

■ Somalis in Sweden

Sweden is one of the most affluent nations in Western Europe with a sophisticated system of health care; Somalia one of the poorest nations in sub-Saharan Africa with an undeveloped system of health care. Why is that, despite this sophisticated system of health care, perinatal mortality should be higher in Somali immigrants in Sweden than in native-born Swedish women, even after adjustment for social and obstetric risk factors? Birgitta Essen and her colleagues (pages 1507-1512) explored this phenomenon, by conducting qualitative research in fifteen Somali women, many of whom had experienced childbirth in both Somalia and Sweden. The women were similar as regards culture and religion, but different as regards age, parity and social background; thus the results of this qualitative research can be generalized to any group of Somali immigrants in a similar setting. The success of this study depended on the trust between the researchers and the Somali women; this was achieved by the relationship which one of the authors, an anthropologist, had already developed in Somali groups living in Sweden. She conducted detailed interviews in the fifteen women, with the help of an interpreter so that no woman was excluded and ambiguities could be resolved immediately. The interviews were semi-structured with open-ended questions. The transcripts were analysed independently by the two principal investigators who identified four themes: the experience of pregnancy and childbirth in Somalia and in Sweden; nutrition; social network; and female genital mutilation.

Although the Somali women thought well of their antenatal care and their care in labour, their knowledge of the medical aspects of this care was scanty; in particular few women could remember receiving any advice about pain relief in labour. The most startling finding, however, was that many Somali women deliberately reduced their intake of food during pregnancy in order to have a smaller baby and so reduce their risk of a caesarean section. This strategy is understandable in Somalia, where maternal mortality is high and obstructed labour is common, and where caesarean section itself carries a high risk of maternal death; these beliefs were carried over to Sweden. The women took a more fatalistic view of infant mortality, being a predetermined act of God. They were less concerned about female genital mutilation causing obstructed labour than about a large baby causing obstructed labour. The authors conclude that the relationship between the nutritional habits of Somali women in Sweden, the birth-weight of their infants and perinatal mortality should be further explored by quantitative research.

The results of this study are humbling to obstetricians,

for it suggests that the Somali women were little interested in our concepts of good antenatal care. We are educated in a tradition of physical medicine, the diagnosis and treatment of disease. Because pathology in pregnancy in Western countries is now rare, obstetricians' perceptions of antenatal care and care in labour has become subsumed into a vast array of screening tests of greater or lesser reliability in order to predict rare adverse outcomes. But pregnant women's perceptions of antenatal care may differ from our own; the experience of the Somali women is an extreme example of how much these perceptions may differ. Of course it is important as far as possible to avoid adverse outcomes in pregnancy, but the content of antenatal care should also take into account women's perceptions of their antenatal care, determined by qualitative research. Qualitative methods of determining the content of antenatal care should be used not just in well-defined groups of women, but in all populations, and in all societies.

■ Effects of screening for Down's syndrome in a population

Much has been published on the effectiveness of serum screening for Down's syndrome in samples of women attending one maternity unit, but less is known about the effects of serum screening in a population. These effects will depend on the ages of the women, the analytes used for screening, the gestational age at which screening is carried out, and the subsequent tests employed to make a definitive diagnosis of Down's syndrome; but above all the effects of serum screening in a population depend on the proportion of women who accept screening. Tracy Cheffins and her colleagues (pages 1453-1459) examined the secular trends in the prevalence of Down's syndrome in South Australia and the influence of serum screening on these trends. There are four important social aspects to this study which may be peculiar to South Australia: the nature of the Australian health service, which is a mixture of public and private care; the Australian National Health and Medical Research Council's recommendation in 1979 that amniocentesis should be offered to older pregnant women; the introduction of serum screening in 1991; and the Medicare rebate in 1993 for serum screening for women in private care.

The number of older pregnant women increased between 1982 and 1996; the total prevalence of Down's syndrome increased during this time, but the prevalence of births of infants with Down's syndrome decreased by 60 percent. By 1996 more than two-thirds of pregnant women accepted serum screening. The number of older pregnant women undergoing amniocentesis was not altered by serum screening, and this, combined with the effects of

amniocentesis in younger women brought about by serum screening, resulted in one in ten of all pregnant women having an amniocentesis in 1996. Even more astonishing is that just before serum screening was introduced one in eight older women underwent chorion villus sampling. The decline in prevalence of births of infants with Down's syndrome was not apparent until 1994, the year after the Medicare rebate was introduced.

The results of this survey are not surprising; what is remarkable is the magnitude of the decline in the prevalence of births of infants with Down's syndrome. This decline is due to two factors. The women of South Australia generally accept prenatal diagnosis, not only on account of age alone in older women, but also on account of serum screening in younger women, where a large proportion of the pregnant population accepted screening. In populations with a lower acceptance of serum screening the decline in the prevalence of births of infants with Down's syndrome will be less, such that a programme of serum screening may not be cost effective. The second factor is that the decline in the prevalence of births of infants with Down's syndrome was not apparent until after the Medicare rebate, suggesting that for any programme of serum screening to be effective the test should be free to all pregnant women.

■ Pregnancy, not childbirth, causes pelvic floor dysfunction

Several small studies of samples of women attending a single gynaecological unit suggest that urinary and anal incontinence can be prevented by elective caesarean section, but Alastair MacLennan and his colleagues (pages 1460-1470) refute this notion. The authors carried out a large population survey, again in South Australia, to determine the prevalence of urinary and anal incontinence and other features of pelvic floor dysfunction, in men and in women. The main strengths of the study are its design and its size, for the method of selection of the participants minimised bias, and the large number of participants enabled the authors to make some precise estimates of the effects of putative causative factors. Pelvic floor dysfunction was

defined as urinary incontinence (stress or urge); anal incontinence (flatus or faeces); symptoms of prolapse; or an operation for prolapse or urinary incontinence. Any one of these criteria constituted pelvic floor dysfunction.

Women experienced urinary and anal incontinence much more frequently than men. There was a linear trend in the frequency of pelvic floor dysfunction with nulliparity, caesarean section, spontaneous vaginal delivery and instrumental vaginal delivery. In a univariate analysis pelvic floor dysfunction was less frequent after caesarean section than spontaneous vaginal delivery, but this difference disappeared in multivariate analysis, which also showed that pelvic floor dysfunction was more common with instrumental vaginal delivery. There was no difference in the frequency of pelvic floor dysfunction, whether delivery was by elective caesarean section or by caesarean section during labour. It may be thought that since the diagnosis of pelvic floor dysfunction was by self-reporting the symptoms experienced by the women may not have been severe; this is not the case, however, since measurement of quality of life by the Short Form-36 showed that women with pelvic floor dysfunction suffered significant physical and mental distress.

What is remarkable about this paper is not so much the comparisons between the various types of delivery, but the frequency of pelvic floor dysfunction in the population. Thus one in eight women who have never been pregnant had some form of pelvic floor dysfunction, compared with one half of the women who had a caesarean section or a spontaneous vaginal delivery and two-thirds of the women who underwent an instrumental vaginal delivery. MacLennan and colleagues describe this as an epidemic. It is likely that the frequency of pelvic floor dysfunction in this population of Australian women is typical of all women who undergo childbirth. The authors conclude that it is pregnancy which is responsible for pelvic floor dysfunction, and not childbirth, unless this is compounded by instrumental vaginal delivery; and suggest that caesarean section will not reduce the risk of pelvic floor dysfunction, except where instrumental vaginal delivery can be avoided.

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