Cultural Traditions and the Reproductive Health of Somali Women

Comprehensive Research Report

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Abstract

Millions of Somalis began fleeing their country in 1991 to escape the civil war. The greatest risk to Somali women was not surviving the war, but giving birth. Somalia has one of the highest maternal mortality rates in the world, with one in 12 women dying in childbirth. Currently, the largest Diaspora of Somali refugees in the United States reside in Minnesota. Utilizing a qualitative research approach, four focus groups with 25 Somali women, two focus groups with 12 Somali men, one focus group with Somali religious leaders and seven in-depth interviews with U.S. health care professionals were conducted in Minneapolis in August 2012 to help develop culturally appropriate reproductive health programs for Somali mothers. The snowball sampling method was used to recruit participants. Twenty key distinctions between Western medicine and Somali cultural traditions were identified. For many Somali women, prenatal care is a new concept. There is a strong desire for female caregivers; and further, significant differences in childbirth practices exist versus cultural traditions. Women express fears regarding cesarean sections and feel that their providers rush to surgery. Providers’ generally poor understanding of female circumcision leads to birthing complications, including obstetric fistula. All Somali women desire post-partum 40-day family support. Education about safe child spacing methods enables Somali mothers to stay healthy and avoid giving birth annually. Lack of two-way communication with health care providers leads to misunderstandings. Importantly, healthcare professionals who have been working with Somali mothers since they began arriving in the 1990s shared a valuable collection of best practices. To provide culturally appropriate birthing and child spacing experiences, providers must understand cultural traditions related to Somali reproductive health; and in turn, Somalis must be educated on Western medical practices to optimize maternal health in a Western medical environment. Somali-led nonprofit organizations and government agencies have a collective obligation to bring the two populations together to plan interventions for culturally competent health care.
INTRODUCTION

Somalia Conflict and Reproductive Health

Somalis began fleeing their country in 1991 to escape the civil war. Since that time the government has collapsed, an estimated one million people have died and nearly 50 percent of the population has been displaced. The total breakdown of social services from a generation of war has virtually destroyed all maternal health facilities, and has resulted in an abhorrent state of reproductive health care. Since 2010, the Horn of Africa has been experiencing the worst drought and famine in 60 years. By 2011, over 13 million people in Somalia, Kenya, Ethiopia and Djibouti were in need of urgent assistance.

Every day in the Horn of Africa, thousands of Somalis, 80 percent of them women and children, flee their country to find food and shelter in neighboring Kenya, Ethiopia, and Djibouti. According to the UN Food Program, one in five women of childbearing age are likely to be pregnant in such a crisis situation. Sadly, providing emergency relief for millions of people over a prolonged timeframe makes the reproductive health care of pregnant women a low priority.

Further, UNICEF cites that the lifetime risk in Somalia of maternal death in childbirth is one in 12 women. This is one of the highest maternal mortality rates in the world. It compares to one in 2,100 women dying in childbirth in the United States. There are many complex contributors to the high maternal morbidity and mortality in Somalia – including cultural traditions – that form the centerpiece of this research project.

Statement of the Problem

Deeply ingrained cultural and religious traditions influence and often inadvertently impede the reproductive health of Somali women. These traditions fall into five key areas including: childbirth, cesarean sections, family size, child spacing and female circumcision.

According to the World Health Organization (WHO), the average Somali woman gives birth at home with the help of a traditional birth attendant, or family and friends. This is largely driven by culture and the belief in a curative medical model based on going to the hospital only when symptomatic or in severe medical difficulty.

In the case of obstructed or prolonged labor where a life-saving cesarean section is required, these procedures can only be performed with the approval of the woman's father-in-law, and if he is absent, the expectant husband. Many women die from this inability to obtain permission, instead of surviving what normally would be a routine procedure.

There is a high value placed on having large families in Somali society. The Quran states that one of the primary goals of marriage is to produce children and populate the Earth. Children are considered a blessing from Allah, and on average, women in Somalia give birth to 7.3 children during their lifetime.

Contraception is heavily discouraged in Somali tradition. Women often are ostracized in the community for using birth control, and many do not practice child spacing with the exception of the Quran-blessed breast-feeding of infants for two years – which does not always avoid

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future pregnancies. As a result, many Somali women give birth annually which is detrimental to their health, and the health of their infants.

Finally, female circumcision is a deeply ingrained custom in Somalia with one of the highest prevalence rates in the world at 98 percent. The type of circumcision most often performed is infibulation, during which the clitoris, the entire labia minora, and part of the labia majora are removed, and the labia majora is sutured leaving only a small posterior opening for the passage of urine and menstrual flow. This practice often leads to difficult delivery and is one of the main causes of maternal mortality in Somalia.

THE PROJECT

Project Description

This study grew out of an interest in researching the cultural influences that relate to the reproductive health of Somali refugees in the camps at Dadaab, Kenya, near the Somalia border. Due to the instability of the camps, it was not possible to conduct research in Dadaab. Studying immigrants in Minneapolis, Minnesota, where over 50% of U.S. Somalis live, was deemed the preferred method to accomplish the goals of the research.

The project intent was to provide a voice for Somali women who have experienced Western reproductive health practices. Importantly, this research gathered Somali suggestions, and best practices of U.S.-based health care providers who have been working with the Somali community since they began arriving in the 1990s, for more culturally appropriate birthing and child spacing programs that could be offered through Western health clinics and hospitals. The question around which I centered my research is: how can the Western medical community more effectively support the cultural traditions that relate to the reproductive health of Somali women?

The ultimate goal of this research is to build trust between the Somali community and the Western health care providers who serve Somali mothers. The project triangulated the perspectives of: 1) Somali women who have given birth; 2) Somali community members, including men and Imams who influence the cultural/religious traditions surrounding reproductive health; and 3) Western health care providers who support Somali women.

The cornerstone of this research – the interviews with Somali women – was conducted in partnership with Isuroon and under the expert guidance of its Founder and Executive Director Fartun Weli6, who is a Somali immigrant with a degree in public health. Isuroon, the Somali word for “self-empowered women,” is a nonprofit organization focused on the reproductive health, empowerment and health inequality of Somali women. The research with Somali men and Imams was conducted with the support of Dr. Osman Ahmed7, Executive Director of the East Africa Health Project and former Director of the Community Health Department of the Somalia Ministry of Health, who is a Somali immigrant with a background in pediatric medicine.

Research Methodology

The following qualitative research methodology was utilized for each participant group. First, focus groups were conducted with Somali women in partnership with Isuroon. Four focus groups with 25 women total were conducted in the Somali language with the support of the Isuroon translator. Isuroon recruited women who had given birth first in Somalia/or refugee camps, and more recently, to children in the United States. Young women ages 18 to 30 and older women

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6 Written consent was obtained to include Fartun Weli’s name in this report.

7 Verbal consent was obtained to include Dr. Osman Ahmed’s name in this report.
ages 31 to 45 were recruited, and divided into focus groups by age range.

Second, the men were divided into two focus groups with 12 men total. The interviews also were structured along age splits. We also conducted a focus group of three Imams to understand their religious beliefs and interpretations of the Quran as it relates to reproductive health. All of these interviews were conducted in Somali with the support of Dr. Osman’s translator.

Third, one-on-one interviews were conducted with seven Western health care providers including obstetricians, nurses and midwives. The health care providers worked at three clinics/hospitals where many Somali women go for maternal health care.

The participants were sampled in the following manner. For the Somali women and men, the snowball methodology was used to identify potential participants for each group. The Imams were recruited based on Dr. Osman's relationships, identifying leaders from the Dar Al-Hijrah Mosque with rich knowledge of the Quran in the area of reproductive health. Initial health care participants were suggested by the Minnesota Department of Health, and I used the snowball method to identify other providers based on those recommendations.

A critical part of the recruiting process was the solicitation of informed consent. Each potential participant was asked if they would like to take part in a research project, which was described to them. It was explained that the process would be completely voluntary and confidential. Importantly, the interviews were completely anonymous and no personal identifying information was collected. Finally, the Institutional Review Board at the University of San Francisco approved the project in May 2012. The research was completed with the support of Isuroon and the East Africa Health Project between August 21 and September 7, 2012.

CHILDBIRTH JOURNEYS: ETHNOGRAPHY

Childbirth is a universal journey shared by women worldwide. It connects us; it bonds us in unique and unexpected ways. I asked the Somali women – strangers to each other, and especially to me as a Westerner – to share their experiences of childbirth as they made the journey from Somalia, to refugee camps, and finally to the United States. As each woman shared her journey, the memories came flooding out of her. The women laughed; they cried; they hugged each other in support. Just a few short moments ago, they were total strangers, now forever connected through their stories of journeys that ended in a foreign land with medical practices that could not be more different from their own culture, their own religion, their own traditions.

Somalia: The Journey Begins

Childbirth in Somalia is rich in culture and religious traditions, and the courage of its mothers. Women for generations, particularly those in remote parts of the country, and marry as young adolescents, have given birth to their first child in the privacy of their homes. When labor begins, women in the extended family gather around providing emotional, physical, and moral support to the young wife getting ready to give birth. Sometimes, if she is fortunate, a traditional birth attendant joins the gathering. The girl in labor walks around, praying through her pain and contractions. She does not ask for drugs for her pain because there are no drugs available.

This process continues sometimes for days on end, while the women wait for the expectant girl to give birth naturally. If her labor is slow, there is no intervention – Allah will determine when the time is right for the baby to be born. The young girl’s labor is especially difficult because, like almost all Somali women, she has been circumcised as a young girl. But the midwife knows how Somali girls need to be cut –“side to side”– to avoid the “cut to the bottom” [obstetric fistula] and help the baby come out.
At the end of four or five days the Somali girl labors on, exhausted from the pain of her labor – but at last Allah provides – and the midwife or an experienced female elder, holds the expectant young mother from the bottom and guides the baby out. After cleaning the nose and throat, and gently slapping the buttocks, the baby begins to cry. The girl's husband, who has not been permitted in the room because Somali culture forbids it, waits outside with the other men. He hears the cry and now knows the baby is alive. It is a good day in Somalia …a day to celebrate.

As a Westerner, these cultural traditions are completely foreign to me, yet I intuitively know that for many of these Somali women this is their comfort zone. Sadly, there are far worse stories to come – of mothers and infants dying from what many in the West perceive as preventable deaths. Even for women who give birth with the support of a midwife – the process can get complicated for unforeseen reasons. One of the Somali women took us back to her first birth during the war, where a midwife's error had a bad outcome.

“I had my first child in Somalia during the war. I was at home and the midwife cut me up to have the baby, and she sewed me up with the cotton still inside me. Since I was only 14, I did not know what she was doing. When she was about to leave, she stuck a long rod in me to get the cotton out. She could not get it out, so she cut the stitches and sewed me up again. My son died.”

This story brought a wave of tragic childbirth memories to the surface. Even in the cities, where hospitals, clinics, and doctors were available, many women still preferred the use of midwives and traditional healers. “In Mogadishu, I had my first child when I was 18. I had a very experienced midwife but the baby was big, so delivery was a problem. She cut me to get the baby out, but he was bruised with an elongated head and was not moving. After I went home, we had a visit from a traditional healer. She burned several spots on the top of his head to fix it. I figured it was necessary because of the birth complications. The next four babies all died in the womb – I would go through nine months of pregnancy and at the delivery the baby always dies.”

After listening to these experiences – I inquired if these infant deaths and labor challenges led the women to seek out a doctor or go to a hospital. The women told me that in the case of what appears to be severely prolonged or obstructed labor, they would go to the nearest hospital. Of course this depends on being fortunate enough to find the necessary transport to get the mother and her unborn child safely over the unpaved dirt roads of Somalia to her destination.

There is much these women fear about cesarean sections. Among the many reasons, in a culture where the family is considered “wealthy” if they have 10 children, the thought of surgery resulting in being unable to bear more children is a tragedy to most Somalis. The following childbirth journey also ended badly. “I was in labor for three-to-four days. Finally we went to the hospital. The doctor said I needed surgery because the long labor made the child breech and he can’t be straightened out. My family took me home because they didn't want a C-section. They thought surgery might cause me not to have other babies. After the fourth day of labor I gave birth to a dead child.”

This final story of Somalia childbirth speaks to the subject of referrals. Even for those Somali women who sought out doctors or hospitals after experiencing prior infant deaths – the outcomes are not necessarily positive. In the opinion of this mother, an experienced midwife could have saved her unborn child. The story is one of probable incompetence, but it drove this woman to stop having babies… at least in Somalia.

“After my second baby’s death, I went to a doctor who said he would help me deliver. When my third child was due, he checked me into the hospital and put me on pain medication. He told me it was a girl but she had her feet coming out first. The nurses said you cannot have the baby here and transferred me to another hospital with baby’s legs still out of me. Her chin got stuck, and when we got to the other hospital, if I had a good midwife she could've fixed me, but they just pulled and she came out dead. I decided not to have babies in Somalia anymore.”
Refugee Camps: The Journey Continues

The Somalis who fled the death, devastation and destruction of the civil war to the current day, walked for weeks on end in the hopes of surviving long enough to reach refugee camps in the bordering countries of Kenya, Ethiopia, and Djibouti. Given that 20 percent of women in these crisis situations are pregnant – it was not surprising to hear the stories of many Somali women who gave birth to several of their children in these neighboring, foreign lands.

The conditions in the camps, particularly in the early days after the war broke out were horrific. Imagine over 100,000 people stuck in a place where there is nothing to do; where if you are hungry there is little to eat; if you are sick, there is little medicine; if you yearn for knowledge, there is little education. Most people who live in these camps have been there since the war broke out, and most will be there until peace is restored to Somalia once again.

The Somali women speak expressively; sharing horror stories about maternal and child deaths in the camp clinics. Many preferred to have their babies in the camp tents or their stick-and-mud huts, with the help of midwives or Somali neighbors. These sentiments are illustrated in the following story – one considered to be a successful childbirth journey.

“I had a girl in Kakuma Camp, Kenya. It was 1999, and there were not many Somalis. They told me horror stories about birth at the hospital. They told me a girl died there while having a baby and they do not like Muslim girls. I told my mother I would have the baby at home; we had a neighbor that was a midwife. When the labor came, I had the baby without many complications, but there was blood that I lost through the delivery and the labor took long.”

At times the camps were subject to attacks and tragedies of a different nature. Rebel insurgents and bandits often entered the camps and raped the women refugees, kidnapped or even murdered humanitarian aid workers, and burned down the camp. These incidents frequently happened in the midst of women giving birth. “I was at a refugee camp called Benadiri in Mombasa, Kenya. One day just before my time came, I was sleeping and the camp was engulfed with fire. Neighbors came over and woke me up. We all started running with our kids tagging along. I started having leaks and contractions, while I was still running. People saw me and stopped to try to assist me and covered me with clothing. After a while the baby came out of me in the middle of the chaos in the fire, but thanks to Allah, we are both still alive.”

This Somali woman felt blessed to have made it out alive with her infant, but other refugee stories do not have such happy endings. In this terrifying story, another woman told us about her childbirth at an Ethiopian camp. “I almost died giving birth to my sixth child. I was held for 21 nights at the refugee clinic. When I had no strength left in me from the labor and was almost dead they transferred me to the hospital. There they asked me to sign away the life of my child or myself – I chose to save the life of my child. I was prepared to have surgery but just before the doctor started the lights went out. They made a hole in my child’s head, crushed his skull and took him out of me dead. 13 mothers having babies were transferred that same night. Only one other infant and myself survived.”

Many of the Somali women who fled the war became refugees in Kenya. While Kenya had a relatively sophisticated health system, this care was only available for the families who had the money to pay for these services. For most refugees, this care was out of reach. A Somali woman with seven children shared her tragic birth experience in Kenya. “One day at 7 months I went unconscious. A pharmacist came and said my relatives should take me to a hospital. Instead they took me to a midwife but when she saw I was in a coma she said she could only help with healthy women having babies, and that I needed a doctor now. But had no money so they brought me back home. One day one of the girls came into my room and saw blood all over the floor – it was the baby coming. When the pharmacist came, the baby was lying next to me with the umbilical cord attached. Now my son is 15 years old – he does not talk or walk. I have to help him eat.”
United States: The Journey Ends

All of the women made heroic journeys from Somalia to neighboring border countries, sometimes migrating to the Middle East or Europe before finally settling in the United States. While Minneapolis is currently home to an estimated 100,000 Somalis, it is frequently the second or third stop in the U.S. in these Somalis’ journeys to resettlement. This city offers families a new life with decent jobs, good schools for their children, and sophisticated health care. They are embraced by a Somali community that shares their culture and religion, yet there is much about Minneapolis life that is still foreign, especially for Somali women who have not experienced childbirth in a Western hospital with a white physician.

What follows is a typical Somali woman’s childbirth experience in a Minnesota hospital. By the time she has made the long journey that brought her to Minnesota, she has given birth to many children – several still alive, some dead and buried, and others disappeared in the war. Despite her protests, she was assigned a male physician during her pregnancy. No one seems to understand this Somali woman’s modesty and genuine discomfort at having another man who isn't her husband see her “private parts.” At 39 weeks, this woman is officially “past due” by Western standards, and her doctor wants to induce labor. But this Somali woman knows her body well and is sure it isn't her time yet, plus all Somali women know the typical length of their pregnancy is 42 weeks. She refuses to take “the labor drug”.

Once she starts “leaking fluid” [her water breaks] at 41-1/2 weeks, she does not say anything to her husband since that is the Somali tradition. After a couple of days, she feels that it is time and her husband drives her to the hospital. She wishes she had her female relatives around her for moral and emotional support, but the woman and her husband are a nuclear family now, as their relatives were left behind in Somalia, so her husband alone accompanies her.

They put the woman in a room with bright lights that blind her. More than anything she wants to walk around like she used to do in Somalia, but she cannot. Instead, they “tie her down,” surrounded by “technology” [fetal monitor]. When the pain gets unbearable they offer her the “injection in the back” [epidural] but she doesn’t like the idea of her legs feeling numb and she would much rather just pray. When it is time for the baby to come out, the nurses hold her legs and tell her to push. This Somali woman is terrified because her best friend said that pushing can “burn your womb” [rupture the uterus].

In one woman's words, “When it is time for the baby to come out, they push you, they hold you from both sides and you feel suffocated. They tell you to lift your head, pushing your chin into your chest [as if] pushing your chin would push [out] a baby!”

It seems that no matter what your tenure in the U.S., once an immigrant, always an immigrant. One Somali woman with eight children, six born in Africa and the last two in the U.S. had a very unfortunate, somewhat atypical experience, which she felt was largely driven by her immigrant status. “In the U.S., as long as you're an immigrant, doctors do not give you proper care. I was pregnant and my child had his umbilical cord wrapped around his neck. When I had the ultrasound the doctors told me there is something wrong with your baby, but they did not fix it. When the baby came out he was strangled with the umbilical cord. I did not sue them because I trust Allah will take care of us, but my baby has a disability from that birth.”

The topic of cesarean sections came up in all of the Somali interviews. Though Somali men aren't going through childbirth, they had much to say about why cesarean sections are problematic. Suffice it to say that they experience their wives’ pain and suffer their own “complications” – as it impedes them from having as many children as possible. “My wife had a C-section with both kids. First they gave her the injection in the back [epidural] and she still has back problems; she complains about pain. My father had 10 kids and I would like to have that many kids, but my wife is frightened and she is afraid of surgeries. My wife says she might die.”
As I learned so well from the Somali community – joy, terror, tragedy and everything in-between is in the eye of the beholder. These childbirth journeys – even the seemingly sedate stories of Western medicine – were as horrifying to the Somali women as their stories of inhumane suffering and death in Somalia and the refugee camps were to us all.

RESULTS

In-depth analysis of the interviews with the Somali community and maternal health care providers revealed substantive differences in reproductive health care between Western medicine and Somali cultural traditions. As the chart below and the following analysis indicate, there is a large gap between Western medical practices and Somali culture, which reinforces the need for more culturally appropriate care.

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Medical Model and Prenatal Care

1. **Somali cultural preference for curative medical model.** Western medicine follows a preventive model of care, which involves screening, assessment, and management of a woman's reproductive health. This notion of preventive care is often an unfamiliar and foreign concept for the Somali community, which follows a curative medical model. In Somalia, people typically go to the doctor if they have a problem or symptoms emerge, and they expect an on-the-spot diagnosis and treatment. The only reason to return to the doctor is if the problem worsens.
2. Somali women often don’t see the value of prenatal care. In Western medicine, when a woman is pregnant, her prenatal care usually begins around eight to 10 weeks and continues every two to four weeks until the baby is born. Somali women are not accustomed to receiving prenatal care and as one of the women stressed, “Here when you get pregnant you see a doctor, but in Somalia, you have to hide your pregnancy.” For experienced Somali mothers, the recommended level of Western prenatal care is viewed as inconvenient. As one Somali woman told her obstetrics and gynecology physician (OB/GYN), “I’ve had eight children and everything was fine. I know my baby is healthy because it is moving. Why do I have to be measured every two weeks?” Some experienced Somali mothers come in at 20+ weeks for an ultrasound, and after that, don't return until they are in labor.

Caregivers

1. Preferred reproductive health provider is a midwife. For women comfortable with Western medicine, their preferred provider is a physician. For Somali women, their preferred provider in the U.S. and Somalia is a midwife. Finding a maternal health provider in the Somali community largely involves word-of-mouth. The stories of unsuccessful childbirth are told hundreds of times over, as are the names of good physicians and midwives who end up caring for large numbers of Somali women.

2. Strong preference exists for female providers. While all women clearly want the best for their babies, Somali women have a very strong preference for female providers. Somali women are very modest and don't like the idea of having to show their “private parts” to another man who isn't their husband. In their respective interviews, a nurse and OB/GYN both commented about a Minneapolis clinic's male Somali residents, “We thought when we brought in two Somali male residents that it would make a difference – they speak the language, they understand what Somali women have gone through, but they still get rejected.”

Childbirth

1. Somali gestation period is 42+ weeks. The typical gestation period for most women is 38 to 40 weeks. In contrast, Somali women confirmed that their gestation period is 42 or more weeks. In one midwife's words, “Somali women are always my late delivery ladies.” She went on to explain Somali women's desire for natural childbirth and their reluctance to do post-dates testing at 42 weeks. “Somali women believe that God determines when the baby is ready to be born. I have seen women go to 43 weeks and the baby dies. But Somali women have this amazing willingness to accept what God has given them and they are at peace with it.”

2. General Somali aversion to inducing labor. This question of post-dates testing for a baby that has not yet been born after 42 weeks is directly related to the Western medical practice of inducing labor. Somalis are culturally “anti-intervention” and their aversion to inducing labor was expressed by Somali women, men, and Western health care providers alike. A Somali husband shared his regret that the couple agreed to induce, stating, “The doctors induced labor and my wife still has back problems – we should have waited for the natural birth.” Finally, several Somali women said they had refused inducing labor because they believed that it “burns the womb,” meaning the uterus ruptures or tears and women can’t carry additional children, which is a tragedy in Somali culture.
3. **Women don’t want to be “tied down” during labor.** Somali women consistently surfaced their discomfort at being “tied down” during labor, or attached to a fetal heart monitor, versus their culture of walking around when they feel labor pains. In a Somali woman’s words, “They tied me down to the bed and made me deliver the baby this way – it created great fear in me.” For these women, the benefits of monitoring the baby's heart rate have either not been explained by their health care providers or they were not understood.

4. **Mixed views on use of pain management.** A number of Somali men whose wives had been given epidurals claimed that it had caused their wives residual back pain. The more religious Somali women preferred to use prayer to help manage the pain of their contractions. Other women complained of epidural problems ranging from numbness in their legs, to itching and allergies, to constant back pain. That said, for some, the pain relief that an epidural provides during labor in the West is “…a piece of heaven.”

5. **Preference for midwife-supported delivery practice of helping guide baby out.** When the time comes for delivery, there was much discussion from Somali women about the Western practice of the mother pushing the baby out versus the Somali practice of midwives holding the woman's buttocks up and helping guide the baby out. In many instances, the midwife will put her hand inside the mother's uterus to manipulate the baby and move it around to enable a successful birth if it is breech or in an unnatural position. One Somali woman commented, “At home, it is normal for the midwife to hold you from the bottom, and to push the child up and out. Then you don't get a cut to the bottom [obstetric fistula].”

6. **Continued discomfort allowing men in delivery room.** According to cultural tradition, men are not allowed in the delivery room in Somalia – this experience is culturally appropriate only for the female relatives. In the U.S., however, much to the dismay of most Somali women, their husbands are frequently with them in the delivery room. As one woman stated, “I don't want my husband to see my vagina when it is swollen, ugly and bleeding.” Many of the Somali men explained that in the U.S., they are a nuclear family, and there is no one in the extended family to help their wives give birth. For this reason, husbands believe it is critical to support their wives in the delivery room.

7. **Language difficulties cause information to be lost in translation.** The last difference noted during the childbirth discussion related to language difficulties. In the U.S., Somali women either struggle to speak English with their Western health care providers, or preferably, use a Somali interpreter. This is compared to speaking to a care provider in one’s native language – which results in clearer communication and less misunderstanding. While Somalis and Western providers both deemed interpreters essential, the two communities expressed frustration and concern that important information was lost in translation.

**Cesarean Sections**

1. **Somali community believes Western doctors rush to cesarean sections.** The Somali community does not understand why doctors don't give women more time in labor to have natural births. Further, there is a perception that doctors are insensitive of this Somali cultural tradition. Physicians have been known say to women in labor, “Either sign for this surgical procedure or sign that you won't give consent and you are responsible for the consequences.” According to Somalis, cesarean sections aren't part of their culture, and are only acceptable if the mother or
child’s life is in danger. In the West, there are many medical reasons for cesarean sections: post-term babies, women whose pelvises are too small for their baby's head to pass, breech babies, umbilical cords wrapped around babies’ necks, premature babies in fetal distress, and more.

2. Concern that multiple cesarean sections will lead husbands to find another wife. As the Imams explained, the English word “surgery” means “slaughter” in Somali, which they believe contributes to the fear a woman has of dying or losing her child during cesarean sections. The other significant fear noted by Somali women was the inability to have additional children. When pressed about why this created such fear, their reason was illustrated in this OB/GYN’s story, “I had a patient who had given birth by C-section seven times. I told her we needed to talk about the risks to her and her unborn children of having additional surgeries. She had a very supportive partner, but nonetheless, she told me ‘Somali men – as soon as we stop having babies, they go find another woman.’” Many women confirmed this fear and said it was one of the major reasons they give birth annually.

3. Somali men have strong opinions on why doctors do cesarean sections. The men’s opinions on why doctors do so many cesarean sections ranged from doctors’ ability to make more money from surgery, to cesarean sections making their jobs more efficient because timing is planned, to doctors using surgery to prevent Somali women from having more children. One Somali man summarized these fears, “In Somalia, almost all births are natural, but we see here up to 70% of births by surgery. Because of this high number, we think the doctors want to make money from the surgeries; they make less if the child was born naturally. They also want mothers to have fewer children. This is why we fear C-sections.”

4. Somali community does not always accept doctors’ surgery recommendations. The Somali community often had difficulty accepting the advice of the physician. A female participant stated, “If women don't like the doctor's recommendation for C-section, she will even go as far as changing doctors when she is in labor to find a different solution.” In other instances, women simply refuse the C-section and risk the consequences. One man's story reinforced Somalis’ frustration with why cesarean sections are necessary, “One day, my wife went to her routine appointment. She drove herself and they checked her vitals. The doctors came back and said she will have a C-section. I asked how could she need surgery when she came by herself. They said we checked her and realized that she needs a C-section and asked me to sign papers. I told them I was not going to sign and they went ahead with the surgery. My wife and child were not in danger.” In this case, either the reasons for surgery were not clearly explained or something important was lost in the translation.

Female Genital Cutting

1. Physicians generally lack understanding of female genital cutting. Most physicians are unfamiliar with female genital cutting, and don't discuss women's preferences for de-infibulation and/or repair until she is in labor and the physician realizes “her opening is too small”. On the other hand, hospitals with experience caring for the Somali community show more sensitivity to these women. One of the midwives who participated in the research stated, “We bring up the topic early in antenatal care and when we do the birth plan at 34 weeks, we show Somali women pictures of a Type III infibulation and an uncircumcised vulva and say this is exactly what we're going to do, and tell us what you want to do after birth in terms of repair.”
2. Somali women’s preference for medio-lateral episiotomies. One woman stated, “In the U.S. they don't know what to do so when the child struggles, and the opening is small, they cut you to the bottom [midline episiotomy] and you can't sit afterwards.” Generally, the women agreed one of the biggest issues they have giving birth is the style of episiotomy, “Our doctors here don't ask how we get cut at home – it's all about bringing the baby out.” Further, they believe that there is a lot of fistula in the U.S. as a result of the midline episiotomy, instead of being cut medio-laterally, as they are cut in Somalia.

3. Differing beliefs regarding female genital cutting repair. One of the final challenges with female genital cutting has to do with the Fircooni style where girls are sewn afterwards. This form of female genital cutting tends to heal after they are cut for birth, so women need to be de-infibulated and repaired each time. One of the providers said there are some in her practice who don't believe in repairing Somali women. She stated, “We have no business intervening in a woman's sexual identity. For many Somali women, her circumcision is a beautiful thing that she is proud of.” The medical profession needs more providers like this midwife, who deal with what many consider to be a human rights violation with such sensitivity.

Postpartum Phase

1. Lack of postpartum support in United States. After Somali mothers give birth, there are major differences in the care the woman receives in the U.S. and in Somalia. In the West, mothers stay in the hospital for two days and then they are released and have to immediately take care of their children and the household, while their husbands go back to work. This is due to the general lack of family support that husbands and wives experience given the typical Somali nuclear family structure in the United States. One Somali woman's comment was funny and poignant at the same time, “After you deliver and leave the hospital, don't be surprised if you end up going shopping at Cub Foods on the way home.”

2. Desire for Somali tradition of 40-day “ummul” postpartum support. Women frequently mentioned the Somali tradition of caring for the ummul (new mother). It was described that as an ummul, you stay in your home for 40 days and are treated “like a queen.” All of your relatives and extended family come over and take care of you, keeping you company, watching your children, and bringing you meals to restore your energy. At the end of the 40-day period there is a celebration – a “coming out” with the baby. The mother looks beautiful and rested. Many women dearly missed the company and support of their extended family in the postpartum period. In one woman’s words, “Somalia childbirth was a better experience for me – I had moral support, physical support and emotional support.”

Child Spacing

1. Exclusive Somali use of the term child spacing. This term refers to the practice of spacing out the birth of one's children by exclusively breast-feeding a child for two years for the health of the mother, new baby, and future babies she will have. According to the Quran, the Prophet says mothers do not get pregnant when they breast-feed; therefore, if they breast-feed for two years there will be three years between children. The Imams explained that to space children and manage childbirth is religious, but to not have children with no logical reason is against the Muslim religion. According to these Imams, pills, condoms and other “medical child spacing methods” are not against their religion if contraception is used for child spacing purposes.
However, Western birth control methods are not part of Somali culture. Even the term “birth control” assumes that people are in charge, and good Somalis know that Allah is in charge.

2. Somalis experience peer pressure to have large families. Somali women and men both spoke of family and peer pressure to have many children. One man said, “My father had 10 kids and I would like to have that many children.” A Somali woman spoke of elder pressure to bear as many children as possible, “There are social and cultural problems that bring families to have many children, such as husbands wanting kids and your relatives expecting you to have many kids like they did.” Somali men agreed that child spacing is consistent with their religion; however, men’s wives who gave birth every year were the envy of the community. Many Somali women described the paradox of wanting to comply with Islam, and its two-year child spacing, yet husbands pressure their wives to have babies annually.

3. Confusion in Somali community whether birth control is allowed by religion. There was a moderate amount of disagreement and confusion among the men and women whether Western methods of birth control are allowed. One Somali man stated, “We use an IUD to space our children and it was acceptable to our Imam. One can also use condoms.” Another man argued that his Imam said condoms weren't allowed in the Muslim faith. One woman inquired of her group, “Religion says mothers should breast-feed for two years and that mothers do not get pregnant during this period – but is this true?” The woman next to her replied, “It is true for some others but I was having babies every year and I was breast-feeding.”

4. Range of child spacing methods in use by Somali families. Many maternal health providers commented that their U.S.-born Somali patients tend to be knowledgeable about child spacing options and are more willing to consider birth control than their Somalia-born mothers. Despite this growing use of birth control, one nurse talked about a Somali patient who had four children in four years and while she does not another pregnancy, she didn't feel she could use birth control because of her religion. Of note, an OB/GYN clarified that breast-feeding works well as a method of birth control for about six months, but as soon as the child begins eating solid food or when the woman supplements with formula, she can begin ovulating and get pregnant again. In addition to pressure from Somali husbands, this could help explain why many Somali women have babies every year.

Quality of Care

1. Overall quality of care is mixed. While most Somali women felt their overall care was positive, a number of women felt they were discriminated against because they are immigrants. One woman shared her experience of being in excruciating labor pain and the nurses were standing outside laughing and telling stories. Another woman said that when a hospital gets a reputation for being racist against Somali immigrants, no Somali women would give birth there. Many Somalis believe that their providers use overly directive communication. When doctors say things like, “If you don't want to have a cesarean section, then find another doctor,” women feel abandoned. What the community is asking for was summed up in the words of this Somali man, “We want our doctors to consult with families. Even if surgery is the best alternative, we want to know our options and have a discussion about it.”
Best Practices: Culturally Appropriate Reproductive Health Care

There are several hospitals and clinics in the Minneapolis area that have been caring for Somali patients since they began arriving in the early 1990s. These providers were interviewed for this research and they were proud to share their best practices for culturally appropriate reproductive health care. A collection of the top 12 best practices was derived, which are summarized in the chart below. An overview of each of these practices follows.

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<td>1</td>
<td>Build 1:1 Relationships</td>
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<td>2</td>
<td>Respect Culture/Religion as Part of RH Care</td>
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<tr>
<td>3</td>
<td>Provide Options/Consult with Families</td>
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<td>4</td>
<td>Hire Somali Staff and/or Speak Somali</td>
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<td>5</td>
<td>Offer Female Providers</td>
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<td>6</td>
<td>Make Midwives Available</td>
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<td>Contract with Competent Interpreters</td>
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<td>8</td>
<td>Understand Female Genital Cutting</td>
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<td>9</td>
<td>Learn Somali Life Stories</td>
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<td>Lecture Staff on Somalia History</td>
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<td>11</td>
<td>Respect Somali Calendar/Holidays</td>
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<td>12</td>
<td>Do Community Outreach</td>
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1. **Build one-on-one relationships.** Several physicians who participated in the research noted the importance of building one-on-one relationships with each Somali woman. One physician commented, “The relationships can’t come from a place of fear – at the end of the day, it’s all about the one-on-one relationship.” Another physician stressed that each Somali woman is different and unique. For all of these hospitals and clinics, establishing relationships and trust is the number one priority. One nurse noted after her clinic moved its office location, most of their Somali patients traveled longer distances to be cared for by them. As one family said, “The clinic we go to doesn’t understand Somali beliefs and we don’t trust them like we trust you.”

2. **Respect culture/religion as part of reproductive health care.** One of the physicians articulated the practice of respecting Somali culture and religion especially well. She said, “Every interaction is a cross-cultural experience. In each visit, you need to ask is there anything about your culture or religious beliefs that you want me to understand?” One clinic in particular trains their entire staff – from front desk personnel to nurses, residents, physicians, and lab techs – in cultural sensitivity to Somali beliefs and practices.

3. **Provide options and consult with families.** The providers uniformly believed that it is critical to ask patients questions about what they want first versus telling them what they need – and to provide options and clearly explain the consequences and risks of each choice. In one nurse’s words, “You need to listen and allow Somali women to voice their desires, then you need to educate them on their options to help them make the best decision possible.”
4. Hire Somali staff and/or speak Somali. One of the clinics had a practice of hiring Somali staff – from the front office to practicing residents to help make the Somali families feel supported and able to communicate more easily in their native language. Several staff, including physicians, also went to classes to learn basic Somali and embraced key aspects of Somali culture to make the women and their husbands comfortable. One of the midwives told me that when the Somali community first came to Minneapolis, she learned enough Somali to be able to conduct an entire visit in “vaginal Somali.”

5. Offer female providers. All of the hospitals and clinics interviewed understood Somali women's discomfort with male providers and they made an effort to offer female providers. At the same time, providers were upfront in explaining that when women go into labor, they will do everything possible to make their female provider available; however, in the case of an emergency, if the female provider is not on call, the best physician available – who may be male – will treat the women.

6. Make midwives available. As this report has clearly indicated, Somali women are most comfortable giving birth with the support of a midwife. One hospital in particular offers patients an entire midwife unit that enables a different philosophy and a less “medicalized” approach for these women. These midwives are wonderfully accepting and supportive of cultural traditions as long as there is no potential harm to the mother or baby. This is about as close as Somali women can come to their experiences with natural births back home.

7. Hire competent interpreters. The need for competent interpreters is essential for Somali women, their families, and the Western health care providers. The more medical terminology that is understood by the interpreter, the better information, options and advice that can be provided to the patient. All of the providers attempt to identify the best professional interpreter services – offering options to Somali women so that an interpreter can be matched to their personality and specific needs. One nurse noted the importance of continuity and availability of interpreters not only for appointments but also for phone consultations.

8. Understand female genital cutting. One of the midwives combines respect for female genital cutting with the opportunity to educate women on the types of female genital cutting and their options for postpartum repair. She uses pictures of a non-circumcised vulva, all the way through a Type III infibulation and commented, “I place a high value on women's desire to have her circumcision the way she wants it.” In addition, an OB/GYN lectures to medical students on female genital cutting. Given that nearly all Somali women experience genital cutting, respecting their sexual identity, supporting women's preferences for medio-lateral episiotomies, and discussing options for repair are all important areas of collaboration for providers who treat Somali women.

9. Learn Somali life stories. One of the OB/GYNs has created a questionnaire for learning about Somali history and trauma, which is now part of every Somali woman's medical record. In her words, “We ask women the appropriate questions to get their stories. Asking how many kids do you have is a really hard question for Somali women to answer. But if we ask how many times have you been pregnant? How many children have you successfully given birth to? How many of your children are still living? How many are with you? With this type of questioning, we have much more information to help build a connection and think about that patient in a more compassionate way.”
10. Lecture staff on Somalia history. That same OB/GYN has created a presentation entitled “Introduction to the Somalia Patient.” In this lecture, based on the evidence she has gathered, she provides an overview of the Somalia war, what it means to be a refugee, what the refugee camps are like, introduces Somali culture, and differences between Somalia and U.S. medical systems. This presentation is provided to all incoming residents and is an excellent tool for understanding the prior lives of Somali patients before they come in for a visit.

11. Respect Somali calendar and holidays. Several providers mentioned that they have learned to pay attention to the Somali calendar. Holidays like Ramadan, Eid and others are very important to the Somali community. The implication is that doctors can help Somali women manage their pregnancies or specific conditions such as gestational diabetes during Ramadan if they choose to fast. Providers also know to prepare for an influx of women after these holidays.

12. Do community outreach. A couple of the clinics and providers noted that they do community outreach. One of the maternal health care providers has spoken on many panels in partnership with the Somali community, and even participated in the making of an educational video for the Somali community. Another clinic used to be located near a number of Somali high-rises in the city, and did a good deal of community outreach to make the Somali population aware of their culturally sensitive services.

RECOMMENDATIONS

This research was intended to investigate how the Western medical community can more effectively support the cultural traditions related to the reproductive health of Somali women. The project effectively gave a voice to Somali women experiencing transnational childbirth. It shed light on Somali attitudes, beliefs and concerns regarding Western health care practices. This research also gathered best practices of Western providers who were working with Somali mothers using culturally sensitive approaches. There is a way for both communities to “meet in the middle,” based on safe birthing, and child spacing experiences that integrate the most important cultural traditions related to Somali reproductive health. Culturally appropriate care would go a long way to ensuring that Somalis embrace Western medicine wherever available, and could be a major step forward in saving lives of many Somali mothers and their unborn children who die needlessly on both sides of the globe.

Western Health Care Providers

1. Western health care providers could benefit from cultural sensitivity training in order to provide “culturally competent” care. The Culturally and Linguistically Appropriate Services (CLAS) Standards of the U.S. Department of Health and Human Services Office of Minority Health defines culturally competent care as the relationship between providers and patients, and the delivery of culturally and linguistically appropriate care to patients and their families by health professionals. Based on the feedback from the Somali community, Western health care providers need to better understand Somali culture and beliefs systems related to reproductive health care. This training should cover the entire spectrum from pregnancy, to childbirth (including cesarean sections and female genital cutting), to child spacing.
2. Minneapolis-based clinics/hospitals who see large numbers of Somali patients should share best practices for culturally sensitive reproductive health care. Beginning with Minneapolis-based providers interviewed in this research and expanding to include other metropolitan areas and states with large numbers of Somali immigrants, sharing best practices with other providers would substantially help expand culturally sensitive reproductive health care nationwide. Moreover, there is no reason why these best practices could not be adapted to international providers in refugee camps and urban areas that practice Western medicine.

3. Western health workers need to embrace culturally appropriate childbirth options as long as they provide no danger to the expectant mother or her unborn child. Research indicates that U.S.-based midwives are currently providing the most culturally sensitive options for care – based on their less “medicalized” philosophy of childbearing. In order to accomplish this in other settings, midwives could offer tours of their facilities, among other options.

4. Western health care providers need to provide education to the Somali community on why cesarean sections are sometimes required. Given the fear and general distrust in the Somali community towards cesarean sections, a major opportunity exists to explain the conditions under which cesarean sections are most frequently indicated, and in turn, to communicate the inherent risks of the surgery to mother/infant. Based on the level of misunderstanding that exists regarding this procedure, it is recommended that any education be provided in the Somali language, so that nothing is lost in the translation.

5. Western health care providers need education and training on female genital cutting. U.S. OB/GYNs need to be educated on the critical aspects of Somali female genital cutting: the four main types, what female genital cutting means to the identity of a Somali woman, planning for de-infibulation during a Somali woman's pregnancy, performing preferred medio-lateral episiotomies, and asking for a woman’s desired level of repair after childbirth. As the Somali community grows nationwide, providers need to embrace and understand these issues. Further, it is important that health care providers separate their own personal views on female genital cutting from Somali women's need for culturally appropriate care.

6. Western health workers need to consult with their Somali patients and provide them with options for care. As the research with the Somali population indicated, many Western health care providers can be insensitive and quite directive with patients and families regarding their care. This is possibly due to language challenges and the inability to freely engage in dialogue as can easily be done in one’s native language. Currently, two-way communication and general sensitivity to adherence versus compliance is being taught to upcoming medical students, interns and residents across the country.

Somali Community

1. Somali families require reproductive health education to better understand the value of Western medicine. While the research indicates that many Somalis are supportive of Western medicine, a significant opportunity exists to provide this population with reproductive health education on why a Western medical model is critical to the health of the mother and her children. Further, it is important to accomplish this in a culturally sensitive way.
2. **The Somali community needs education on the value of prenatal care to the health of mothers and their unborn children.** Generally, Somali women have not benefited from prenatal care before moving to the United States. While most women adhere to some amount of prenatal care, they do not typically take advantage of the monthly appointments in the same way that U.S.-born women do, and in particular, experienced mothers find them to be inconvenient. There is an opportunity for Western hospitals and clinics to explain the benefits of prenatal care throughout pregnancy.

3. **Imams need education on natural child spacing methods and Western birth control in order to help influence the Somali community.** It would be beneficial to educate the Imams on the full range of child spacing options – from the Quran-blessed breast-feeding method to Western birth control – and the chances of getting pregnant when using each of them. With this knowledge in hand, when families come to their Imams to discuss child spacing options, they will be in a better position to bless a fuller complement of methods for the Somali community.

4. **The Somali community needs clarity from Imams regarding which methods of child spacing the Quran supports.** Many of the Somali men and women were confused as to which methods of child spacing the Quran and their Imams permit. Once the Imams have been educated about the potential range of available child spacing methods, Somali families need to better understand which methods they can use. Given the significant influence that Imams yield in the community, they could help discourage the practice of bearing children every year – which is unhealthy for the mother, the children, and the economic condition of the family as a whole.

5. **U.S.-based Somali communities should organize to provide care for ummuls during the 40-day postpartum period.** Because the extended family ummul tradition is missing in Western culture, Somali communities around the country should organize volunteer support for ummuls during the postpartum period. Ideally, Somali elders should act as volunteers, given their highly respected status in Somali culture, and their relative lack of meaningful roles in the United States. This should be organized by Somali-led local or national NGOs that focus on reproductive health care or immigrant resettlement.

6. **Gender equality training is needed for Somali men in the United States.** Given that the traditional male-dominated Somali gender dynamic is still entrenched in much of the community, and endorsed by men in particular, there is an opportunity for Somali men to participate in gender equality training. The purpose of this peer-to-peer training would be to promote women's rights, and celebrate new images of manhood by creating male champions for gender equity as it pertains to caring for children, managing the household, and making family decisions.

7. **Somali interpreters should be trained in reproductive health/medical terminology to enable improved provider-patient communication.** There is frustration on the part of the Somali community and Western health care providers with interpreters’ knowledge of medical terminology, both of whom felt that much of the communication was lost in translation. Therefore, a curriculum should be put together which all interpreters are required to pass before being hired by clinics or hospitals. The certification course should be developed by Somali or Somali speaking medical personnel and supported by local interpreter services around the country.
Convening Agencies

1. A Somali-led NGO should act as a lead convener in cross-cultural education to bridge the gap between the Somali community and providers. This research initiative was based on the hypothesis that a gap existed between the Somali population and Western maternal health care providers. Based on the demonstrated significance of this need for cross-cultural education, and the requirement that a central party with an understanding of both communities coordinate the above-mentioned approaches to bridging the gap, it seems that a Somali-led NGO, and specifically, one taking a public health approach, should play a convening role.

2. Somali-led NGOs specializing in reproductive health should develop interventions for culturally appropriate reproductive health care. The provision of culturally appropriate reproductive health care is extremely important for the Somali community if they are to embrace Western medicine. With lead funding from State Departments of Health, or the U.S. Department of Health and Human Services Office of Minority Health, these Somali-led NGOs can help develop interventions in reproductive health care – specializing in culturally appropriate pregnancy, childbirth, and child spacing experiences for Somali mothers.

3. The MDH should help fund recommended programs for Western health worker cultural competency and Somali community education. The myriad programs recommended in this section will require funders to ensure their proper development and implementation. The Maternal and Child Health Section of the Division of Community and Family Health or the Refugee Unit would be strong funding candidates given their respective charters. Any support they can provide to help secure additional funding would be most useful.

4. Clinics/staff in Somali refugee camps should be trained in culturally appropriate reproductive health care. There is an opportunity for humanitarian agency personnel working in camp clinics to be trained in culturally appropriate reproductive health care. This sensitive care for mothers is essential if providers are to build trust among Somalis in Western methods practiced in camp clinics. Humanitarian relief agencies currently operating clinics for reproductive health care are excellent candidates for this training. If the UNHCR advocated this training for on-the-ground service providers, it could go a long way toward the provision of culturally competent care.

5. Refugee camps need to make community health workers and midwives available to support Somali home births. For Somali women unwilling to give birth in refugee camp clinics, community health workers and midwives must be available to support home births, and properly trained to recognize when an emergency referral is needed. Development organizations supporting the use of midwives and community health workers should help develop these programs and the staffing of such personnel needs in the Somali refugee camps.

6. Somalia's Ministry of Health needs to secure funding to reestablish the maternal/child health clinics that were destroyed or closed during the war. Now that Somalia has elected a Somali president for the first time since 1991, the Ministry of Health is in a position to begin working to reopen and rebuild the 250 maternal and child health clinics that were lost since the war began. This will require substantive development funding which could come from multilateral or international development organizations that were/are currently working in Somalia to provide reproductive health care.
7. Development agencies working in Somalia or the Horn of Africa must train new midwives to support home births. The vast majority of births in Somalia still take place at home. Given this fact and the high rates of maternal mortality in Somalia, new midwives must be hired, trained and deployed, especially in remote areas where it is virtually impossible to travel to local clinics or hospitals. International development agencies who promote safe motherhood programs in Somalia are strong candidates for this critical work if the nation is to succeed in reducing the number of mothers who die in childbirth.
BIBLIOGRAPHY


APPENDIX

Literature Review

There is not much current literature about the cultural traditions that influence and often impede reproductive health among Somali refugees or immigrants. In addition, the research is not based on interviews with the full complement of participants who must collaborate to provide a culturally appropriate reproductive health experience for Somali mothers. Importantly, there needs to be additional research that provides guidance on how health care providers can integrate Somali customs into the Western reproductive health experiences of Somali mothers; and in turn, how the Somali community can receive education to optimize women's reproductive health under a Western medical model. The most recent reports cover four themes summarized below: concerns about pregnancy and childbirth; fear of cesarean births; impact of female genital cutting on childbirth; and resistance to family planning and contraception.

Concerns about Pregnancy and Childbirth

There is scant literature regarding reproductive health in Somalia. The most prominent report (Leigh & Sorbye, 2010) cites a range of challenges that contribute to the high maternal mortality rate, including: high levels of illiteracy and isolation among Somali women, low knowledge levels about the health risks associated with pregnancy and childbirth, and strong mistrust of the preventive medical model. Social and cultural traditions associated with reproduction all adversely impact decisions to seek reproductive health care until it is too late to save mothers or their children. According to a UNICEF study (Prendiville, 1998), the majority of maternal deaths in Somalia can be attributed to obstructed labor, hemorrhage, eclampsia, and infection.

In Somali refugee camps, only one major piece of literature exists on women’s reproductive health. This seminal research report on pregnancy and childbirth among Somali refugees was conducted in Dadaab, Kenya (Extending Service Delivery Project & USAID, 2008). Qualitative interviews highlighted strong cultural traditions and beliefs that constrain reproductive health choices among refugees. Deeply traditional attitudes include male-run families and women relegated to secondary roles with little power over their reproductive health. There is wide mistrust of the health providers in the camp – who are neither Somali nor Muslim. Finally, conservative religious leaders wield considerable influence in the camps.

The majority of the available literature sources from the West, addressing Somali knowledge and perceptions about pregnancy and childbirth experiences as immigrants. The nations studied include: Australia, Belgium, Canada, Norway, Sweden, United Kingdom, and the United States. One of the most frequently cited research studies (Herrell, Olevitch, DuBois, Terry, Thorp, Kind, & Said, 2004) was conducted in Minneapolis with Somali women through focus group discussions. The research was executed with the objective of developing culturally sensitive health education materials to bridge the gap between Somali immigrants and health providers. While women's childbirth experiences were positive, women reported racial stereotyping and felt that health care providers didn't understand the cultural differences of Somali women. In terms of delivery experiences, women expressed strong fear of cesarean births. Finally, women wanted more information about what happens in the delivery room, pain medications, why prenatal visits are important, the roles of various hospital staff, and how interpreters are used.

The other qualitative studies recently conducted in the U.S. (Hill, Hunt, & Hyrkas, 2011; Pavlish, Noor, & Brandt, 2010) had several common themes. First and most important, Somali women's reproductive health beliefs contrasted sharply with the preventive model that drives Western medicine – resulting in divergent expectations regarding treatment and health care.
provider interactions. Second, many Somali women didn't understand the purpose of prenatal care, because they believe that Allah determines birth outcomes. Finally, there is a lack of familiarity and comfort with hospital delivery and the Western health care system, which was frustrating for both Somali women and health care providers.

**Fear of Cesarean Sections**

One of the consistent themes across the literature is women's strong fear and aversion to giving birth by cesarean section. In Somalia, it is customary for women to labor at home for as many as three to four days in an attempt to have a natural birth before seeking hospital care. Given the high maternal mortality rates in Somalia, most women who fear cesarean sections are relating it to knowledge of others who did not survive the procedure in Somalia.

All of the qualitative studies of Somali immigrants in the West revealed highly consistent findings regarding Somali women's extreme negative attitudes about cesarean delivery (Beine, Fullerton, Palinkas & Anders, 1995; Herrel et al., 2004; Dundek, 2006; Brown, Carroll, Fogart, & Holt, 2010; Essen, Binder, & Johnsdotter, 2011; Hill et al., 2011). In general, Somali women felt that U.S. clinicians tended to rush to cesarean sections at the first sign of prolonged labor.

Not surprisingly, because of the high levels of maternal morbidity due to cesarean sections in Africa, the vast majority of women across the Western literature expressed a fear of dying as a result of cesarean sections. Other major concerns included: future infertility, fear of disability, inability to function in their home roles, and risks of anesthesia. Finally, cesarean births represented an unwillingness to wait for Allah’s help with the birth.

**Impact of Female Genital Cutting on Childbirth**

According to the WHO, an estimated 130 million girls and women worldwide have experienced female genital cutting to date, and at least two million girls per year are at risk of undergoing the procedure. In Somalia, nearly all women have experienced female genital cutting and 80 percent undergo infibulation. These high levels of infibulation are known to result in an alarming number of obstetric complications, which increase maternal and infant mortality. Childbirth requires an incision to open the infibulation with subsequent repairs (Lancet, 2001).

In the West, the literature on female genital cutting primarily deals with the challenge of educating health care providers about this unfamiliar practice. Five qualitative studies deal with female genital cutting in the context of giving birth in the West (Ameresekere, Borg, Frederick, Vragovic, Saia, & Raj, 2011; Chalmers & Omer-Hashi, 2002; Thierfelder, Tanner, & Bodiang, 2001; Upvall, Mohammed, & Dodge, 2009; Vangen et al., 2004) and the need for health care providers to better understand this tradition in order to provide culturally sensitive care.

Further, circumcised women are frequently treated in ways perceived to be offensive to their cultural values, likely driven by the lack of health care provider experience assisting Somali immigrant women who have undergone female genital cutting during pregnancy and childbirth. Somali women wished their caregivers were trained on this specific reproductive health need.

**Resistance to Family Planning and Contraception**

In Somalia, Islam is the national religion. The religious belief system indicates that children are a gift from Allah, who will determine how many children a family will ultimately have. The more children a Somali family has, the more blessed they are. Further, both men's and women's status are based on their ability to produce children.

There are two conditions under which Somali families are permitted to use modern contraception under Islamic law. The first justification is the economic situation of the family; the second reason is the wife's health condition. These two exceptions aside, most couples in
Somalia have little knowledge about women's contraception or condoms, and they are generally not in favor of family planning.

In the West, one might anticipate that attitudes toward family planning among Somali families would shift as they face raising children without extended families and experience economic challenges supporting large numbers of children. While this is true, regardless, the research indicates that religious beliefs and male-dominated households make couples highly reluctant to use contraceptives in the West. There are two studies in the literature regarding the use of contraceptives by Somalis in Finland (Degni, Koivusilta, & Ojanlatva, 2006; Degni, Mazengo, Vasilampi, & Essen, 2008), both of which indicated a broad aversion to contraception for religious and marital reasons.