was the possibility of something going wrong during delivery, which could possibly result in death. She had always been frightened by the thought of a caesarean birth, which had often given her sleepless nights as she explains:

> *"Stress comes from anywhere here in South Africa, I fear for my life because of giving birth, you know here they like C-section always and C-section is a problem, it's an issue of life and death and they just inject you for family planning without asking if you agree to that, it's just a big scandal." (Kamiler, interview Somali woman, Nov 2021)*

The challenge of facing death amplify mental health problems, to her the whole process of giving birth has been scandalized because of the lack of consent. This instead of lessening anxiety (Barker, 2012) and improving satisfaction with birth experience (Konheim-Kalkstein et al., 2018) proves otherwise as it painted with more danger and uncertainty. The characterization of South Africa as a host nation where "stress comes from anywhere" by Kamiler above effectively renders it as an unsafe place to be.

In another similar context Amigos listed a chain of daily stressors which adds to the challenge of giving birth:

> *"As Somali women giving birth and most of us through forced C-sections, it's like every person who is here, everything needs money, delivery, medication, rent, food etc. And if you are not working, you become stressed, so we have identical problems of stress and depression……" (Amigos, Interview Somali woman, Nov 2021)*

Amigos' response highlights how migrant women evaluate birth as presenting identical challenges of stress and depression. Borrowing from Konheim-Kalkstein et al (2018)'s position that birth stories provide an intimate glimpse into women's birth experiences in their own words, I argue here that Amigos' views and those of other participants in this study eventually leads us to the understanding of the emotions attached to the process of giving birth and post-delivery phase far away from home and home being Somalia.

Conclusion

This paper has demonstrated how migrant mental health and wellbeing in the city of Johannesburg can be read, using a maternal lens through the discourse of fear and anxiety. These are central in the lived stressors that impact on the psychological well-being and preparedness of the migrant women during childbirth period. These fears and anxieties might be imagined or real encounters with C-section delivery in the lives of the women. Understanding and making sense of Caesarean birth - based on data on fears and anxieties - presents the health landscape of the greater Johannesburg city as incomplete without the psychological component. Through the narrative from the Somali community lastly, it is worth to keep in mind that the subject (about maternal health particularly caesarean birth) is always political and contested. Always infested with both institutional influence and emotive forces.

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