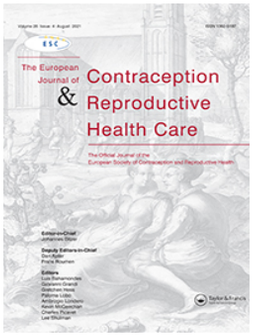

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RESEARCH ARTICLE

Culture clash of female Somali adolescents and sexual and reproductive health services in Oslo, Norway

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ABSTRACT

Objective: Culture influences an individual's perception of health needs. The influence of culture also applies to Somali individuals' perception of their sexual and reproductive health (SRH) and uptake of related services. An understanding of female Somali adolescents' SRH needs is vital to achieve inclusive health coverage. No research has, however, been conducted to explore the SRH needs of this population group in Oslo; hence, the aim of this qualitative study was to minimise the knowledge gap.

Methods: Fourteen young women aged 16–20 years were recruited using the snowball technique with purposive sampling. In-depth interviews using a semi-structured interview guide were used to collect data, and thematic analysis was applied.

Results: Participants perceived SRH as a very private matter and open discussion of SRH was extremely limited owing to certain Somali cultural beliefs and values. As the participants intend to practise chastity before marriage, they believed that existing SRH services were largely irrelevant and inappropriate. Where they felt the need to access SRH services, participants wished to do so in a way they considered culturally appropriate.

Conclusion: Somali culture markedly influences individuals' perceptions of SRH services. It is recommended to modify existing SRH services by increasing confidentiality and anonymity in order to take into account the cultural requirements of female Somali adolescents.

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KEYWORDS
Culture; female Somali adolescents; immigrant youth; Norway; sexual and reproductive health services

Introduction

Adolescents comprise one-sixth of the current world population [1]. Adolescence brings about various physical and mental changes that may influence a young person's perceptions of their health and health needs [2]. Adolescents are more vulnerable to negative and/or unintended health outcomes in comparison with other age groups [3]. This particularly applies to female adolescents, who are more at risk in terms of their sexual and reproductive health (SRH), owing to their physiology and the gender inequality enforced by certain cultural norms [4]. It has been estimated that 2.1 million unplanned births, 3.2 million abortions and 5600 maternal deaths could be prevented each year if female adolescents comprehensively benefitted from contraceptive use [5]. Globally each year there are 44 births for every 1000 female adolescents, and 3.9 million out of the 5.6 million adolescent abortions performed annually are estimated to be unsafe [5].

Female adolescents often feel uncomfortable seeking SRH care, largely because of cultural influences, confidentiality concerns and uncertainty about the health care services available to them [3,4]. Perceptions of SRH are culturally modified and are greatly influenced by individual and group expectations [6,7]. In sociocultural contexts where sexuality is considered to be an inappropriate topic for open discussion and attitudes towards health care vary, research shows that adolescents may be highly reluctant to engage with SRH services [4,8].

Somali culture and SRH

An individual's culture, including their family values, traditions and religion, affects their views on SRH [4,9]. People who migrate from a region with relatively conservative values to one that is generally more liberal are likely to have different attitudes towards SRH services from those of the host population [9–11]. This may lead them to significantly underuse available SRH services [6,12]. Somali women living in Norway have the highest fertility rate in the country [12] and contraceptive use among immigrant women in general is quite low in comparison with that of the host population [13]. The unmet need for contraception among Somali women in Oslo has been estimated to be 20.2%, which is more than twice as high as that in the rest of Norway and other Scandinavian countries [12]. Statistics Norway estimates that Somalis constitute the largest non-Western immigrant group in Norway, numbering 42,802 people [14]. Somalis in particular require the attention of the SRH services: Open Society Foundations estimated that, in 2013, 80% of Norwegians born to Somali parents were

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below 10 years of age and therefore on course to embark on adolescence [15].

Somali culture is built upon traditional Islamic teachings in which sexual conduct, particularly the notion of remaining a virgin until marriage, is important and matters related to sexuality and reproduction are viewed as intensely private [4,9]. Studies have shown that this tends to create a general negativity towards SRH services [9,11] and contraception [12], with women expressing concerns about being judged by their cultural community and, if they were to access SRH services, of being accused of having premarital sexual relations [4,9].

Somali individuals worldwide are reluctant to access SRH services, especially for contraception and family planning advice [12,16,17]. They instead apply their own cultural interpretation of the benefits and importance of contraception [16,18,19]. Also, as SRH needs and services are perceived as a particularly sensitive, private topic, open discussion of SRH is usually avoided [8,20,21]. Furthermore, some Somalis feel their own stance on SRH is directly contested by the free availability and promotion of SRH services [4].

An essential part of ensuring SRH among adolescents requires a programme of awareness and promotion of modern contraceptive methods according to international guidelines [22]. This approach is highly controversial for Somali immigrant communities [4,21]. Controversy particularly applies to the comprehensive, secular type of sexuality education that is prevalent in the Western world, as it presents as acceptable certain behaviours that many Somali immigrants believe to be forbidden, such as premarital sexual relations [4,21]. Notably, Somali women have been found to have a strong desire to adhere to the principles of their culture and Islamic faith [10]. Nonetheless, they wish to use SRH services when they believe they are appropriate [10]. The implementation of SRH measures may, however, be challenging owing to the conflict between Somali culture and the westernised care delivery system [10].

SRH services for adolescents in Oslo

Although SRH services tailored to the needs of adolescents have been given global priority for several decades, meeting adolescents' SRH needs is an ongoing public health concern [3]. In Norway, especially in Oslo, various youth programmes have been implemented that focus on approaches to prevent negative outcomes of sexual engagement and relationships. These services are provided free of charge and include counselling and provision of contraceptives, sexuality education sessions in schools, testing and treatment for sexually transmitted infections (STIs), pregnancy testing and information about abortion. Despite the intention for Oslo's SRH programmes to be adolescent-friendly, uptake of SRH services among Somali adolescents has been at a notably lower rate than hoped [4]. Measurements of how suitable these services are for the intended population group appear not to have considered the cultural standards of female Somali adolescents in Oslo, which generally contrast with those of the native Western majority [20].

There has been no previous research on the use of SRH services by female Somali adolescents in Oslo, despite their need for these services. This study was therefore performed to explore perceptions of SRH services among female Somali adolescents in Oslo; understand the cultural influences on SRH service uptake; and gain information that could contribute to the development of strategies for maximum outreach, or to modify existing SRH services, so that the Somali perspective is taken into consideration.

Methods

Study setting and recruitment procedure

Qualitative research using in-depth interviews was carried out in Oslo. As the city has the highest Somali population in Norway (15,915, of whom 6171 are Norwegians born to Somali parents) [14], the chosen interview technique maximised the chances of acquiring an optimal number of participants.

The inclusion criteria were female sex and having both parents from Somalia (to avoid a mixed cultural view due to familial diversity); currently living in Oslo; 16–20 years of age; and willing to take part in the study. The age of 20 was chosen as the upper limit, as pregnancy below this age is more complicated and hazardous compared with pregnancy above 20 years of age [5].

The participants were primarily recruited at a youth SRH clinic. Secondary recruitment was undertaken in parallel using the snowball technique, i.e., recruiting from the wider social networks of existing participants or contacts [23].

Data collection

Purposive sampling was used to select individuals who could give the greatest amount of input regarding the phenomenon under study [24]. After giving their informed consent, participants were interviewed in English and the interviews were audio-recorded or transcribed. Pseudonyms were used to protect participants' privacy. In-depth interviews gave participants the space to voice their thoughts in a confidential and comfortable setting and in a place of their choosing. An interview guide based on the Health Belief Model was used to explore participants' perceptions and illustrate the influence of their attitudes, cultural values and belief systems vis-à-vis SRH service-seeking behaviours [25]. This method enabled conversation to flow freely and with flexibility [25]. In-depth interviews continued until the point of saturation was achieved (when no new information was gained and the same information was repeated) [26].

Data analysis

The Health Belief Model was used as a framework and thematic analysis tool. The model explains an individual's health-related behaviour and preventive health service uptake. It can predict whether someone would use a particular service, after taking their personal perspectives into account and working on the assumption that a person would take a health-related action if they felt that by doing so a negative health condition could be avoided. However,

the Health Belief Model requires the person to have a positive expectation of recommended health promotion initiatives and it assumes that they would be confident enough to take the preventive action if they were in a supportive environment [27].

Thematic analyses, in accordance with the Health Belief Model, were based on patterns of meaning found in the interviews that corresponded to the study's central concept [25]. To further develop the themes, previous studies on similar topics that examined Somali and wider Muslim populations in the West were examined.

Interviews were manually coded by identifying remarks made by multiple participants that consistently reflected a certain topic or influence (e.g., opinions on the youth clinic and/or SRH, or the interviewees' identity as Somali and Muslim). Once coding was completed, interviews were separated according to similar expressions of thought within the conversations, and themes were generated by reading and rereading the transcripts, listening to the audio recordings, checking the relevant field notes and drawing up interview summaries to further identify common attitudes.

Ethical issues

The study was conducted according to the Declaration of Helsinki. Ethics clearance was obtained from Norwegian Social Science Data Services (reference no. 50753/3/AGH). The project was exempted from the regional committees for medical research ethics of Norway guidelines (reference no. 2016/1645a).

Rigour was ensured by having participants cross-check transcripts of their own interviews during data collection and by conducting multiple consultations with co-authors and Somali researchers during and after data collection and analysis [28]. Furthermore, cross-checking and summarising of the data analysis and study results were performed by the authors in the process of writing up the project.

Results

The study comprised 14 participants from 48 individuals approached. All participants were Muslim and unmarried and had Somali parents (Table 1). Three main themes emerged from the data: (1) SRH services were not culturally sensitive; (2) SRH services were only suitable for sexually active people; (3) SRH services were irrelevant for the interviewee at the present time.

SRH services not culturally sensitive

The main SRH services under evaluation were initially those provided by a youth clinic in Oslo (Sex and Society, www.sexogsamfunn.no) and listed in Table 2. Participants expressed negative opinions about the promotion of SRH measures for adolescents and the way in which youth SRH services were delivered. Participants showed a strong aversion to attending sexuality education sessions provided by the clinic in their schools:

> [T]here was a video presentation that was … so awkward … I think the total thing was awkward. We were in the back of the class, sitting down in the back to get it over [with] … It was so embarrassing.
>
> Rushana, 17 years old

> I don't remember [the SRH sessions]. I was not quite sure that I should be in the class.
>
> Shabnam, 17 years old

There was also some concern among the participants that attending these sessions, or the clinic, may give the impression that they were not in fact abstinent:

> What is the point of taking [a] class on it? Why [do] they want us to know this? … Do you think we are having it [sex] and pretending? … I am not sexually active. Me and my friends have no reason to be there.
>
> Lilian, 19 years old

The participants felt that the sessions contradicted their principles of privacy and modesty. The majority were, however, willing to discuss SRH services available through general physicians, school nurses and municipal health centres:

> If someone needs help, they can go to the *helsestasjon* [municipal clinic], in school, or [their] general physician … They can go to [the] store for getting [contraceptive] products.
>
> Maria, 18 years old

> [My preferred SRH service provider] would be [the] school health nurse or my doctor.
>
> Sara, 18 years old

The participants placed a good deal of importance on the availability of online SRH services:

> Online services are good options for getting answers. About any personal question … I check online. It is anonymous, right. That's all I need.
>
> Jebin, 20 years old

> I get everything from [the] internet, actually.
>
> Lina, 18 years old

These responses indicate that Somali adolescents perceive SRH as an intensely private subject; and the trust that participants placed in their general practitioner, the school health nurse and internet resources likely reflects an associated desire for confidentiality and anonymity. On the other hand, their unwillingness to engage with SRH services provided by the clinic indicates that open provision of health delivery does not fit their ideal expectation of SRH service provision.

SRH services only suitable for sexually active people

The majority of participants felt that the sexuality education programme, contraception and other SRH services were only useful for sexually active individuals. They recognised that the educational and practical services offered in general were of value but viewed them chiefly as solutions to, or ways to avoid, unwanted health outcomes:

> They can get treatment if they need from the youth clinic, also testing. If there is a chance to get them [STIs], it's best to be sure.
>
> Habiba, 19 years old

> In unprotected sex it is a definite choice to go [to the youth clinic] that can serve on time.
>
> Lilian, 19 years old

Table 1. Demographic data of the study participants ($N = 14$).

Variable	Number
Mean age, years	18.6 (range 16.5–20)
Mean length of residency in Norway, years	16.2 (range 8–20)
Mean length of time spent in education in Norway, years	9.7
Participant recruitment	
Youth SRH clinic	4
Snowball technique	10
Relationship status	
Single	12
In a relationship but not married	2

Table 2. SRH services available at the Sex and Society clinic discussed during interviews.

- Adolescent health services: youth counselling, free contraception, awareness of sexual and reproductive health rights
- Contraceptive services: contraceptive provision, contraceptive counselling
- Sexuality education: at the clinic and in schools
- STI testing and treatment
- Pregnancy testing and information
- Online chat and telephone contact
- Drop-in services, with or without an appointment, from Monday to Thursday 15.00–19.00 h
- Advocacy on policy development for youth SRH
- Awareness campaigns, discussion sessions in national media
- Courses for health professionals

> I think it [sexuality education] is important. To get to know about that [sexual health] and not to have the consequences; and if you get the knowledge then it helps to not to get them or the diseases.
>
> Rushana, 17 years old

When specifically asked about their thoughts on contraception, remarkably similar sentiments were expressed:

> [Contraception is] very important … If you are sexually active and you do not plan to have kids, you need to take the appropriate measures. Not to become pregnant, it's a must-have thing.
>
> Sara, 20 years old

> [Contraception] is very important, as they [sexually active individuals] get the option to prevent pregnancy and to prevent disease.
>
> Lina, 18 years old

The participants acknowledged that SRH services could help to prevent negative SRH outcomes and the opinions they expressed of the services within this specific context were largely positive. Participants' own reluctance to make use of SRH services at the present time (and, to some extent, the underuse of SRH services by female Somali adolescents in general) has been discussed under the first theme and is further explored below.

SRH services currently irrelevant

The prevailing opinion among the participants regarding their SRH needs may be neatly summarised in one of the statements:

> I am not sexually active, so I don't have any SRH needs.
>
> Lilian, 19 years old

Participants believed that female SRH needs were confined solely to conditions such as pregnancy and contracting STIs. Since they intended to remain abstinent until marriage, they did not consider themselves to have SRH needs at present:

> I am quite religious, and my friends [are] too, so we have no special need for them [SRH services].
>
> Lilian, 19 years old

> I have no special health need[s]. Seriously, I [have] never felt any need of that sort.
>
> Halima, under 18 years old (exact age not given)

> I want to know what to do if I get pain [during my] periods, that's all. I don't have much [other] need at the moment.
>
> Jebin, 20 years old

Indeed, several participants echoed the same idea: that they would consider using SRH services, such as those provided by the youth clinic, after marriage:

> For Somali girls it [the clinic] is not a very important service actually … I may need them [the clinic's services] after marriage.
>
> Halima, under 18 years old (exact age not given)

> I want it [contraception] after marriage.
>
> Shabnam, 17 years old

> It [contraceptive provision] is important if someone has a boyfriend or is married.
>
> Maria, 18 years old

That the participants were unmarried, sexually abstinent and felt they had no need to use the services of the clinic supports the tenets of the Health Belief Model (Figure 1): practising abstinence left them with no room for contracting an STI, having an unintended pregnancy or risking an unsafe abortion. Therefore, the likelihood of their seeking preventive services for these issues was non-existent at this stage.

Discussion

Findings and interpretation

The views of this group of female Somali adolescents were strongly influenced by the predominant ideals of their culture and religion, which require sexual abstinence until marriage and discourage open, detailed discussions of matters relating to sexuality and reproduction. These are the principal barriers to the use of SRH services among this population group and they greatly discourage those within it from accessing SRH services [10,20].

The effects of Somali culture on participants' understanding of their SRH needs was clear and eventually determined the sensitivity of the service provision. Our study participants were aware, however, of the importance of

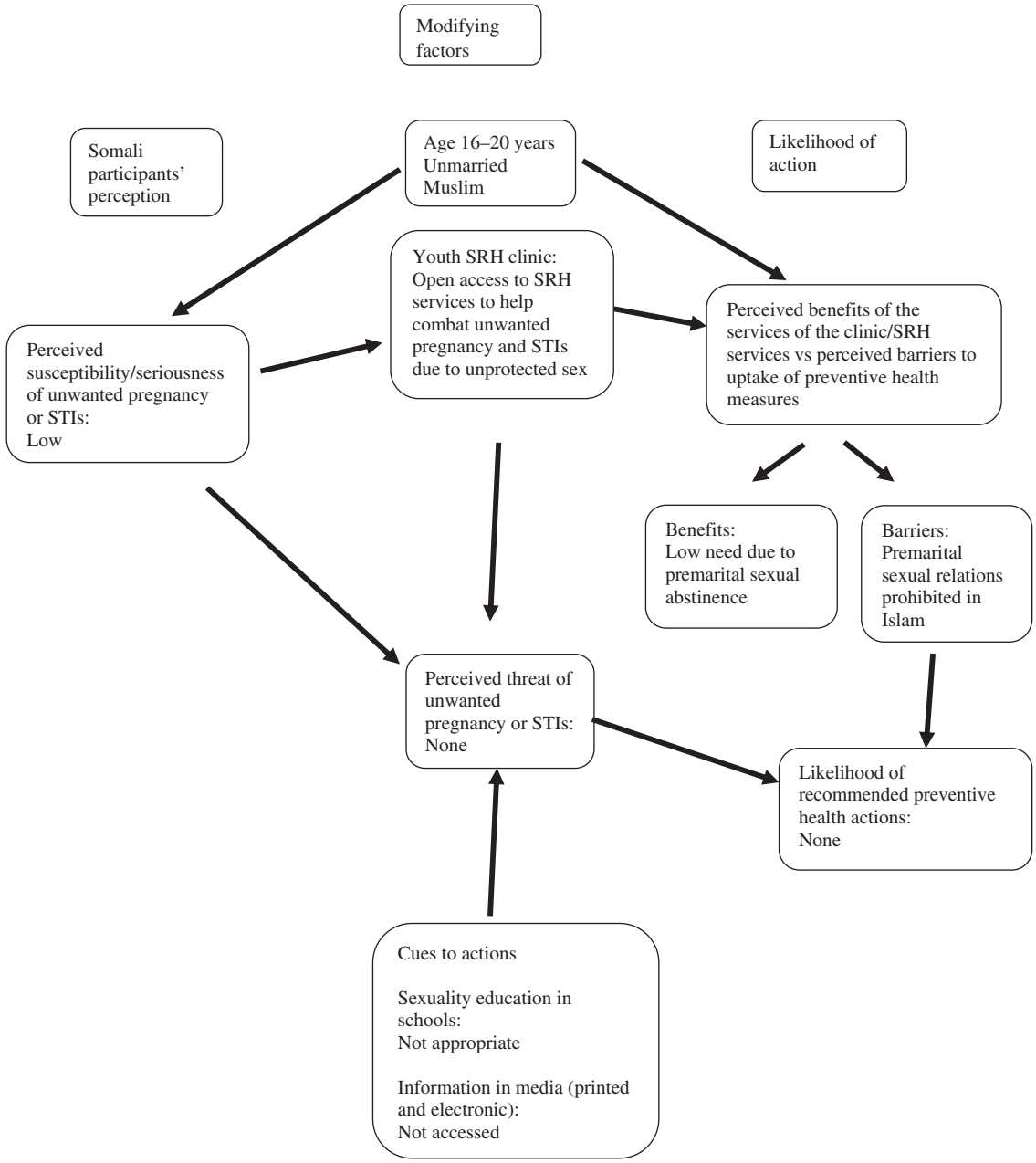

Figure 1. The Health Belief Model illustrating the perceptions of the study participants and the likelihood of their using the available SRH services.

contraception to minimise the potential risks of engaging in sexual activity. Moreover, they showed a preference for greater privacy and confidentiality in SRH service provision [20].

Access to contraception and SRH knowledge may be affected by the enforcement of certain cultural gender roles, which typically takes place within the family and, on a wider scale, within the relevant cultural community [4,9]. Hence, women tend to try to find a balance between their culture and the host country's culture in regard to their SRH needs and service use, which is challenging [10].

Similarities in relation to other studies

The majority of the participants were aware of how sexuality education could inform healthier lifestyles and choices. However, the timing and mode of delivery of sexuality education sessions were considered to be culturally insensitive and inappropriate. Studies on similar population groups have reported the same findings [21,29].

The perception that SRH services were useful only for sexually active individuals was also observed in studies among immigrant Somali women [8,16]. Furthermore, participants' preferences and suggested improvements to existing SRH services for an increased, secure online presence to maintain privacy and cultural sensitivity support the findings of previous studies [3,8].

They clearly defined the circumstances within which they would themselves use contraceptive services, which were, again, clearly influenced by their culture. This study's findings are consistent with wider research which indicates that female Somalis only consider contraceptive services to be relevant once they are married [4,20].

The cultural contrast between Somalia and Norway is stark. While Somalia retains a collectivist perspective on SRH practice [4,9], Norwegian culture places value on informed individual choice [30]. Regular use of contraception is not the norm in Somalia (where the prevalence rate is reported to be $<$10% [12]), with popular opinion on the matter being influenced by the decisions of religious

leaders [19]. Conversely, in Norway, contraception is a popular preventive health measure [13]. Contemporary sexuality education is non-existent in Somalia [4], whereas health awareness programmes constitute a core part of Norwegian public health. Moreover, Somali culture provides a framework for constructing SRH needs solely based on abstinence [4,8,11], which is not the case in Norway [30]. Thus, sexuality education [21], contraception [7,16,17] and general SRH matters [11,20] are controversial because of valued Somali principles of modesty, chastity and sexual accountability.

Strengths and limitations of the study

There are two key strengths of this study. First, the study process is explained clearly and in detail to facilitate similar future research on this sensitive issue. Second, the study provides important information about a minority group, on whom research is limited.

The main limitations of the study are the recruitment process and the language barrier between the participants and the interviewer. Married female Somali adolescents, who could have given rich data on wider perceptions of SRH services, especially those related to contraception, were not included. Moreover, the participation refusal rate of more than 70% and the fact that the majority of the participants were selected during secondary recruitment via snowballing might have led to less variability in the information gathered. However, the follow-up interviews, which enabled sustained communication with participants and allowed a certain amount of trust to develop, limited bias to some extent. Also, the language barrier was addressed as interviews were cross-checked by the participants at least twice, shortly after the main session and/or later by follow-up, to ensure accuracy of the information (participants were requested to have another interview owing to time constraints during the first interaction).

Relevance of the findings

The findings contribute to further understanding about Somali girls' choice of SRH services and decision making as well as barriers to SRH uptake. Recommendations are given to increase the outreach of SRH services.

Future research

To gain a wider perspective of cultural influences on SRH, it would be useful to seek the views of first-generation Somali migrants, young married Somalis and marginal groups such as undocumented and recent Somali migrants. To inform a culturally sensitive sexuality education programme, a study including both male and female Somali adolescents may indicate their expectations and provide recommendations for a culturally inclusive programme. Simplified online services and sexuality education compliance are also potential topics for study. Finally, a comparative study among Somali adolescents and their Western peers could be conducted to measure acceptance of sexuality education and its mode of delivery.

Conclusion

The adolescent period, with all of the challenges of sexual maturity, may become more complicated without access to SRH services. The reach of SRH services may be limited by cultural boundaries that require greater privacy. Strategic changes are recommended to help alleviate the impact of factors limiting SRH service use. Further studies of SRH service use and perceptions of SRH service provision in this particular population would also be beneficial to understand the unique cultural challenges faced by female Somali adolescents.

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