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Refusing Cesarean Sections to Protect Fertile Futures: Somali Refugees, Motherhood, and Precarious Migration

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Abstract: Amidst globally rising practices of cesarean sections, Somali refugee women in Kenya are rejecting the operation in attempts to protect their future reproductive capacities. In a context of displacement and insecurity, women's reproductive bodies can be crucial to their security and strategies for onward migration. Somali women's resistance to C-sections mirrors prevalent practices of female circumcision, as both are perceived by physicians as medically harmful, but by women as essential to achieving gendered expectations of marriage and motherhood. The strategic modification and protection of reproductive capacities are

situated in multifaceted social and political ruptures, and women's refusal of surgery is part of a long-term, future-oriented pursuit of motherhood and survival.

Keywords: Motherhood; Refugees; Cesarean Section; Female Circumcision; Migration; Resistance; Somalia; Kenya

The pained shuffle of a woman in labor was unmistakable as Malyuun, a 22 year old Somali woman, slowly, agonizingly, entered a small privately owned hospital in the Eastleigh area of Nairobiⁱⁱ¹. Escorted by her husband, mother, two sisters, and a brother, she made her way to the closest bench in the waiting room, before heavily slumping against it, not fully sitting down. Her brother approached the reception desk, politely but insistently requesting that she be seen to very quickly. He was waved towards the cashier's window to pay an initial deposit and consultation fee, as Malyuun was helped to stand upright again, and she slowly began her shuffle towards the labor ward.

This was not Malyuun's first hospital visit of the day. A short time earlier she had made her way to another hospital in Eastleigh, known throughout the Kenyan capital and beyond for its large Somali population as "Little Mogadishu." Malyuun and her family had delayed even that hospital visit, because of the popular notion that women who arrive at hospital too early in their labor will be forced to undergo unnecessary interventions. At the first hospital Malyuun and her family were informed that the baby was in a "bad position" and therefore a vaginal delivery would be impossible. Unhappy and highly suspicious of this diagnosis, her family had argued with the medical staff before calling a taxi to take them for a second and hopefully more desirable opinion.

Following a quick physical examination, the nurse-midwife at the second institution gave Malyuun the same information – the baby was in transverse lie position so could not be delivered vaginally and she would have to undergo a cesarean section. Once again, Malyuun

refused. Several of her relatives went to speak to the matron, after the midwives had failed to persuade them to reconsider. The matron, a stout, determined middle-aged Kenyan woman who had worked in Eastleigh for over a decade sat Malyuun's husband, brother, and one of her sisters down in her office to explain the situation, using her well-worn copy of Myles midwifery textbook to illustrate the position of the baby and what the operation would involve.

The matron, switching between English and Kiswahili, made her points repeatedly, using different vocabulary combinations in both languages in an attempt to fully explain herself. The brother spoke good English and Kiswahili and translated for the other two. The three debated amongst themselves in Somali, and they wondered whether an obstetric scan would help them. Picking up on the English word "computer", which Somalis in Eastleigh used to refer to scans, the matron interrupted telling them the "computer" would make no difference because they could identify the position of the baby from the physical examination. After a lengthy discussion, they returned to Malyuun and the other family members, where the argument continued. Malyuun did not want the operation, and neither did her mother or sisters, who were adamant that she should not have it. Malyuun's brother and husband tried to convince them, and eventually Malyuun, looking utterly exhausted and in agony, agreed. Up until the moment she was taken into theater, her mother and sisters tried to convince her to change her mind.

Malyuun's experience was not unusual, and in many similar cases I observed, the laboring woman maintained her refusal to undergo a cesarean section. For some of these women, the refusal appeared justified when the baby was eventually delivered successfully, albeit often with significant trauma to both mother and infant. In many other cases, the charged debates over cesarean sections between midwives, patients and their families only came to an end

when the baby died. In such cases, the families readily and without exception attributed the death to God's will and, as such, no medical intervention could have altered the outcome. Somalis in Nairobi and elsewhere can broadly be described as pronatal, that is, they desire frequent childbearing and large families. 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 Eastleigh, producing many children was described as a religious requirement, a symbol of wealth, and a continuation of the patrilineal clan and by extension of the Somali nation. This responsibility to physically and socially reproduce the nation 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.

In Eastleigh, where people live in legal ambiguity because of fluctuating and haphazardly enforced refugee encampment policies, and endure daily police harassment and extortion, reproduction and mothering took on new meanings for Somali women. This is what I spent 20 months conducting ethnographic research on, focusing on women's experiences of forced migration, kinship, and reproductive health in Eastleigh, between 2009 and 2011, with further brief research visits in 2012, 2013, and 2014. During this time, I volunteered in the small hospital where Malyuun gave birth to her first child, while conducting further research in several other small hospitals, clinics, and pharmacies in the area. While living in Eastleigh, I conducted semi-structured and informal interviews with Somali women and men and their health care providers, including nurse-midwives, doctors, consultants, pharmacists, and other hospital staff. In hospitals, I observed consultations and deliveries, chatted with women and their relatives in waiting rooms, rubbed the backs of laboring women, and ran errands for midwives. I also traced the reproductive experiences of women, where I was present for first

pregnancy tests and hospital visits, prenatal appointments, miscarriages, childbirths, and infant care, including medical check-ups and vaccination clinics. Most of this time was spent with women in their homes as they went about their daily lives. Frequent childbearing meant that I was able to accompany some women through two pregnancies, and subsequent visits have been marked by, and in two cases scheduled to coincide with, the arrival of new children.

During interviews and informal conversations, women emphasized the importance of childbearing for their families, their own social status, and a responsibility to reproduce new generations of Somalis. Older, “successful” mothers of several children would proudly thank God for their reproductive achievements, while younger women with few or no children expressed anxiety at the pressure to procreate quickly and often, fearing the repercussions if they failed to do either. Far from being singular acts of childbearing, achieving motherhood meant the recurrent process of conceiving and delivering many children, often on an annual basis. Reproduction and motherhood are highly “gendered performances” in which moral and social expectations are continually realized and produced as part of “discursive and performative constructions of gender” (MacDonald 2007, 9). Physically producing large families allowed women to perform, produce, and achieve valorized notions of motherhood, and crucially enabled them to create their own webs of kin relations, which often spread across multiple countries and continents to other diaspora settlements.

Rahma, an elderly Somali woman, lived with one of her adult sons in Eastleigh, while her other children were all in the United States of America. She was entirely financially reliant on her geographically remote children, all of whom sent regular remittances. Without them, she told me, she would have been stuck in a refugee camp, or might have returned to Somalia. Samira, a much younger mother of four small children was living alone when we first met. Her husband had also managed to relocate to the United States several months

earlier, and she relied on him for financial support. “I miss him but, *Insha’Allah* (God willing), we will be able to join him out there” she told me, before adding “we have a strong bond” as she gestured towards their children, who were sprawled out on a mattress watching Tom and Jerry cartoons.

Producing and raising children helped women living with everyday insecurity to establish themselves within transnational kinship networks, which were often essential for physical and economic security, and could provide possibilities for onward migration. Over 25 years of conflict and displacement had reinforced kinship as the primary and most reliable sources of support, while migration opportunities – whether illicit, or by obtaining visas or “family reunification” procedures – reconstituted perceptions of kinship as grounded in marriage, and above all, blood. Women were able to situate themselves in kinship networks by solidifying their marriage by producing new blood ties. Why then, was a procedure intended to save the lives of both women and their infants, or reduce the risk of serious complications, so frequently rejected, particularly by women?

Cesarean Sections in Clinical and Anthropological Perspectives

Cesarean sections (C-sections) are surgical operations in the front wall of the abdomen, performed when a vaginal birth is expected to involve undue risk of harm to the woman or the baby. C-sections can be scheduled in advance, for example if the placenta is low lying in the womb, if the baby is in a position that will make a vaginal delivery difficult, or if the woman has a pre-existing medical condition, such as high blood pressure or an infection. Alternatively, a woman already in labor might be given an emergency C-section, perhaps if labor is not progressing fast enough, if the baby is not getting enough oxygen, or if the woman is bleeding heavily. Although increasingly commonplace throughout the world, cesarean sections are major abdominal surgery interventions that have lengthy recovery periods and can have serious implications for future pregnancies. The increased risk of

obstetric complications with every C-section means that women who repeatedly give birth in this way are limited in the total number of safe births they can have, compared with women who deliver vaginally.

Among Somali refugee women in Eastleigh, motherhood is a gendered expectation and status contingent on female bodies being reproductively capable. Somali refugee women perceive cesarean sections in the context of the need to protect their reproductive potential and thus their present and future security. While medical technologies are frequently used to enhance fertility, they can also be seen as threatening to women's capacities to achieve idealized notions of motherhood. The medical limitations imposed by C-sections have the potential to constrain women's ability to perform and achieve a concept of motherhood that is understood not as producing one child, but several.

Somalis are not alone in refusing cesarean sections (Richard et al. 2014; Tully and Ball 2013) and Somalis living in other regions also refuse it (Essén et al. 2011; Vangen et al. 2000, 2002). In Sweden, refusing cesarean sections is one of the primary causes of perinatal death among women from East Africa, particularly Somalis (Essén et al. 2011, 76). The reluctance to undergo a cesarean section has been ascribed to a fear "more to do with socioeconomics and poverty than with culture" (2011, 79).

The WHO has specified that an "ideal rate" of between 10 and 15 percent of births should be delivered by C-section (WHO 2015, 1). Although there is no evidence that higher rates have any clinical benefits for women or their children, the practice has become increasingly popular across the world, with some going as far as describing it as an epidemic (Porreco and Thorp 1996). National statistics on C-sections in Kenya indicate a steady increase in the practice, with significant differences between urban and rural areas. In 2014, the national rate was 14.4 percent, while in Nairobi county it was 24.9 percent, with even higher rates found in the high-end hospitals in the capital (Juma et al. 2017, 7). Fetal distress and prolonged labor

were identified as primary indications for emergency C-sections, while previous C-section scars and cephalo pelvic disproportion were indications for elective procedures. Although pharaonic circumcision, which is the most common form practiced in Somalia, has been identified as a cause of obstetric complications and an indication for C-sections, this was not the case in Eastleigh, where female circumcision was the norm among Somali patients and doctors were highly familiar with the practice and its potential complications.

Increasing global rates of C-sections are an intimation of the power of medical technologies in the pursuit and modification of gendered bodies. Cesarean sections, as high technology interventions, are perceived as a marker of modernity and status in areas of Brazil and India where they have become more common than vaginal deliveries (Donner 2008, 111; Behague 2002). Unlike most vaginal births, C-sections leave visible traces of past pregnancies and interventions, which are themselves situated in local understandings of women's bodies and reproductive capacities. In Ecuador, the scar of a cesarean section physically represents a woman's socioeconomic ability to access private medical facilities, symbolically raising her above those who are forced to endure vaginal deliveries in state facilities (Roberts 2012).

When technical interventions in pregnancy and labor such as cesarean sections are identified as a form of inherently positive progress, their refusal can be seen as an act of negligence from the perspectives of both medical professionals and their patients (Edmonds 2010). This was certainly the position of many of the doctors and midwives in Eastleigh who were visibly exasperated by the frequent refusals from their Somali patients, and expressed both personal and professional frustration.

The growth of high-tech monitoring and management of childbirth have also marked a decline in low-intervention midwifery (Jordan 1992, 1997). Responsibility for the international overuse of C-sections is generally directed at physicians, who are portrayed as homogenous, anonymous medical tyrants who seek to control women's reproductive

capacities, while the discourse surrounding this issue is often one of gendered power and oppression. Many authors lay the blame for this “largely uncontrolled international pandemic of medically unnecessary cesarean births” (Sakala 1993, 1177) on “institutional patriarchy.” Such an analysis builds on, among others, the “technocratic model of birth” (Davis-Floyd 1992, 1994) that has become prevalent in the USA and many other parts of the world. In this model, female bodies and particularly their reproductive capacities are perceived as “abnormal, unpredictable, and inherently defective” (Davis-Floyd 1994, 1127). High rates of C-sections are therefore a logical institutional response to remedy and manage the pathological female body. While these arguments are compelling, they do not consider what becomes of such a technocratic model in countries with high maternal and infant mortality, such as Kenya, and a relatively low-resource setting, such as a small hospital in Little Mogadishu.

Hospitals were usually staffed by nurse-midwives, with the assistance of a junior doctor. In the case of an emergency C-section, or any other emergency surgery, the staff had to call on a surgeon and anesthetist to assist them. Such senior consultants were often based at the high-end hospitals located in more affluent parts of the city. The omnipresence of traffic jams, coupled with potholed and sometimes flooded roads in and around Eastleigh, often resulted in lengthy waits for the arrival of the required specialists.

The responsibility for the safety of women in labor therefore usually fell on low-income women (and sometimes men, but most nurse-midwives were women). These women, in my experience, did not see the female body as inherently weak or defective, as they are so often depicted in medico-technical settings (Davis-Floyd 1994; Martin 1990). Pregnancy and childbirth were frequently described as evidence of women’s strength, with midwives often emphasizing the physical strength of African women, who, I was told, did not need pain relief (whether they needed it or not, it was not routinely offered or available). Yet working

in a country of high maternal mortality, they were acutely aware that risks and complications were inherent in childbirth, and that they, as nurse-midwives on the bottom rung of a biomedical hierarchy of expertise and training, were ultimately responsible for the safety of women's lives.

Cesarean Sections and Female Circumcision

Midwives' and obstetricians' focus on medical risk and management were not reflected in their Somali patients' attitudes to C-sections. Women were concerned less with the immediate risk to their health, and more with the potential risk to their ongoing reproductive capacities. Somali women refused cesarean sections because they believed the operation would curtail their capacity for future childbearing. They understood C-sections as an act in the present that radically alters possibilities for the future. In this respect, the perception of cesarean sections reflects the practice of female circumcision, an act that is equally concerned with reproductive futures and anxieties about gender and kinship.

Pharaonic circumcision, where external flesh including the labia minora and majora and the clitoris are removed and the remaining skin is sewn together, mirrors cesarean sections in that the body is opened and then closed. Both leave scars, an indication of past acts and future potentials. Girls in Somalia, where female circumcision is near universal and pharaonic is the most common form, usually undergo the procedure between the ages of four and ten. In Eastleigh, some younger women expressed a desire to perform slightly more moderate forms of circumcision on their daughters, and some even contemplated abandoning the practice altogether, but pharaonic remained the most common practice.

The most prominent explanation for circumcision was that it curbed women and girls' erotic desires so as to prevent sexual activity outside of marriage. Such behavior would in itself be shameful, but more importantly could produce children that ruptured processes of patriarchal lineage and could not be recognized as legitimate in the eyes of God. Circumcising girls

before they became sexually aware was therefore intended to protect the futures of the girl, her family, her future husband's lineage, and their future children. With so much emphasis placed on female chastity and reproductive purity, it is perhaps surprising that divorce and remarriage are common among Somalis in Eastleigh and elsewhere. A woman might contribute children to multiple lineages throughout her life, therefore purity is not simply a question of virginity, but the ability of women to repeatedly produce children that are legitimate in the eyes of her husband and God.

As the visible exterior of essential interior processes, vulvas are therefore a central focus for future prosperity, extending well beyond the individual. Reminders of this significance re-emerge periodically, such as at marriage, when a woman becomes sexually active and is "opened" and once again at childbirth, when she is opened even further. Like closing in circumcision, both of these openings are conducted by others. By her husband during sex (unless he is incapable, in which case the woman must be surgically opened by a doctor or by non-medically trained women, often those who perform circumcisions), and later by a medical professional or birth attendant in the form of an episiotomy. These prescribed acts of opening and closing are located in one particular bodily area, which is where cesarean sections notably differ. Opening the abdomen relocates processes of reproduction (social and biological) that have occurred at, in, and through the vulva since childhood.

There is a notable distinction between the meanings of an act and an intimate, bodily understanding of the act itself. Both the abdomen and the vulva are visible to very few people throughout life, particularly in adulthood. People are aware that circumcision takes place, and many women have witnessed it and have had personal experiences of it. Men never witnessed circumcision and had little or no involvement in its planning or performance. In the case of cesarean sections, people had a general idea of what takes place, but no detailed first-hand account of it. Like other highly technical interventions, cesarean sections were shrouded by a

cloud of medical obscurity. In my experience, this mattered very little to the people who encountered it. They were more concerned, as was the case with many medical therapies, with what it did, rather than how or why it did it. Somali women's fears were not about the opening and closing of bodies, but with the opening and closing of future possibilities. In Sudan, like in Somalia and among Somalis in Eastleigh, both male and female circumcision serve to render incomplete bodies suitable for marriage and reproduction (Boddy 2007). Biological sex is insufficient to recognize bodies as appropriately gendered in a way that is necessary to meet the social and moral requirements of those genders. Instead, biological sex as defined by genitals "indicates a potential that needs to be socially clarified and refined. Genital cutting makes it possible for persons to embody their envisioned moral gender" (Boddy 2007, 112). In Eastleigh, abdominal cutting, in the form of C-sections, presents the opposite side of the coin. It negates the possibility for women to fully realize their gender, as defined by the social and moral status of motherhood. Where pharaonic circumcision acts as a "guarantor of kinship" (Boddy 2007, 111), through the maintenance of family honor, the preservation of female chastity, and ensuring "moral motherhood," C-sections can be understood as an inhibitor of kinship, as they limit the capacity to produce legitimate kinship.

Circumcision as a symbolic act brings sharply into focus the *fertility potential* of women by dramatically de-emphasizing their inherent sexuality. By insisting on circumcision for their daughters, women assert their social indispensability, an importance that is not as the sexual partners of their husbands, nor, in this highly segregated, male-authoritative society, as their servants, sexual or otherwise, but as the *mothers of men*. (Boddy 1982, 687, my emphasis)

Women in such contexts gain social identity and status by becoming less, not more, like men. It is their capacity to produce children that sets them apart. If cesarean sections limit and

eventually end a woman's capacity to bear children, she becomes more masculine and therefore loses her capacity to be socially and physically productive and her morally valorized status as a mother. This is not a question of bodies becoming visibly more or less masculine or feminine, but of the prestige that emanates from women's capacity to perform gendered expectations by conceiving, gestating, and delivering many children.

Migration and Motherhood

Perceptions of C-sections and the implications they have for future fertility must be understood in relation to precarious displacement and desires for onward migration. The notoriety of Eastleigh as a distinctly Somali neighborhood has expanded internationally over recent years, as a result of its assumed associations with Islamic fundamentalism and terrorism, as depicted (highly inaccurately) in the 2015 film *Eye in the Sky*. In Kenya, Eastleigh is renowned as a significant commercial hub, where regional wholesale traders and local shoppers converge for food, clothes, homeware, and electrical goods. The economic, political, and environmental instability in the region has resulted in Kenya hosting refugees from several of its neighboring countries, most notably Somalia, Ethiopia, and South Sudan. Kenya introduced an encampment policy in the early 1990s in an attempt to contain the diverse refugee populations, and eventually condensed several camps scattered across the country into two large camps, managed by the United Nations High Commission for Refugees (UNHCR). Kakuma in the north has hosted a fluctuating population of refugees, while Dadaab, the oldest and, until recently, largest refugee camp in the world, has primarily hosted people fleeing periodic bouts of conflict, drought, and famine in Somalia. Despite the widespread hostility towards Somalis in Kenya and the provision of basic accommodation, schooling, and health care in Dadaab and Kakuma, tens of thousands of Somalis have left the camps, or have avoided them altogether, and have opted to live elsewhere in the country, most notably in Eastleigh. Little Mogadishu has long been home to

a significant Somali population (Lochery 2012), including both immigrants and ethnically Somali Kenyan citizens, but the outbreak of the war in Somalia in 1991 rapidly increased the number of Somalis in the neighborhood.

The visibility of the large but legally dubious Somali population in Eastleigh, coupled with a thriving business community, has made Eastleigh a hotspot for harassment, extortion, and arrests at the hands of the Kenyan police and military. Following terrorist attacks on an upmarket shopping mall in Nairobi in 2013 and on students at Garissa University in 2015, both of which were immediately but inaccurately attributed to Somalis, the everyday violence that was a mainstay of life in Eastleigh intensified to include extensive police crackdowns, mass detentions in makeshift camps, forced deportations, and an increasing number of extrajudicial killings. The Kenyan government formally responded to the terrorist attacks by reiterating its longstanding threats to close Dadaab and return the population to Somalia^{ii[2]}. At the time of fieldwork, refugees and their descendants were only allowed to remain in Kenya on a temporary basis and were supposed to remain within the camps. The protracted conflict has resulted in multiple generations of “refugees” growing up in limbo, prohibited to work, and largely disconnected from the state. This exclusion (which in reality was far more porous, as some Somalis can marry Kenyan citizens or procure forged identity documents) reinforced Somalis’ sense of being temporary in Kenya, while they perceived their ties to relatives in other countries as being durable. Most people aspired to neither a sense of belonging or the potential for socio-economic gains that permanent legal residence might enable. Somalis derived a sense of belonging in family and Somali national identity, and rejected the possibility of “becoming Kenyan.” Somalis and Kenyans regularly expressed disdain for each other and accused each other of being moral degenerates and religiously inferior. The one Somali woman I knew who married a Kenyan man who was not ethnically Somali was disowned by her family for doing so.

A generation of conflict has produced Somali enclaves across the world, notably in North America and Northern Europe. The precarity and violence of life in Kenya and the apparent affluence and security of life “outside” make onward migration an obvious attraction. Resettlement is the luxury of a tiny percentage of refugees, therefore most people seek alternative routes that are financially and logistically supported by remittances sent from relatives already living in more affluent settings. Illicit migration was broadly seen as too risky for women traveling without male kin, thereby confining them to the obstructive bureaucratic processes of visa applications and family reunification. Somali women’s experiences and opportunities were grounded in their roles as daughters, sisters, mothers, and wives, emphasizing the deeply gendered nature of migration and the significance of kinship networks.

Regardless of whether onward migration was illicit or official, everyone depended on transnational kinship networks, where biological relationships were defined by Somalis as stronger and more legitimate than marriage. Somali men and women were aware that, in order to obtain visas or family reunification, the state required them to produce evidence, such as birth or marriage certificates, or blood for DNA testing. Like Somalis themselves, the bureaucratic regulations for migration often draw on specific concepts of the family as the primary unit of belonging, with blood relations perceived as the most authentic and verifiable.

Somali women in Nairobi were evidently using such policies in order to make strategic decisions in relation to marriage and childbearing. The gendered expectations of women are produced at the intersections of local and transnational sociopolitical entanglements, and for Somali women this includes international migration and citizenship policies, an ongoing war, and contemporary discourses of terrorism and security. Bearing many children therefore emerges as a “tactical manoeuvre” to pursue a safer future than the one currently available

(Challinor 2017, 135). Somali women recognized that marrying a man who might have the social and economic capacity and opportunity to migrate out of Kenya was a practical strategy to improve their own chances of migrating, but only if they were able to secure their relationships through the production of multiple children.

Marrying and bearing children did not become such a focus only when people were displaced. In Somalia, people consider producing large families to be a religious and cultural imperative. As a gender-defining role, motherhood can be understood as both a “quest for conception” (Inhorn 1994) and a “patriarchal fertility mandate” (Inhorn 2000, 139), and in high fertility societies women can endure profound suffering if they fail to reproduce and achieve the status of “culturally valorized motherhood” (Inhorn 2000, 143). Displaced women in Eastleigh considered it an essential duty in their roles as Muslim women, wives, and mothers. For migrant women, pregnancy, childbirth, and raising infants can produce new responsibilities, new encounters with the state or other regimes of power, and the challenge of negotiating complex medical systems in a foreign country, often with limited social or familial support.

When I first met her in Eastleigh, Fatuma, a 19 year old who was born as a refugee to Somali parents in Kenya, was cautiously excited about being pregnant with twins. She had been married for several months and had already lost one pregnancy. “My husband was very disappointed the last time. He was sure it was a son. The whole family (her husband’s family) was unhappy. Now that I have two it helps.” Fatuma, like other Somali women, continued to belong to her agnatic family, even after marriage. Her ability to produce children was crucial to the success of her relationship with her husband, and her status within his immediate family and clan.

Although children belong to their father’s family throughout life, the maternal-child bond is perceived as perhaps the most unyielding relationship, which allows women to achieve a

potentially impermanent yet significant status amongst their affines. In Somalia, and in cases where families were present in Kenya, divorced women usually return to their own family in the event of divorce. The status of women like Fatuma within her husband's family was impacted by a context of displacement in which it was not always possible to return to or rely on one's own kin.

The temporary nature of life in Eastleigh, with people continually moving in and out of the area, between Somalia, the camps, and beyond Kenya, meant that women were acutely aware of the pressures to reproduce. Fatuma's immediate family had all left Kenya or died, which left her with only distant relatives to rely on if her marriage failed. This was the case for, Safiya, a 21-year-old Somali woman who lived in an apartment in Eastleigh with her aunts (women who belonged to her father's clan) and her three-year-old daughter. Two years earlier her husband had been resettled in Sweden with his mother and sisters, as part of a UNHCR recognized family unit. Like many refugees in Eastleigh, her husband feared that if he informed UNHCR that he was married with a child, he would no longer be considered part of his mother's family for resettlement. Although his mother regularly sent her money, Safiya only had sporadic contact with her husband. "I don't think he will ever help us get out (of Kenya), so I need to find my own way. I have family in Ohio, so we will try to go there." Resigned about the deterioration of her marriage, she was primarily concerned not about her relationship with her estranged husband, but her ability to migrate and find future security for herself and her child.

Many women in Eastleigh lived in similar situations, sharing accommodation with other women and their children, combining their income from remittances and occasional work selling clothes or tea. Some maintained contact with their husbands and were optimistic about eventually reuniting with them, while others had given up, lost contact, or had divorced.

Women like Safiya, with only one or two children, were most likely to comment that they had been abandoned or left to wait indefinitely.

Popular discourse about “good Somali women” drew together Islamic ideals of marriage and motherhood that emphasized bearing and raising children who are well versed in Somali language and culture, in an often-hostile migratory setting. For men, decisions around family and reproduction were caught in the tension to fulfil their own gendered and religious expectations and their desire to migrate, which were far more likely to depend on financial support from natal kin, rather than marriage or procreation.

In conversations about marriage, men usually discussed the quality of women in terms of their ability to reproduce children and care for others. Abdikadir, a young man who had grown up in Kakuma refugee camp, was visibly relieved when his wife Halimo finally delivered their first child, a son, after being told that she would need a cesarean section. The consultant had been delayed in traffic, and Halimo was in excruciating pain when a senior midwife was able to manipulate the infant’s position with an internal-external version, with one hand inside the uterus and the other externally positioned on Halimo’s abdomen, and aid her to deliver vaginally.

Although it was a combination of circumstances – a delayed physician, a highly skilled and experienced midwife, and the perseverance of Halimo – that resulted in the safe delivery of the child, Abdikadir beamed as he praised his wife’s love for him and their son, which had given her the strength to deliver vaginally. Family members congratulated him on being a “real man” now that he had become a father. The birth of a son meant that his new status of fatherhood was compounded by a continuation of his lineage, as Abdikadir told me, “Halimo is a good woman. A strong woman. And now a mother! *Masha ‘Allah, Alhamdulillah* (Praise to God, thanks to God) I have a good wife. They said she would need the operation, but she was strong enough to bring the boy even before the doctor arrived!”

Conceiving, gestating, and delivering a son were perceived as acts of love and devotion that transformed Halimo and Abdikadir into parents and therefore full adults, solidified their marriage into a family, and contributed a male heir to carry his father's name and clan. While a daughter would not have the same significance for the patriline, the birth of children, and especially the firstborn, was always a moment of celebration. Halimo's success was particularly pertinent for her, as Abdikadir had an unusually large family in Kenya, with his parents and several siblings spread across Nairobi, Mombasa, and Dadaab refugee camp. He and Halimo had therefore been able to continue patrilocal residence, a practice that for others had been disrupted by displacement and the dislocation of families. Halimo had felt pressure to produce children as soon as possible, and she later told me that the "threat" of a cesarean section also felt like a threat to her position in the family. A painful and prolonged vaginal delivery of a son, despite a recommended cesarean section, had cemented her position as a wife and mother committed to her family.

The acts of marital and maternal devotion are embodied in the physical demands of pregnancy, childbirth and infant rearing, acts of love that many people stated were impossible for children to ever fully reciprocate. There was a widespread perception that women who had "the operation" were not strong enough to give birth vaginally because of personal, physical, or emotional deficiency, and many people raised questions about the woman's suitability as a mother. It is evident that fears of infertility, or the inability to produce children, can be intrinsically bound to fears for the future of marriage (Pashigan 2002, 134).

Displaced Births and Private Hospitals

The state-run Pumwani Maternity Hospital, the largest maternity institution in East Africa, is located immediately adjacent to Eastleigh, and another government clinic with basic maternity facilities was situated within Eastleigh itself, however, almost all women I met opted to deliver in private hospitals. Government institutions, in partnership with UNHCR,

provided basic prenatal and childbirth services to refugees for a nominal registration fee, on par with Kenyan citizens. The terrible reputation of government facilities, particularly Pumwani, meant that Kenyan and refugee women avoided them wherever possible, and went to private institutions, despite the substantial fees.

Somalis in Nairobi were in the unusual position of being socially marginalized in the city, yet dominant as residents and consumers in Eastleigh. To the physicians, who were often Kenyan, Somali women were simultaneously undesirable migrants and valuable customers. Unlike contexts in which migrants are framed as a drain on health services (Goldade 2011; Makandwa and Vearey 2017; Willen 2012), Somalis were economically contributing to a plethora of clinics, pharmacies, and hospitals. Their roles as patient-consumers of medical services allowed them to circumnavigate the surveillance and management that is usually a mainstay of obstetric care.

Women and their families chose hospitals based on recommendations from relatives and friends. Some hospitals gained reputations for particular strengths, such as fertility treatments or simple comforts like hot running water, while rumors spread rapidly about inadequate services, and notably about hospitals that were perceived to be too quick to suggest a C-section. For undocumented migrants, private facilities also offered a degree of distance between themselves and the state, as well as the ability to assert which therapies they did or did not want. During group discussions on medical care, Somali women and men told me that they were acutely afraid of non-consensual sterilization, particularly when doctors recommended contraceptives^{iii[3]}. Somali women frequently rejected HIV testing, a routine aspect of prenatal care in Kenya, on the grounds that it was an insult to married women, and many were also suspicious that it might be a secret government plot to infect Somalis with the virus. Midwives often expressed exasperation at trying to provide care for Somali women who frequently resisted medical processes that were, from the midwives' perspectives,

intended to keep them safe. They perceived refusing C-sections that would result in the death of their child as bad mothering. This refusal was consistent with the perception of Somalis as irrational, unruly, and dangerous.

In these situations, women and their families were equally aware that the child might die without surgical intervention, but as many people argued, whether the child lived or died was ultimately determined by God. During interviews and numerous conversations in hospital waiting rooms, Somali women told me that they feared both the operation itself and the potential long-term consequences of a C-section. Many of the people I met in Eastleigh's hospitals feared surgical procedures in general. While discussing this with one young man who was hanging around the waiting area while his sister was in labor, he joked, "can you imagine what operations are like in Somalia? Would you want one?" then adding in a more serious tone, "this is Africa, if someone goes for an operation, you can't be sure they'll wake up."

This fear was reflected in many conversations I had with people on the topic of surgery, but was most evident in the case of Saido, a young woman who appeared substantially older than her mid-twenties. Saido was living in Somalia when she went into labor with her first child. She told me that her labor was prolonged and the delivery obstructed and so it was decided at some point, although it was unclear by whom, that she would need to have a cesarean.

According to the doctors who cared for Saido in Nairobi, it appeared that whoever cut her belly had little if any medical training. Saido's problems during delivery had left her with an obstetric fistula and as a result of the attempted cesarean, she had a gaping wound stretching across her abdomen. Saido's baby did not survive and she struggled to recover. Her family decided to take her to Kenya for medical care, and brought her to Dadaab refugee camp where physicians assessed her and, because of their limited capacity, took her to Nairobi. The doctors and nurses who cared for Saido remarked to me that they had doubted whether she

would survive, and were amazed at how well she had recovered. It took several surgeries and months in hospital before Saido was well enough to leave. Whenever I spoke to her, Saido seemed cheerful and only ever spoke about her injuries and her loss in terms of her gratitude towards those who had helped her survive. Although her case was the most extreme that I encountered, it illustrates explicitly why many people had such a strong fear of surgery and cesareans more specifically. Although she recovered, Saido will never have children, which will almost certainly have ramifications for her future.

Another reaction, and one that was readily evident, was that cesarean sections are considerably more expensive than vaginal deliveries. With all costs included, they could exceed 100,000 Kenyan shillings (roughly US\$1000 – vaginal deliveries were a tenth of that). Although high costs and fears of surgery are valid concerns, I found women and their families to be broadly in favor of biomedical interventions, from treatment for infertility, to the uptake of pregnancy testing and particular forms of antenatal care, as well as the near universality of deliveries taking place in medical facilities. Somalis in Eastleigh, it appeared to me, were not only willing to undergo medical procedures, they were also prepared to pay a great deal of money for them, often gathering hundreds or even thousands of US dollars from across the diaspora to pay for it.

Cesarean Sections and Onward Migration

In this pronatalist and uncertain context, the threat that cesarean sections posed to future fertility was understood by Somali women as a threat to their marital, socio-economic and migratory prospects. During my research, women who had cesarean deliveries were recommended cesareans for all future deliveries, as they were categorized as “high risk” for complications including uterine rupture. I did not observe or hear of any attempts at vaginal birth after cesarean (VBAC) as occur in other contexts. This had little to do with the medical procedure itself, indeed VBACs were routinely practiced in hospitals in more affluent parts

of the city. The reluctance in Eastleigh reflected the anxieties felt by medical staff that they were responsible for the women in their care and the reputation of their hospital. Physicians and midwives suggested that scheduled C-sections were a safer option than attempting VBACs when emergency obstetric care was not available consistently, and patients might ignore their medical advice if they thought another option was available.

Somali women emphasized this necessity of further C-sections and the associated threat to future fertility in interviews, informal conversations, and when I observed women speaking to doctors and nurses. Although my interlocutors had different degrees of understanding of what the operation involved, women and men unfailingly stressed to me that it limited the number of future pregnancies and deliveries a woman can have, and many were specific that they understood it to mean that you can only have two or three more^{iv[4]}. I heard women discuss this limitation during appointments with obstetricians, and on several occasions the physician used it as an opportunity to suggest sterilization. Somali women and men, commonly discussed it as a warning about the threat of C-sections. As one woman stated, “If it’s your first baby and you have to have a cesarean then you know that you can only have a few more. It doesn’t matter so much if you already have six or seven children, but if you don’t have any, or maybe only one, then it’s a problem.”

Throughout the world, Cesarean sections are a technological response to the messy, unpredictable nature of childbirth. Their routinization further reproduces the perception of women and their sexual and reproductive capacities as pathological and in need of control, with an assumption that pregnancy and birth can be managed and their outcomes predetermined (Davis-Floyd 1998, 1992; Jordan 1997; Sargent and Browner 2005). This perception of control is particularly apparent in the prenatal expectations of affluent women when compared with those of working class and lower status women (Martin 1990; Layne 2003).

Women in Eastleigh were very conscious that they had limited control over their lives, reproductive, migratory, and otherwise. Yet, in the case of cesarean sections, women and their families were in a position in which they could make decisions that could have a potential impact on their reproductive futures. More specifically, they were in a perceived position of control, albeit one that must always be tempered in light of God's will. Put simply, if God intended for a child to live or die, it would, regardless of any medical interventions. Yet the refusal of cesarean sections presents a way in which women can maintain some control over their reproductive capacities and futures in an otherwise precarious context.

Technical interventions in the practices of reproduction can illuminate the complexities that occur when kinship and science merge. In pronatalist contexts this is particularly vivid, as we see the politics of women's bodies, as crucial to the reproduction of both families and nations, emerge as a site of private and public concern. Pronatalism situated within a context of religious nationalism can naturalize particular reproductive interventions. For example, in Israel, the country with the highest rate of fertility clinics per capita, where fertility treatments are fully subsidized by the state, national pronatalism and religious doctrine coalesce in reproductive interventions (Kahn 2000). Despite the exclusion of undocumented migrants from medical services and the state more broadly, partial access to prenatal care, delivery, and infant immunizations present exceptional zones of inclusion in Israel, which has been partly attributed to historic national pronatalism (Willen 2005, 71). Medical technologies become a powerful technique for religious and nationalist politics where the production of mothers and children are perceived as the reproduction of citizens and the nation itself. In Turkey, cesarean sections have been politically framed as an "antinatalist procedure" (Erten 2015, 8) that limit national growth. State attempts to reduce C-sections,

and even ban them unless medically necessary, reflect desires to put idealized womanhood and reproduction at the center of tropes about national identity and productivity.

In Eastleigh, people refused C-sections for familial rather than national concerns, but had similar anxieties about protecting the purity and prosperity of future generations. Where wealth – in its broadest definition – is amassed through the reproduction of kinship networks, C-sections can be seen to significantly weaken women’s capacity to draw on and contribute to such networks by limiting their ability to produce many children. Facing multiple forms of structural oppression, as African, Muslim refugee women, with constrained strategies for maneuver, fertility can be understood as the “one great gift” (Boddy 1982, 683) bestowed on girls and women who are otherwise marginalized. In Eastleigh, as in Turkey, Israel, and many other places, women’s capacity to control that gift speaks to their status and significance within society. In moments of social or political unrest, the capacity to achieve motherhood can be fundamental to realizing social and economic status and security, by performing and producing of kinship.

Motherhood, on moral and practical levels, is therefore central to attempts to mitigate risk and create desirable futures. Agency in this context of social and medical uncertainty is not the implementation of prior intentions and rational choice in order to achieve future plans, but is the conscious attempt to navigate the unpredictability of displacement, fragile kinship bonds, and childbearing through “judicious opportunism” (Johnson-Hanks 2005, 370). Rather than pursuing specific and clearly defined goals, women perform motherhood as a process of social and moral fulfilment that is deeply embedded in equally uncertain avenues for onward migration. In Eastleigh, the future may depend on God’s will, but women were acutely aware of the divine role of motherhood, the possibilities it can present, and the fate that awaits those women who fail to attain it.

Using medical therapies to pursue motherhood allows women to perform gendered expectations in visible ways. Yet cesarean sections are an ambiguous technology that can facilitate motherhood by saving the lives of women and their infants and reducing serious injury, while at the same time denying it by limiting the possibility of future childbearing. Cesarean sections are a heavily relied upon solution to obstetric problems, yet they can result in profound crises for women and their families who perceive motherhood not in the singular act of producing a child, but in the ongoing process of perpetual reproduction.

Reproductive technologies can illuminate the fragility of “the once taken-for-granted relationship between citizenship, nation, and state” (Deomampo 2015, 211), and the assumptions relating to ideas of blood, kinship, and nationality. Kinship in contexts where citizenship has been rendered empty emphasizes the needs for other forms of belonging, and in this case the reliance on motherhood as achieved through multiple and regular pregnancies.

Mothing Futures

Somali women’s refusal of a medical procedure intended to save lives, although often perceived as irrational, draws attention to the multifaceted local and global forces that shape experiences of displacement. Rather than simply blaming “patriarchy,” the persistence of such refusals are enactments of a limited yet active response to the social and political shifts that have taken place in these women’s lives. Whether we refer to the patriarchy of biomedicine or of Somali society in Eastleigh, both are too simplistic to grasp the complex intersection of multiple forces that Somali refugee women face. The relentless significance of fertility and reproduction clearly does not speak to a static, unchanging religious or cultural imperative to bear children, but to the ways in which fertility, reproduction, and motherhood can take on new significance within dramatically shifting social terrains.

People living in precarious or otherwise marginal contexts can respond by refusing to plan for the future, opting instead to “live for the moment” (Day, Papataxiarchis, and Stewart

2000). The perception of refugees as trapped in a relentless present, stripped of their past and future, and with only scarce opportunities for local settlement or migration, might suggest that living for the moment is the only option available. Yet protecting the possibility of recurrent childbearing and migration are future-oriented goals that require a degree of long-range planning. Somali women's refusal of emergency surgery is an act "in the moment" that may appear irrational. Yet the refusal of emergency medical care is an attempt by people in extreme precarity to exercise autonomy and authority, and make decisions for their futures. Central to this long-term planning and decision making is the role of the mother, the obligations it demands, and the ways in which it must be pursued and performed. Control of the body, in this context by genital cutting or refusing cesarean sections, indicates control over the process and status of motherhood. Only adequately gendered and fertile bodies are capable of producing the appropriate relationships that allow women to be mothers and to engage in broader familial networks. To be a mother is not defined by an individual relationship to one child, but can be achieved to greater or lesser extents through multiple pregnancies and deliveries. Motherhood is not only a status, therefore, but an ongoing performative process of becoming that is enhanced by the successful birth of each child and ideally continues throughout a woman's reproductive life.

Crucially, the concept of motherhood can simultaneously be a variable status and a highly productive social process that renders women meaningful. It is through this rendering that new, long-ranging networks of belonging can be produced, and fragile relationships, including those with children and their paternal kin, can be made to appear lasting. In diverse patriarchal contexts where women's agency is highly constrained, becoming a mother, and particularly a mother of men, can transform women from insignificant individuals and patrilineal dead ends, to a position that is worthy of recognition. It is through this

transformation that motherhood can be utilized by women as a technique to pursue future goals and desires.

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^{i[1]} I have changed all names in this manuscript for the purpose of anonymity. I have used anglicized versions of Somali names for the benefit of non-Somali readers (Halimo instead of Xalimo, Abdikadir instead of Cabdiqadir). The participants in this research were accustomed to using both, due to the prevalence of English names on Kenyan government and refugee documents.

^{ii[2]} As of February 2017, the Kenyan High court has blocked the government’s decision to close Dadaab refugee camp.

^{iii[3]} The American Center for Disease Control and Prevention, among others, attributed a measles outbreak in Minnesota in 2017 to the low uptake of the MMR vaccine among Somali Americans. Somali parents refuse the vaccine because they fear that it can cause autism, a

belief that neither originated with nor is exclusive to Somalis (Leslie et al. 2018, 1810). This fear of concealed consequences of medical interventions and mistrust of practitioners are similar to what I observed in Nairobi. In Eastleigh, however, Somalis were primarily suspicious of interventions on adult reproductive capacities, rather than childhood vaccinations.

^{iv[4]} I met one woman who was about to have her sixth cesarean delivery, however this was highly unusual.