

Fall 12-14-2012

Cultural Traditions and the Reproductive Health of Somali Refugees and Immigrants

Nancy S. Deyo

University of San Francisco, cndeyo@yahoo.com

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University of San Francisco

**Cultural Traditions and the Reproductive Health
of Somali Refugees and Immigrants**

**A Thesis Presented to
The Faculty of the College of Arts and Sciences
Master's Program in International Studies**

**In Partial Fulfillment
Of the Requirements for the Degree
Master of Arts in International Studies**

**By
Nancy Deyo
November 2012**

**Cultural Traditions and the Reproductive Health
of Somali Refugees and Immigrants**

In Partial Fulfillment of the Requirements for the Degree

MASTER OF ARTS

in

INTERNATIONAL STUDIES

by

Nancy Deyo
November 2012

UNIVERSITY OF SAN FRANCISCO

Under the guidance and approval of the committee, and approval by all the members, this research project has been accepted in partial fulfillment of the requirements for the degree.

Approved:

Advisor

Date

Academic Director

Date

Dean of Arts and Sciences

Date

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Acknowledgements

First and foremost, I would like to thank my husband, Chris, and my parents, Jerry and Gloria for their unconditional love and support of my academic goal of going to graduate school to pursue a second career. Heartfelt thanks also to Dr. Anne Bartlett who has been such an inspiration to me throughout this program and as my thesis advisor for this research project. It is her passion and commitment to the crisis-affected people of Darfur and South Sudan that sparked my own interest in researching the reproductive health needs of displaced women in the Horn of Africa.

A very special thank you to Fartun Weli, Executive Director of Isuroon for being such a dedicated research partner throughout the entire project. My research with the Somali women – the heart and soul of this project – would never have been possible without you. I would also like to thank Dr. Osman Ahmed, Executive Director of the East Africa Health Project for his support and participation in the research with the Somali men and Imams. Finally, my appreciation goes out to the maternal health care providers who shared their best practices with me and contributed substantially to this research.

My deepest gratitude goes out to the brave and beautiful Somali women who chose to contribute to this research project. I hope that I have done justice to the information you have generously provided to me, and that I have made your voices heard. May you have the opportunity to access the culturally sensitive reproductive health services you need and deserve, to bear your children safely, and remain healthy.

Chapter One Introduction

Somalia Conflict and Reproductive Health: An Overview

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.¹ 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. Successive seasons of failed rains, increased food prices, under-development, poor governance, aggravated conflict, and limited humanitarian access have resulted in extreme food insecurity, water shortages and acute malnutrition. By 2011, over 13 million people in Somalia, Kenya, Ethiopia and Djibouti were in need of urgent assistance.²

There were many causes of the famine beyond the immediate drought, and they included intensification of the fighting after two decades of conflict, the absence of a stable government and the failure of the international community to act. That said, The Al-Shabaab Islamist militants are largely blamed for exacerbating the food crisis. This insurgent group, who controls southern Somalia and has ties to Al Qaeda, catalyzed the famine through a combination of preventing farmers from growing surplus crops by demanding most of the harvest as a form of tax payment, and banning most of the humanitarian relief organizations from the region.

Fiercely opposed to any Western interference, and calling themselves protectors against foreign intervention, Al-Shabaab claimed that aid created dependency and that these relief

¹ UNHCR & Women's Refugee Commission. (2011). Refocusing family planning in refugee settings: findings and recommendations from a multi-country baseline study.

² ReliefWeb (2011). CARE'S response in the Horn of Africa. Retrieved from www.reliefweb.int

organizations were subversive groups galvanizing the locals against the establishment of the Islamic Sharia system. By virtually shutting off the food supply, Al-Shabaab has caused mass displacement of the population who were left with little choice except to flee in search of food and water.³

What is it like to be a refugee in a war zone besieged by drought and famine? Imagine being a Somali woman forced to leave your home and community because there is no food or water to sustain your family. You walk hundreds of miles with your children to a refugee camp in a foreign land. As you make your long trek, you watch other mothers caring for their own dehydrated, starving children on the brink of death – or already dead. You pray it won't happen to your own children. You pray it won't happen to you. You encounter violent militias and bandits along the way who kidnap and rape women and children at will, putting you at risk of contracting HIV/AIDS or becoming pregnant with an insurgent's child.

This scene plays out every day in the Horn of Africa as 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 United Nations 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 puts the reproductive health care of pregnant women low on the priority list.⁴

The United Nations High Commissioner for Refugees (UNHCR) states that complications during pregnancy/childbirth are the leading cause of death and disability among women of reproductive age in developing countries. To make matters worse, in crisis settings, the risks of dying from pregnancy-related causes are even higher. More than 60 percent of the world's

³ The Guardian (2011). Al-Shabaab bans aid agencies in Somalia and raids offices. Retrieved from www.guardian.co.uk/world/2011

⁴ Every Mother Counts. (2011). The impact on maternal health in the Horn of Africa. Retrieved from www.everymothercounts.org

maternal deaths occur in 10 countries, nine of which are experiencing or emerging from armed conflict.⁵

Further, UNICEF cites that the lifetime risk in Somalia of maternal death in childbirth is one in seven 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 – a 300 times difference in the maternal mortality rate.⁶ There are many complex contributors to the high maternal morbidity and mortality in Somalia – including cultural traditions – which form the centerpiece of this research project.

Statement of the Problem

Deeply ingrained cultural and religious traditions influence and often impede the reproductive health of Somali women. These traditions fall into five key areas, which will be discussed in turn, including: childbirth, cesarean sections, family size, child spacing and female circumcision. But first, it is important to understand the organization of Somali society and family structure.

This is a patriarchal, clan-based society where traditional clan membership, though dynamic and complex, provides social support, physical security and a sense of identity. The literature on Somali lineage identifies two major clan groups, the Samaal who are predominantly pastoral nomads and the Saab who are primarily agro-pastoralists. Four major clan families are descendants of the Samaal and comprise 75 percent of the population: the Darood, the Dir, the Hawiyya, and the Isaaq. The descendants of the Saab represent approximately 20 percent of the population and form the two minor clan families: the Digil

⁵ WHO, UNICEF, UNFPA & The World Bank. (2010). Trends in maternal mortality: 1990 to 2008.

⁶ UNICEF (2011). Maternal mortality statistics. Retrieved from www.childinfo.org/maternal_mortality.html

and the Rahanweyn. Each of the clan families resides in different regions of Somalia.⁷ The further division of the clan families into sub-clans, primary lineage, and so on forms a highly diverse population within what is more commonly thought to be a homogeneous society.

Modern day Somalis, whether urban dwellers, pastoral nomads or farmers are still, in their hearts and minds, bound by clan allegiance and male dominance. These factors have a large influence over women's roles in the clan hierarchy and the family, where the elders are assigned positions of highest respect. In general, women's role is to support men's views, ideas and decisions without participating in the process. Traditionally, a woman's role in the family is to bear and raise children, which previously excluded them from taking part in clan political, economic or military decisions. While women's roles have changed notably in Somali society over the past generation as women's growing economic independence enables them to question male family dominance, the concepts of women's human rights and gender equality have a long way to go before they are fully realized.

Somali women's increased economic livelihood notwithstanding, men's attitudes toward women are further influenced by two mutually reinforcing factors: customary tradition and interpretations of Islamic law (the vast majority of the population is Sunni Muslim). Men are the head of the household; it is culturally unacceptable for a man not to be perceived as being in charge of his home. Although most women in Somalia and Somali immigrants have jobs due to the financial hardships caused by war and the pressure to support extended families back home, respectively, the preferred role is for the husband to work and for the wife to stay at home with the children and manage the household. In traditional households, women are subordinated to men, and defer to them on a range of

⁷ Civil Military Fusion Centre (2011). Clan structure in Somalia.

family matters. The only division of labor where women consistently claim superiority over men is their competence in raising children. Nonetheless, a minimal value is placed on women's health with the exception of acting as a vessel for childbearing.

According to the World Health Organization (WHO), only 2 percent of deliveries take place in a health facility, supported by professionally trained staff. This means 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 different 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. This gets very complicated in refugee camps as the men most often are absent. Many women die from this inability to obtain permission, instead of surviving what normally would be a routine procedure. Even in immigrant populations, there is strong resistance to cesarean sections based on the belief that the inherent risks of multiple surgeries will lead to the inability to bear additional children or even death.

This fear of infertility is driven by the high value placed on having large families. The Quran states that one of the primary goals of marriage is to produce children and populate the Earth. These children will add honor to a father's lineage and enhance his status and reputation. Children are considered a blessing from Allah, and on average, women in Somalia give birth to 7.3 children during their lifetime.⁸ In the refugee camps, women often care for as many as ten children in their family. Even among immigrant populations, where

⁸ Talle, A. (2008). Precarious identities: Somali women in exile. *Finnish Journal of Ethnicity and Migration*, 3(2), 64-73.

nuclear families and economic challenges are often the norm, couples feel significant peer pressure for the woman to bear many children.

As such, contraception and abortions are heavily discouraged in Somali tradition. Women often are ostracized in the community for these practices, and generally do not practice child spacing with the exception of the Quran-blessed breast-feeding of infants for two full years – which does not always avoid future pregnancies. As a result, many women give birth annually which is detrimental to their health, infant mortality is high, and dangerously low neonatal birth weights are all common in Somali society.

Finally, female circumcision is a deeply ingrained custom in Somalia, practiced for centuries, with one of the highest rates of circumcision 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 is the most common reason for prolonged or difficult delivery and is one of the main causes of maternal mortality in Somalia. Childbirth requires cutting, and if it is legal in the country where the woman gives birth, partially or completely repairing the infibulation causes additional morbidity and increased chances of maternal and child mortality.⁹

The Western medical community is having difficulty understanding the reproductive health practices of Somali women, and is not broadly sensitized to the cultural traditions that become central to childbirth and child spacing in particular. 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 refugees and immigrants?*

⁹ Ford, N. (2001). Tackling female genital cutting in Somalia. *The Lancet*.

More research is required to provide both analytic and programmatic guidance on how health care providers can integrate Somali customs and religious beliefs into the Western pregnancy, childbirth, and child spacing experiences of Somali refugees and immigrants; and in turn, how health care providers can deliver comprehensive education for Somali families and key influencers in the community to help them better manage women's reproductive health in a Western medical model based on preventive, long-term care.

The Project

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, situated in northeastern Kenya, close to the Somalia border. Due to the extreme instability of the camps and the vulnerability of the population, it was not possible to conduct research in Dadaab at this time. Studying a more stable refugee population – immigrants in Minneapolis, Minnesota where over 50% of the U.S. Somali population lives – was deemed to be the preferred method for protecting human subjects and accomplishing the goals of the research.

My purpose in this research project is to provide a voice to Somali women who have experienced Western maternal health practices giving birth first in hospitals/clinics in Somalia or in Somali refugee camps, and now in the United States. It is meant to compile a sampling of their knowledge, perspectives and beliefs into a coherent format, which will shine a light on Somali attitudes about Western reproductive health practices. Importantly, this research will gather Somali women's suggestions, as well as best practices of Western health care providers who have been working with the Somali community since the immigrant influx began in the 1990s, for more culturally sensitive birthing and child spacing programs that could be offered through Western maternal health clinics and hospitals.

This research project consists of a literature review and a series of in-depth qualitative interviews. The question of how the Western medical community can best accommodate the cultural and religious traditions related to reproductive health among Somali women is addressed through original research. My research combines the perspectives of Somali women (four focus groups with a total of 25 women), Somali men (two focus groups with a total of 12 men), Somali Imams or religious leaders (one focus group with three Imams), and the Western maternal health care community (seven one-on-one interviews).

The interviews with Somali women were conducted in partnership with a female partner, the Executive Director at Isuroon (the Somali word for “self-empowered women”), who is a Somali immigrant herself. The interviews with Somali men and Imams were conducted with the support of a male partner, the Executive Director of the East Africa Health Project, who is also a Somali immigrant.

Such an in-depth research study that compares Somali refugee/immigrant cultural traditions with Western medical practices is both important and unusual in the public health, medical and humanitarian relief research on reproductive health among the Somali population for several reasons. First, most reports and research in the literature are focused only on Somali women’s knowledge and attitudes about pregnancy and childbirth in Western nations. Second, many studies are singly focused on one specific topic within reproductive health such as fear of cesarean births, impact of female circumcision on childbirth, or resistance to family planning and contraceptive use. Third, the inclusion of Somali men, Imams and Western maternal health providers is quite infrequent in the literature. Lastly, research comparisons of Somali refugee and immigrant populations have not been identified in the literature to date.

There is a need for more in-depth qualitative research on the cultural traditions related to reproductive health among Somali women that compares the perspectives of the many actors highlighted in this introduction. It is my hope that this project will contribute to future research and academia, and address gaps in humanitarian relief and non-governmental organizations' knowledge concerning ways to develop comprehensive health education materials/programs for the Somali community to introduce them to Western medicine. Most important, this research seeks to enable Somali refugees/immigrants and the Western medical community to "meet halfway," with improved trust and a common understanding of how to provide a positive, culturally sensitive Western birthing environment and child spacing experience for Somali mothers in all locations.

There must be a medically effective way to provide reproductive health care that will not require Somali women to sever their cultural and religious ties. Attempting to create a supportive birthing environment that embodies Somali cultural values, and communicating the health benefits of spacing out future births are both critical. If these goals could be accomplished it would be a major step forward in supporting the cultural traditions of a significant but frequently overlooked refugee and immigrant population, and hopefully can help reduce the maternal mortality rate of Somali women.

Chapter Two Literature Review

Introduction

At present, there is not much academic anthropological or sociological literature about the cultural and religious traditions that influence and often impede reproductive health among Somali refugees or immigrants. This literature review will focus on the most recent research and reports surrounding the reproductive health of Somali women that come from the public health, medical and humanitarian relief sectors.

This chapter will begin by broadly situating what it means to be a woman in Somalia during the war, sharing stories that illustrate the incredible difficulty of women's lives surviving and giving birth in a war-torn country. The review will then address the main themes in the literature, analyzing the continuities and discontinuities of women's reproductive health in Somalia, Somali refugee camps, and Somali immigrants' pregnancy and childbirth experiences in the West. The four themes in the literature that tie these diverse experiences together include: concerns about pregnancy and childbirth; fear of cesarean births; impact of female circumcision on childbirth; and resistance to family planning and contraception.

Women and War in Somalia

Somalia gained its independence in 1960, and a new nation – the Somali Republic – was formed through the union of two liberated British and Italian colonial territories. A government was formed with Aden Abdullah Osman Daar as its first president. A new constitution was drawn up in 1960, and the people of Somalia ratified it by popular referendum in 1961.

After a brief period of optimism and independence, Somalia's then-president Abdirashid Ali Sharmarke was shot and killed in 1969 by one of his bodyguards. This assassination was immediately followed by a military coup, in which the army seized power in a bloodless takeover. Mohammed Siad Barre, who at the time was commander of the army, spearheaded the coup. Barre quickly dissolved the Parliament and the Supreme Court, and suspended the Constitution. Over a period of several years, a one-party government based on authoritarian socialism and Islamic rule was established.

In the 1970s and 1980s many Somalis had become disillusioned with life under a military dictatorship. As the Cold War drew to a close, the Somali government became increasingly totalitarian. Resistance movements led by myriad militias sprang up across the nation, dedicated to the opposition and overthrow of then-president Barre.

Civil War erupted in 1988-1991, disrupting agriculture and food distribution in southern Somalia. Many of the conflicts were based on clan allegiances and resource competition between warring clans. This conflict culminated in the collapse of the regime in early 1991 and the ousting of the Barre-led government by a coalition of clan-based opposition groups, backed by Ethiopia and Libya. Somalia then descended into turmoil, factional fighting and outright anarchy. Since the end of the Barre era, Somalia has not had a central state authority and its government infrastructure has crumbled. The 2012 election of Hassan Sheikh Mohamud as the first president of Somalia since the dissolution of the Transitional Federal Government is the first hope for a representative government and the prospect of peace since the war began two long decades ago.

Critical to this research is the impact that the war had on ordinary people, families, and the lives of women in particular, as the political rebellion gave way to human chaos, carnage,

and a virtual bloodbath. The first signs of war as told by Somali refugees included roadblocks, decreases in food aid, agency workers leaving town, and bandits hijacking cars, stealing not only money but valuables like the gold and the clothes off of the backs of the women. As government opposition quickly gave way to clan-based conflict, physical insecurity increased as every Somali became a target simply by belonging to a certain clan. In one woman's words, "All Somalis were targets. Everyone was running in all directions. Some people were running toward the fighting. Others were running from the fighting. Everyone was looking out for their own clan, their own family." (Horst 2006, page 57)

The Somalia war in the 1990s was characterized by the brutal murder of innocent civilians, schools and hospitals were closed as the social services infrastructure imploded, farms were burned, livestock were slaughtered, and families often were forced to separate and flee for their lives. "When the gunmen came, there was no time to [find each other or] gather anything; people just ran. We drank water from the few mud puddles we could find." (Roble & Rutledge, 2008, page 22) Not only was dehydration massive, but importantly, the starvation from the ensuing famine which began in 1992 was heartbreaking. "People were eating carcasses of dead animals they would find on the street. At one time we were in the bushes and so hungry that we decided to eat leaves." (Horst, 2006, page 58)

Horst (Ibid, pages 43-44) provides an ethnographic account of a Somali woman who was separated from her husband when the war broke out. "Nuradin was in Mogadishu when the war started. So when the war occurred, we were separated. We lost track of one another and I tried to look for him, but I missed my children too much... During our flight, we met a militia that was against our government and for some hours we were caught up in an exchange of fire. These were dreadful hours and I was afraid no one would survive... I went

to Mogadishu with my children and I was separated from my husband for six years. I did not think it was possible that my husband was alive, but I stayed single and tried to provide for my children using my own strength.”

Women who were forced to flee to neighboring countries experienced tremendous fear and trauma during the war. One woman's horrifying story shows the daily terror that so many women lived through trying to save themselves and their children, yet hundreds of thousands never survived. “From morning to evening, I was thinking about whether I would survive the afternoon, or whether I would survive the night. I was worried because people were losing their lives so suddenly. From morning to evening, I did not get tired of carrying my children.” (Ibid, page 60) A young girl's words illustrate the heartless brutality of the militias who, when they did not murder women outright, raped them with impunity. “They would beat you, they would kill you... A neighbor of ours used to work for the government. They raped her. They tortured her. They beat her badly. They took her clothes. They raped her in front of her husband and just left her there on the ground.” (Ibid, page 60)

Many women have similar stories to the ones outlined here, which demonstrate the widespread nature of the violence that ravaged Somalia. Imagine over a million people, mostly women and children, running from large cities and small villages, on buses, in cars, and on foot – all fleeing gunmen – and a mental picture begins to form of the mass humanity that needed to be housed in refugee camps in the neighboring countries of Kenya, Ethiopia and Djibouti. As previously noted, one out of five women in crisis situations such as the Somalia war is pregnant. So what did the childbearing experience of these Somali women entail, including those on the run, those who survived to reach the relative safety of the refugee camps, and the women who risked their lives to remain in Somalia?

For women on the run, their courageous life stories are difficult to comprehend. One woman was pregnant when the militia came to her village. She started running and the movement stimulated her contractions. She had to stop in the bushes to give birth with no one to help her. She was then forced to pick up her newborn child and start running again (Roble & Rutledge, 2008, page 22).

If these pregnant women were lucky enough to survive the bandits, starvation and dehydration to reach the camps, what was their childbirth experience like? Sadly, even when their birthing situations became dire, the vast majority of the women didn't want to go to the few existing clinics for help. Mothers resisted coming until it was too late. They described the clinics as dirty, small and inadequate. The clinics were understaffed and under equipped. Many mothers died when they came to give birth – they were badly malnourished and not strong enough to survive their labor, and many of their babies died as well (Ibid, page 24).

Finally, there were many distinct challenges faced by the women who chose to remain in Somalia to give birth. The Somali public health system imploded along with the rest of the government infrastructure when the war broke out. In an environment where women's reproductive health, and emergency obstetric care in particular, is uniquely dependent on a comprehensive functioning health system, there were enormous gaps in access to and provision of reproductive health services.

These reproductive health problems break down into several key areas, which have worsened as the war dragged on. First, there has been no reproductive health financing for many years. Second, there is a dramatic shortage of qualified reproductive health care professionals, especially qualified midwives to support the birthing process in homes or in clinics/hospitals. Third, while there were 250 maternal and child health centers at the start of

the war, most have closed down or been destroyed. Given Somali women's high fertility rates, the remaining number of clinics is woefully inadequate for the large population of pregnant women who might need to be served in an emergency referral situation. Moreover, the sheer size of Somalia exacerbates this problem due to the vast distances that need to be traveled in the midst of a war zone.

The combined result of these factors is illustrated in the following tragic story. A nomadic woman living in an isolated settlement experienced a problem in labor. After 24 hours, the worried family began to discuss sending the woman to the nearest hospital. Because of the long distance involved, the family prayed and gave traditional medicine to the woman to assist the delivery instead. Because there was no progress preparations were made to send the woman to the hospital. A camel was used to carry the woman to the nearest rural settlement, then the family waited for a passing truck which dropped them at a village, after which a series of trucks and small vehicles brought the woman and her family from village to village until they arrived at the hospital. The journey had taken six days. Upon arrival, the woman had been in labor for eight days and her condition was critical. She was seen immediately and resuscitation was commenced. Both the mother and her baby died half an hour later (Prendiville, 1998, page 358).

If this story is multiplied thousands of times, the appalling suffering, morbidity and mortality of mothers in childbirth becomes clear, translating to a lifetime risk of dying in Somalia of one in seven women.

The Literature

There are several key trends in the available research: Western medicine associates Somali women's cultural traditions as a "problem," and in turn, Somali women distrust Western

medicine. Further, the research is not based on interviews with the full complement of participants who must collaborate to provide a culturally sensitive birthing environment and child spacing experience for Somali mothers. In sum, there needs to be an increase in the academic research that provides analytic and programmatic guidance on how health care providers can integrate Somali customs/religious beliefs into the Western pregnancy, childbirth, and child spacing processes of Somali refugees and immigrants; and in turn, how Somali women and key influencers in the community can receive comprehensive education to optimize women's reproductive health in a Western medical environment.

With this in mind, I will now turn to the four major themes in the research: concerns about pregnancy and childbirth, fear of cesarean sections, impact of female circumcision on childbirth, and resistance to family planning and contraception. For each theme, I will highlight the existing literature in Somalia, followed by an analysis of the research conducted in Somali refugee camps, and finally, an examination of the current literature in the West.

Concerns about Pregnancy and Childbirth

As previously stated, Somalia has had no functional central government since 1991. The nation has been engulfed in civil war and conflict for the better part of a generation, yet the greatest risk to women's lives is not war but giving birth. The shockingly high rate of maternal death in childbirth of one in seven women also reflects how a generation of civil war has resulted in virtually all maternity and child health facilities being shut down, damaged or totally destroyed.

While there is little recent literature regarding reproductive health in Somalia, the most prominent report (Leigh & Sorbye, 2010) comes from a collaboration of Somalia health

authorities, with support from several prominent multi-lateral institutions. Given the high levels of illiteracy and isolation among Somali women, knowledge levels about the many health risks associated with pregnancy and childbirth are low and not informed by modern medical practices. There is poor demand for, and strong mistrust of the preventive medical model. For example, only one out of four pregnant women seeks out antenatal care. Social and cultural traditions associated with reproduction – such as marriage of adolescents as young as 15 years old, frequent and close pregnancies, and the home birthing tradition – all adversely impact decisions to seek reproductive health care until it is too late to save mothers or their children.

There is a range of other challenges that contribute to the high maternal mortality rate in Somalia. Financial obstacles such as pervasive user fees impede poverty-stricken families from seeking care at private clinics and hospitals – virtually the only remaining facilities available. Logistical challenges including long distances and the lack of transport vehicles for rural and nomadic populations also play a role. Poor service quality, unpredictable hours, high percentages of unskilled staff, and the lack of supplies all undermine trust in reproductive health care services and further exacerbate the large numbers of women who die in childbirth.

Further, according to a UNICEF study (Prendiville, 1998), the majority of maternal deaths in Somalia can be attributed to the following causes: obstructed labor, hemorrhage, eclampsia, and infection. This is why access to emergency obstetric care becomes so critical in Somali development programs designed to reduce maternal mortality. During home births, traditional birth attendants described the myriad challenges of referring women for emergency care. Often, families question the need for these referrals, and thus see traditional birth attendants as less skilled than others who attempt to manage these problems using

traditional methods. The heartbreaking story shared in the opening of this chapter illustrates this lack of confidence and the association between hospitals and bad outcomes that delay or prevent a family's decision to seek referral help when it is needed.

In short, Somali women have faced multiple, complex reproductive health challenges since the onset of the war. Reproductive health status is very poor with women experiencing increasingly high levels of morbidity and mortality. According to CARE (1999), the total lack of a functioning health infrastructure and the customs and religious practices surrounding women and childbearing only serve to exacerbate the problem.

In Somali refugee camps, only one major piece of literature exists on women's reproductive health. This lack of literature is likely due to several factors: the severely protracted nature of the conflict, the 2010 drought and subsequent 2011 famine, and the extremely vulnerable nature of the female Somali refugee population.

The seminal research report on pregnancy and childbirth among Somali refugees in Dadaab, Kenya was conducted in 2008 by the Extending Service Delivery (ESD) Project on behalf of the United States Agency for International Development (USAID). Qualitative interviews with women, men, religious leaders and Western health care providers highlighted strong cultural traditions and beliefs that constrain reproductive health choices among refugees. Social pressures are powerful motivators, reinforced by a fear of stigma for non-compliance. 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, religious leaders have conservative attitudes and they wield considerable influence in the camps.

Most women do not deliver at the health facilities unless there is a severe complication, but

prefer to deliver at “home” in camp, assisted by friends, family and if they are fortunate, traditional birth attendants or a midwife. The primary reasons for not going to health facilities were: 1) negative myths and mistrust of Western health care services, and 2) lack of knowledge about how the available health facilities can be of assistance.

Much of the women's mistrust is based on strong concerns about “bad” drugs or providers, and a preference to use traditional providers and traditional birthing methods. Many suspect that they will be given “abortion drugs,” or that “they will be issued the wrong drug.” (Ibid, pages 12–13) Finally, women's vehement aversion to being exposed to male health providers was a consistent reason for not seeking the pregnancy and delivery services offered at camp clinics.

Consistent with the main causes of maternal mortality in Somalia, humanitarian relief organizations reported that most of the maternal deaths in the camps were attributed to delays in seeking care for obstructed labor. Many deaths were caused in the refugee camps by families' delay or refusal to allow surgical interventions to save a woman's life during labor and delivery. Of note, when the women were asked for reasons why they get very sick or die during pregnancy and delivery, some of the most commonly mentioned reasons included: malnutrition, anemia, bleeding, health effects of frequent deliveries, and not getting to the hospital in time.

With respect to antenatal care, a higher percentage of refugee women received health care during their pregnancy versus women in Somalia. Other reasons for increases in antenatal care included: easier access and lower costs for health care versus those in Somalia, and an increased awareness of the importance and availability of antenatal care and delivery services based on clinic outreach programs in the camps. That said, the women at Dadaab

generally only attended antenatal care late in their pregnancy when, based on camp policy, they were able to obtain additional food rations.

Finally, respondents were asked about their use of postpartum health services. Not surprisingly, women will only seek postpartum care at a health facility if there are complications such as a severe infection. Consistent with the Somali culture of curative versus preventive medicine, one woman stated, “If the woman is not sick, she does not go.” (Ibid, page 14) Moreover, both men and women stressed that Somali culture requires a 40 day confined rest period at home for both the mother and infant following a delivery, thereby delaying or eliminating the use of postpartum services.

Recommendations for future programs in the refugee camps were as follows: 1) work with health care providers to improve cultural understanding of Somali reproductive health practices and beliefs so that they can be more effective advocates for reproductive health care; 2) community mobilization to raise awareness and dispel myths of modern medicine – particularly focused on males and youth; and 3) religious leaders trained and educated on the health benefits of Western reproductive health services 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 in Western nations. The nations studied include: Australia, Belgium, Canada, Norway, Sweden, United Kingdom, and the United States. The U.S. studies are focused in cities where the majority of the 100,000 and growing Somali diaspora resides.

This literature review identified four studies related to Somali women's experiences and beliefs regarding pregnancy and birth in Western nations. Three of the four studies were qualitative, primarily based on focus group interviews with Somali women. In two studies, in-

depth interviews with Somali women and health care professionals were also conducted. The quantitative study compared pregnancy outcomes of Somali-born women to women born in six Western nations, but given its statistical nature, did not shed light on the cultural or religious traditions related to reproductive health among Somali women (Small, Gagnon, Gissler, Zeitlin, Bennis, Glazier, Haelterman, Martens, McDermott, Urquia, & Vangen, 2008).

Perhaps the most significant difference between these Western studies and the literature on pregnancy and childbirth in Somalia and the refugee camps is that Somali immigrants in the West are giving birth in hospitals and clinics versus their previously stated preference for more traditional home births. While the reasons for this trend were not cited in the research, it is likely that these women have far more access to maternal health care hospitals and clinics in these large Western metropolitan areas, the majority of the costs are borne by insurance, and they are slowly adapting to Western methods of childbirth, which only a percentage of urban Somali women in cities like Mogadishu may have experienced before the war decimated most of the more modern maternal and child care facilities.

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. Central to its importance is that the research was executed with the objective of developing culturally sensitive health education materials to bridge the gap between Somali refugees/immigrants and Western health providers.

Overall, while women's childbirth experiences were positive, the women reported racial stereotyping from the nurses. The following quote reflects this perceived discrimination, "If the nursing staff see you are foreign or of a different color, they treat you badly." Another perception was, "The nursing staff let the medical students practice on us." (Ibid, page 347)

Women also felt that health care providers didn't understand the cultural differences of Somali women, and further, the differences that exist among Somali women in the immigrant population. One participant elaborated, “[Health care providers] met us just yesterday, so I would advise them to get to know us first because some of us are educated and some of us are not. We are totally mixed – just like them. They should wait before treating us like primitive people.” (Ibid, page 347)

In terms of labor/delivery experiences, women expressed strong fear and apprehension of cesarean births (see the following section for details), and were concerned about median (midline) episiotomies practiced in the United States versus medial lateral episiotomies commonly practiced in Somalia because they perceive that it is more difficult to give birth to large babies this way. Finally, differences in the approach to pain management during labor in the United States were negatively compared to the traditional Somali practice, “You know during my labor the doctors asked me to take a deep breath. I don't like that. I would rather say the Quran instead of taking a deep breath. Why do I have to waste time breathing when I can say my prayers.” (Ibid, page 347)

In addition, women wanted more education and 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 given cited concerns about their medical competence. All of these factors would be new to these women who are accustomed to home births and a curative medical model in Somalia. Not surprisingly, women's sources of information on childbirth ranged beyond their physician, midwife or clinic to relatives such as their parents or friends who had a previous childbirth experience.

Unlike Somalia and the Somali refugee camps, most women in this Western study

attended prenatal visits and believed that this type of care was important. Some of the reasons for prenatal care provided in the study included preventing complications during pregnancy and childbirth, getting to know your doctor before delivery, and ensuring that doctors record patients' wishes on their medical charts. The influential outcome of these findings was a childbirth video, which was translated into the Somali language for use with patients.

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 biological, preventive model that drives Western medicine – resulting in divergent expectations regarding treatment and health care provider interactions. Preventive care, simply stated, was not part of health care in Somalia, and therefore was difficult for the women to understand. One participant stressed, and most agreed that, “A lot of Somali people think that if they go to the doctor, it's what makes you sick so staying away from the doctor makes you pretty healthy.” (Hill, Hunt, & Hyrkas, 2011, page 355)

Second, many Somali women didn't understand the purpose of prenatal care, because they believe that Allah determines birth outcomes. Based on this religious practice, given that Allah controls the time of delivery, women did not commonly accept inducing labor, and there was consensus that exact due dates are irrelevant in Somali culture. Third, consistent with Herrell et al. findings (2004), women reported a fear of cesarean births, which will be discussed in the following section. Finally, there is a lack of familiarity and comfort with hospital delivery and the Western health care system overall, which was frustrating for both Somali women and health care providers given the propensity in Somalia and the refugee camps for home births.

In conclusion, these studies indicate a simultaneous need for cultural education of health care providers that is sensitive to Somali beliefs and attitudes and educational materials for Somali immigrants that demystify Western medicine while allowing Somali women to maintain their cultural/religious beliefs within this new context. Limitations to these studies include: 1) small numbers of women interviewed; 2) lack of inclusion of men, adolescents or key community leaders; 3) these women had a mean of 1.2 children born outside the U.S. and one child each born in the U.S. which is a small family size in a culture where women have an average of 7.3 children – implying that these women may not have been a representative sample of the Somali refugee population; and 4) the absence of actionable materials/courses developed for health care workers to help them provide more culturally sensitive care for Somali mothers.

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. In the words of one woman, “Cesarean section is a nightmare. I was thinking of women in Somalia who did not survive.” (Essen, Johnsdotter, Hoveliuss, Gudmundsson, Sjoberg, Friedman, & Ostergren, 2000, pages 1509-1510)

Clearly, the implosion of the maternal and child health infrastructure during the war and the resulting lack of qualified professionals to perform these life-saving interventions

serve to exacerbate the maternal mortality rates from unsuccessful cesarean births. While quantitative statistics do not exist, anecdotally women uniformly perceive that there are fewer cesarean sections performed in Somalia than are performed in the West. That said, there are much higher levels of adverse outcomes for both mothers and their neonates – possibly because they unsuccessfully labor for so many days before seeking hospital interventions.

According to Holder (2004), women in Somalia equate safe delivery with a vaginal delivery. She tells the poignant story of a woman who refused any medical intervention, especially cesarean section, after many days of labor. On day five of her labor, the woman was scheduled for a cesarean section. She refused repeating ‘Inshallah... Inshallah...’ Due to her adamant refusal, her brother and husband were contacted for consent to the cesarean section. They ignored the request and would not come to the hospital. While the woman ultimately survived, her baby did not (Ibid, page 43).

Prendiville (1998) also describes delays in life-saving treatment that can be experienced in Somalia hospitals while the families search for drugs, supplies or money. This final story illustrates the high levels of maternal and infant mortality in Somalia that drive women's fear of cesarean sections. A woman was admitted with a diagnosis of prolonged labor. The labor was diagnosed as obstructed and the obstetrician decided that mother and baby could be saved if a cesarean section was performed. The doctor demanded \$300 and refused to undertake the procedure without being paid the full amount. The family departed to raise the money. Two days later, midwives realized her uterus had ruptured. The woman had been unattended. She was finally taken to the operating theater for a cesarean section where she and her baby died (Ibid, page 358).

In Somali refugee camps, performing cesarean sections can be even more complex than these surgeries tend to be in Somalia. As stated in the thesis introduction, this is largely due to situations of obstructed or prolonged labor, where the process of obtaining cesarean section approval from male relatives in the refugee camps gets very complicated as the men are most often absent. Many women or their unborn infants die from the inability to obtain this critical permission, instead of surviving what under normal Western medical circumstances would be a routine procedure.

At the Dadaab refugee complex, the physician in charge of the maternity unit at the Hagadera Hospital explained that in Somali culture, consent for cesarean section must come from the woman's father-in-law, and if he is absent, the expectant woman's husband. Herein lies the problem. The majority of the Dadaab refugees are women, as their husbands and male relatives either remained in their villages to protect their belongings or were working in Mogadishu at the time the famine struck and their families were forced to flee without them in search of aid. This means hospitals are sending someone either to villages or to Mogadishu in search of the men for consent. The result is that women remain in labor for two or more days before hospitals find the right people to consent to this life-saving operation. In addition to losing the unborn infants, women run the risk of dying or developing obstetric fistula. This delay in obtaining consent has substantively hindered progress in reducing the maternal morbidity and mortality of Dadaab refugee women (Inter Press, 2011).

Similarly, the ESD Project (2008) asked respondents why women at Dadaab die or get very sick during delivery. Both adult women and adult men stated that cesarean sections or complications after a cesarean section are a main cause of death and illness. Consistent with what women experience in Somalia, given these high mortality and morbidity levels, it is no

wonder that both women and men perceive that cesarean sections result in maternal and infant death.

The UNHCR Dadaab study (2010) obtained consistent results when asking respondents why women die or get very sick during pregnancy and labor. Some of the most common reasons related to cesarean sections, including: women's general fear of cesarean sections, delay in making critical decisions when cesarean section is indicated, and overall reluctance by mothers to seek medical help when attempting to deliver at home due to cesarean section fears. Interestingly, there is also deep mistrust between the refugees and Western health workers due to language, culture and religious barriers. The community broadly believes that Western doctors rush to perform cesarean sections without attempting normal deliveries which leads women to stay at home until their labor is in a very advanced stage. For example, due to communication and language barriers, they feel that husbands are forced to sign consent forms by doctors, and thus, most are very afraid. Yet, because of camp policy the family feels that they have no choice but to still go to the hospital for delivery, otherwise their babies will miss out on the food ration inclusion (Ibid, pages 22-24).

These experiences in Somalia and the refugee camps combined contribute to the intense apprehension that Somali immigrants in the West have toward cesarean sections. These fears, and the similarities and differences versus women's experiences on the African continent are addressed in the following pages about Somali women's attitudes toward cesarean sections in the West.

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; Essen et al., 2000; 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 – this is compared to their experiences in Somalia where women only seek hospital care after three to four days of 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 rarely expressed in Somalia or the refugee camps 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.

Essen et al. (2000) studied women in Sweden whose primary fears of cesarean delivery were that they would die on the operating table. Sadly, this fear could lead women to avoid seeking care when obstetric emergencies requiring cesarean sections might occur. In this research, where women equated vaginal deliveries with safe deliveries, many voluntarily decreased their food intake in order to have a smaller fetus and an easier delivery, thereby avoiding cesarean section and maternal or infant mortality. These dangerous, self-inflicted strategies could be viewed as survival behaviors related to their former lives in an environment with high maternal mortality compounded by high fertility rates.

Beine et al. (1995) cited that most of the women in their San Diego study believed that American doctors were highly likely to perform cesarean sections – many claiming that if a woman does not deliver on her stated due date, that the baby is simply cut out. In the words of one participant, “In our country, whenever you have a baby, they don't scissor you [cesarean section]... We don't think it's good.” (Ibid, page 380) The specific concerns in this

study were less dramatic than those of many women fearing death, including the fear that cesarean births would limit the number of babies that could be delivered and would affect the spacing of pregnancies.

The women in the Brown et al. research (2010) also voiced the above-mentioned concerns about cesarean sections. 75 percent of the participants expressed strong aversions to cesarean sections, stating that deaths occurred both in Africa and the United States. One woman stated, “Most of the people who get C-section, they die.” (Ibid, page 223) Based on the discussions that the researchers had with participants, women's fears were based on personal observations both in Somalia and refugee camps, as well as stories that they heard throughout the Somali community in the West.

Of note, Somali women were adamant that they experienced longer gestations than their U.S. counterparts. As a result, they believe that U.S. physicians were likely to induce labor or perform cesarean sections too quickly versus physicians in Somalia, and that physicians ignored women's desired natural processes and their faith in Allah's will regarding the timing of their delivery. This notion was reinforced in the Herrell et al. study (2004) where women remarked that cesarean births are performed far more often in the U.S. than in Somalia. In one woman's words, “I didn't understand why the medical staff chose for me to deliver by cesarean section before my due date.” (Ibid, page 347)

A final study (Essen et al., 2011) was unique in that it compared beliefs and attitudes toward cesarean sections among Somali women with their obstetric care providers. The Somali belief system that cesarean section delivery would likely result in maternal death is consistent with other research across Somalia, the refugee camps and the West. Further, this fear often resulted in families denying the provider's recommendation or deciding not to

return to the same clinic when it was time to give birth. While the obstetric providers were all aware of these Somali fears, they expressed the firm conviction that cesarean section is preventive care intended to save the life of the mother and infant. Physicians commented that Somalis resist cesarean sections even in emergencies. This puts doctors in difficult situations because it could be a very demanding emergency where delivery has to occur within a few minutes, and if there is resistance on the part of the patient or relatives, it puts the medical team under significant pressure. Clearly these Somali women's fears were both stressful and frustrating to physicians who practice preventive medicine (Ibid, page 13).

All of the above-mentioned fears and apprehensions of Somali women are entirely rational when viewed in the context of women's pre-migration experiences where Somali women have extremely high fertility and maternal mortality rates. Finally, it is interesting to note that while families participated along with women regarding cesarean delivery decision-making, the previously mentioned Somali custom of male decision-making described in the refugee camps was not validated in the existing research among Somali immigrant women in the West.

Primary limitations with the Western studies include: 1) small numbers of Somali women interviewed; and 2) a general lack of Western health care provider perspective on these fears and how they were addressed or managed in the delivery room.

Impact of Female Circumcision on Childbirth

According to the WHO, an estimated 130 million girls and women worldwide have been circumcised to date, and at least two million girls per year are at risk of undergoing the procedure. In Somalia, as previously noted, 98 percent of women have been circumcised and

80 percent undergo infibulation. These high levels of excision and 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 in all cases (Lancet, 2001).

A World Health Organization study of female circumcision and obstetric outcomes (Lancet, 2006) cited the following obstetric complications, including: cesarean section, postpartum hemorrhage, stillbirth or early neonatal death, infant resuscitation, and extended maternal hospital stays. Not surprisingly, risks increase with more extensive forms of female circumcision. These problems are exacerbated by the fact that women who undergo female circumcision as young girls in Somalia now live in a war-torn nation with no infrastructure for health care or health research. The implication is that complications such as obstructed labor or postpartum hemorrhage have more serious negative outcomes among the majority of women who give birth at home, outside of hospital settings where emergency obstetric care is more likely available. In sum, female circumcision is one of the main causes of prolonged delivery and maternal morbidity and mortality in Somalia.

In Somali refugee camps, there is very little available literature on the effects of female circumcision and obstetric outcomes. That said, there is broad knowledge in the Somali refugee community that female circumcision leads to higher levels of maternal mortality. In the ESD Project (2008) and the UNHCR Dadaab study (2010), women uniformly believed that the effects of female circumcision were one of the primary reasons that women die or get very sick in camps during delivery. The male refugees and the Western health workers, who both noted that complications from female circumcision often result in excessive bleeding and subsequent death, confirmed this sentiment.

According to public health experts and physicians (Inter Press Service, 2011), nearly all of the Somalis at Dadaab practice female circumcision. This practice is a major obstacle to maternal health and Dadaab gynecologists cited that women who have undergone female circumcision are twice as likely to die during childbirth and more likely to give birth to a stillborn child than other women who have not experienced female circumcision. Other studies in many African countries have linked female circumcision to increases in maternal and infant morbidity and mortality due to obstructed labor.

Despite these perspectives on negative outcomes, the participants in the ESD Project (2008) cited that social pressures and fear of shame are primary justifications for female circumcision, and that it is practiced to keep the dignity of the girls. Uncircumcised females are still not considered “decent” women in the community. According to social norms, female circumcision is a requirement for marriage. Sadly, while women claim that this practice is perpetuated for men, it is the mothers and elder women who typically insist on the continuation of this practice in Somalia and the refugee camps.

In sum, the experiences of infibulated women in Somalia and in the refugee camps are quite consistent. While maternal and infant morbidity and mortality are high among circumcised women in both groups, this strong cultural practice persists despite the recent declaration in Somalia that the practice of female circumcision is illegal and punishable by law. Clearly, local culture and social norms trump national law, and it will take much more than outlawing the practice to end this centuries-old custom in Somalia.

In the West, the literature regarding female circumcision primarily deals with the challenge of educating health care providers about this unfamiliar practice. Five qualitative studies specifically deal with Somali female circumcision in the context of giving birth in the

West and the need for health care providers to better understand this customary tradition in order to provide culturally sensitive care. Overall the studies indicate that the specific gynecological and obstetric health care needs of Somali immigrants who have undergone female circumcision are not understood or adequately addressed.

Cesarean sections were often performed in Western nations because of uncertainty over how to handle female circumcision during delivery – much to the fear and dismay of the Somali women. Physicians did not typically discuss female circumcision in the context of antenatal care or at the time of delivery despite the fact that nearly all of the women had been circumcised. All of the women interviewed wished their health care providers had discussed their circumcisions with them before they gave birth (Ameresekere, Borg, Frederick, Vragovic, Saia, & Raj, 2011; Vangen et al., 2004). While women experience obstetric challenges in Somalia, refugee camps, and the West due to female circumcision, at least the physicians in Africa were familiar with this culturally widespread practice.

Somali women in the West were especially fearful of not being cut open sufficiently to prepare for vaginal births. This is completely understandable given that the issue of deinfibulation was not discussed with women prior to their labor and no plans for deinfibulation or reinfibulation were made in advance. These findings suggest that infibulated women need carefully planned deliveries, and correctly performed deinfibulation and reinfibulation following delivery, if reinfibulation is legal in the country where they are giving birth.

Thierfelder, Tanner, & Bodiang's research (2001) found that there was consistently inadequate communication between circumcised Somali women and health care providers, given that the health care providers rarely saw circumcised patients. Unfortunately, this gave

rise to misunderstandings and culturally insensitive consultations. When Somali women first arrived in the 1990s, many of them recalled doctors treating them with shock or surprise. Doctors asked whether they had suffered an accident or a burn. Others were asked if medical students could observe examinations, as their genitalia were viewed with medical interest, which provoked shame and fear among the Somali women.

Further, circumcised women are frequently treated in ways perceived to be offensive to their cultural values, indicating the need to modify attitudes toward women who have experienced this practice. Disrespectful treatment of the women was common and their emotional pain is clear in this woman's recollection, "Always negative comments are made in front of me. They say 'without the clitoris a woman is like a container carrying pregnancy but not a real woman'..." Yet another hurtful comment was, "I had an ultrasound early in my pregnancy. They all called each other and laughed so hard. My genitals were on display... A group of white-coated staff came to look and talk to each other with disgust." (Chalmers & Omer-Hashi, 2002, page 273) This type of inappropriate behavior would never occur in Somalia or even with Western physicians in Somali refugee camps who commonly take care of circumcised women.

This insensitive treatment is likely driven by the lack of health care provider experience assisting Somali immigrant women with circumcision during pregnancy and childbirth, and importantly, Western providers are not trained in this critical aspect of Somali perinatal care. Somali women explained that they wished their caregivers were specifically trained on the needs of circumcised women in pregnancy and childbirth. The following comments reveal their beliefs that health care providers were often not informed of appropriate care for circumcised patients. One woman stated, "I wish that health care professionals would be

trained in this issue so they will treat us with respect and not like animals.” (Ibid, page 278)

Clearly, these and other studies indicate that health care providers must be trained in culturally competent methods in order to provide adequate maternal care for circumcised women (Upvall, Mohammed, & Dodge, 2009). Health care providers who interact with circumcised women in a negative manner must be made aware of the denigrating impact of their comments, body language, and facial expressions. Unfortunately, communication and language barriers limited women's ability to ask questions related to the care of their circumcisions during childbirth. Moreover, discussing circumcision, especially with other family members present, may be considered a very private matter for the women, and not a topic for comfortable conversation with health care providers.

In general, most of these studies were conducted among Somali women and are limited by the exclusion of the health care provider perspective, which is so critical to developing culturally sensitive and appropriate care for circumcised Somali women. It is the responsibility of these Western providers to acquire knowledge of Somali women's challenges as immigrants living with female circumcision who are in need of reproductive health services. Female circumcision is the norm for Somali women, and much like the acceptance of any other anatomical features, they must be treated with respect and an understanding of this widespread cultural practice.

Resistance to Family Planning and Contraception

In Somalia, for more than 1,000 years the people have been practicing Muslims. Islam is the national religion. The religious belief system, as previously noted, 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. According to Comersamy, Read, Francis, Cullings, & Gordon (2003), a man's status is measured by his ability to produce children, particularly boys. Similarly, a woman's status is based on her level of fertility. Sexual intercourse is seen primarily as a means to procreate.

The family structure in Somalia, rooted in both Islam and cultural tradition is patriarchal. For example, the Quran requires wives to be obedient to their husbands. When it comes to family decisions, the husband typically has the last say. Men head the household and women are subordinated to their husbands on most matters. As a result, most Somali women believe if they do not deliver babies for a few years, the husband will divorce her and marry another woman. Further, the Quran allows for Somali men to have as many as four wives. Sadly, this unbalanced power relationship between husbands and wives often drives women to have as many children as physically possible during their childbearing years.

Because 'Allah will provide,' husbands and wives do not discuss when they want to begin having children or how many children they wish to have. Modern birth control methods are against religious and cultural traditions in Somalia, and a World Health Organization (WHO) 2006 survey reported that only 1.2 percent of married Somali women used modern contraceptives, with slightly higher use reported among women in urban areas. Using contraception equates to voluntary infertility and has a significant impact on women's position in society. The only child spacing method that is sanctioned in the Quran is breastfeeding for extended periods of time up to two years – for the health of the mother, for the health of her new baby, and for the health of her future children. Withdrawal is also noted as a religiously acceptable method of child spacing, though it is cited much less frequently than

breast-feeding.

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 – although many Muslims also believe that Allah will provide ample food and budget for each child. That said, severe economic hardship could justify the use of contraception, although the ultimate decision lies with the male head of household, after consultation with the Imam or religious leader. The second frequently experienced reason that Islam supports contraception is the wife's health condition. Somali women who bear children every year for many years in a row can suffer negative health consequences. 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 (Degni, Mazengo, Vaskilampi, & Essen, 2008).

Despite the strong religious and cultural resistance to family planning and contraception, it is critical to recognize the impact that large, closely spaced families have on the high maternal and infant morbidity and mortality rates in Somalia. Leigh & Sorbye (2010) cite evidence that maternal and child survival can be severely compromised if births are less than 24 months apart. Maternal and child health also are at risk if mothers give birth at too young an age. Given Somalia's extremely high fertility rates, the combination of early childbearing and women's closely spaced pregnancies results in the health of women and their children being severely endangered.

Child spacing/family planning methods can protect women from too closely spaced pregnancies that endanger their health. They can also help young women who marry as young as 15 years of age wait with their first pregnancy until it is safe. According to Leigh & Sorbye

(2010), if high-risk pregnancies could be avoided, the number of maternal deaths would decrease by one quarter. On a related note, if children are born at least two years apart, many child deaths could be avoided as closely spaced children are at a higher risk for disease (Ibid, page 31).

In the refugee camps, there is also significant Somali resistance to family planning and contraception. The primary research report on reproductive health among Somali refugees in Dadaab, Kenya (ESD & USAID, 2008) explored strong cultural traditions and beliefs that constrain family planning choices among refugees. The general consensus among women, men and religious leaders – consistent with the literature on Somalia – was that Allah determines the number of children that a woman has, and as a result, Somali women are encouraged to have children early and to have as many as possible.

Somalis take great pride in having large families and feel that producing many children is necessary for clan survival. Interestingly, a few of the male refugees even believed that, “...family planning is a Western idea promoted to decimate Muslims” (Ibid, page 23). Participants also associated the number of children in the family with reduced poverty. One woman stated, “Having more children leads to a better life for the family because there is work possibility for income and wealth.” (Ibid, page 23)

One of the primary reasons for not going to health facilities, aside from those previously mentioned in the pregnancy and childbirth section of this literature review, was that postpartum, women are afraid they will be forced to use family planning methods by the health facilities in the refugee camp. For families who wish to practice family planning, most fear going against cultural norms or facing the social stigma that results from having fewer children. The women in the study agreed that those who do not have children or only have a

few children are shunned. One participant stated, "...women are called bad names and abused for only having one or two babies." (Ibid, page 24)

According to religious leaders, who wield significant power in the camps, families must follow the Quran which states that breast-feeding until the infant is two years old is the only acceptable method of family planning – drugs and modern methods are not acceptable within the religion or culture. This, too, is consistent with the Muslim religious practice of child spacing in Somalia.

This research was supplemented by an assessment of the use of modern family planning methods among the refugee population in Dadaab (UNHCR, Dadaab Sub-Office, 2010). Consistent with the World Health Organization data from Somalia, the uptake of modern family planning methods was very low. Less than one percent of married women within the Dadaab refugee camps used family planning. Major reasons for this low uptake were: 1) among those not using family planning, women reported social, cultural and religious influences as key reasons for non-use; and 2) low levels of education among the women, and unequal power relations between men and women also are key drivers of low family planning use across the research.

Among the Somali refugee community there is no limit to the number of children a woman should have and, due to religious and cultural beliefs, this is never discussed in the family. Discussing these issues is sinful as it interferes with Allah's divine role, "If he is giving you more why ask for less; if he decides you should have one it will be one; if ten it will be ten..." (Ibid, page 21).

Finally, UNHCR and the Women's Refugee Commission (2011) conducted a five-country study on family planning. While the contraceptive prevalence rates (CPR) for the

two Somali refugee sites in Djibouti and Kenya were higher than those at Dadaab, they were still quite low, at 5.1 percent and 6.8 percent, respectively. Cross-cutting themes included: 1) contraceptive use is heavily influenced by religion and marriage status; 2) awareness of family planning methods is quite low. Each theme will be discussed in turn.

The role of religion in the refugee community cannot be understated as it relates to family planning attitudes. Women in the camps cited both religious and partner opposition to family planning, and said that hiding the use of family planning is necessary in order to deal with community and/or familial disapproval. In the words of one research participant, “If you decide to use family planning, the society will abuse you, or you will be stigmatized, and they will tell you that you are adopting a culture instead of your own.” (Ibid, page 15)

Given the strong influence of religion in Somali families’ lives, it is not surprising that knowledge of modern contraceptive methods among refugee women was low. The most widely known methods of family planning included the condom, injectibles and oral pills. A woman participating in the study said, “If you are using a method, you are fighting with God's creation.” (Ibid, page 15) Men also had a deep mistrust of family planning methods, though their mistrust was largely due to misconceptions of grave side effects, including high blood pressure, cancer, infertility, and even death.

While adeptly highlighting many of the critical cultural and religious traditions practiced by Somali refugees, the Dadaab UNHCR report in particular has several limitations. The report has little analysis of the data and no conclusions or programmatic actions to be taken. Finally, the reproductive health coordinator in the camp who was not Somali, conducted participant recruiting, which questions the validity of the sample.

In the West, one might anticipate that attitudes toward family planning among Somali

immigrant families would shift as they face raising children with smaller, more nuclear families and experience severe economic challenges. While this was found to be true, the research still indicates that religious beliefs and marital traditions hold constant as men and women consider the use of contraceptives in the West. There are two studies in the literature regarding the use of contraceptives by Somalis living in Finland, both of which indicated a broad aversion to contraception for religious and marital reasons. Both studies utilized qualitative and quantitative methods of data collection among Somali immigrants.

Degni, Koivusilta, & Ojanlatva (2006) cite that the attitudes of Somali women toward contraceptive use – 73 percent did not use contraceptives – were connected with religious beliefs and issues involving marital relations. Overall, these immigrant women avoid contraception because of religious/social reasons that are consistent to those expressed by women in Somalia and the refugee camps.

However, among the higher percentage of women (27 percent) who did use contraceptives, the experiences of motherhood among Somali women living in Finland were completely different from their experiences in Somalia. A woman with seven children commented on this difference in Finnish cultural norms, “What used to be a woman's pride in Somalia has become her humiliation in Finland. Having many children was an object of pride and respect for a woman in Somalia. In Finland, it is shameful to have several children. I think Finns are irritated to see Somali women with several children so I have decided to use contraception and not have children anymore.” (Ibid, page 194)

Another frequently mentioned reason for using contraceptives in the West was that the women were exhausted from taking care of so many children. Women do not have the help in Finland that they used to have from extended families in Somalia, who served to ease the

married couple's household responsibilities. In particular, every adult female helped with childcare and this support is largely lacking in the West. Unfortunately, another factor shifted Somali women's propensity to use contraception – the impolite and insulting attitudes of physicians and nurses toward them. One woman commented, “In the hospital, the nurses always stare at Somali women as if we were not human beings. I still remember how two nurses came to me before going home after my fifth baby and said ironically ‘bye-bye and see you again next year’. Their reaction caused me much embarrassment and I decided not to give birth in Finland anymore.” (Ibid, page 194)

Similarly, among the Somali married men in Finland (Degni, Mazengo, Vasilampi, & Essen, 2008), 63 percent avoided use of condoms and were opposed to women's contraceptive use primarily for religious reasons. In the words of one man, “My wife will become pregnant until God will take away that right from her.” (Ibid, page 301) Those disapproving of women's contraceptive use said it was an act of unfaithfulness to use contraception. One man claimed that the side effects of contraceptives are Allah's punishment of women who use them. Even the 37 percent of men using condoms expressed a preference for natural methods as required in the Quran.

Among those using contraception, the men reiterated the women's perception that changes within the Somali family structure in Finland should be reasons for using condoms. As one man stated, “Our responsibility is to take care of our children. In Finland, we are unlikely to get the kind of support we always received from our parents and other relatives in Somalia.” (Ibid, page 300) Another man, in support of birth control, stated, “In the interest of the Somali community in Finland, flexibility and adaptability of Islamic law are needed. If Somali parents cannot afford to meet the children's needs or bring them up in the way of Islam, men should

use condoms or women hormonal contraceptives...” (Ibid, page 301) Clearly, changes in the family structure and economic conditions, which were not present in Somalia, have had an influence on the steady uptake in the use of contraceptives among Somalis living in Finland.

While the combination of qualitative and quantitative methods suggests robust learning, there are limitations to the Finland research. First, there are only two studies of the use of contraception in the literature. Second, it is important to understand Somali immigrants from other Western nations to better understand the breadth of issues related to family planning. Third, there are no programmatic outcomes based on the research that address the needs and wants of Somali immigrants in a culturally sensitive manner.

Conclusion

The research and literature related to reproductive health in Somalia and Somali refugee camps, and reproductive health in Western nations were conducted by humanitarian relief agencies/NGOs in developing nations and within the various fields of public health and medicine in Western nations.

As briefly noted in the introduction to the literature, there are several major trends throughout the research – across the themes of pregnancy and childbirth, cesarean sections, female circumcision, and family planning. First, Western medicine associates Somali cultural beliefs surrounding pregnancy/childbirth as a “problem.” In turn, Somali women have a significant distrust of Western medicine. Second, the findings presented lack implications and recommendations for pregnancy, childbirth and child spacing programs. Most important, the research is not based on interviews with the combination of actors who must collaborate in a culturally sensitive manner – from the Somali women who are having babies, to the key

influencer community that supports their cultural and religious reproductive belief systems, to the Western providers who serve the Somali population.

Many of the conclusions provided in the literature call for culturally sensitive materials that introduce Somali women to Western methods of pregnancy/childbirth and a few suggest that Western health care providers could benefit from better understanding the Somali population's culture and belief systems so as to provide them with a better childbirth experience in Western hospitals and clinics. As noted, only one study conducted in the West (Herrel et al., 2004) appears to have actually provided educational materials in the form of a video for both Somali women and health care providers.

There is a need for more in-depth qualitative research on the cultural traditions related to reproductive health among Somali women that triangulates the perspectives of Somali women who have given birth first either in Somalia or in the refugee camps and more recently in the West, key influencers in the community who can comment on the cultural/religious traditions surrounding pregnancy, childbirth and child spacing, and the Western health care providers who support Somali women in all three locations. A program-oriented research approach would enable the above-mentioned communities to "meet halfway," with a common understanding of how to provide a positive, culturally sensitive birthing environment and future child spacing experience for Somali mothers.

Chapter Three The Project

Project Description

This research project is designed to provide in-depth insight into the cultural traditions related to the reproductive health of Somali immigrants in the United States. The project was conceptualized to triangulate the perspectives of: 1) Somali women who have given birth first in Somalia or the refugee camps, and more recently, in the West; 2) key influencers in the Somali community, including men and Imams (religious leaders) who can comment on the cultural/religious traditions surrounding pregnancy, childbirth and child spacing; and 3) Western maternal health care providers who support Somali women. I developed this project and its methodology with the input of my thesis advisor.

The interview questionnaires are comprised of original questions developed after reviewing the available literature and identifying the gaps presented in the research. After the questionnaires were designed, they were reviewed by the two Minneapolis-based NGOs involved in the Somali segments of the project. Upon recorded collection of the interview data, the Somali interviews were transcribed, and I then reviewed and analyzed both the Somali and the health care provider data to create a summary of the findings.

The primary objective of the research is to identify and develop culturally appropriate pregnancy, childbirth and child spacing programs for Somali mothers. The ultimate goal is to build trust between the Somali community and the maternal health care providers who serve Somali mothers. After discussing the project with the Women's Refugee Commission and the International Rescue Committee, they suggested that I conduct the project in a more stable refugee environment than the Dadaab camps in Kenya, which could both protect human subjects and accomplish the objectives of the research. Minneapolis, Minnesota – where over

50 percent of the U.S. Somali population lives – was deemed to be the ideal location for the research.

Through the Minneapolis Department of Health, the Refugee Unit connected me with potential names of NGOs and individuals to reach out to for partnership and support in this project. The cornerstone of this research – the interviews with Somali women – was conducted with the partnership of Isuroon and the expert guidance of the Founder and Executive Director Fartun Weli¹⁰, who is a Somali immigrant herself 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, and is the primary beneficiary of this research. The research with Somali men and Imams was conducted with the support of Dr. Osman Ahmed¹¹, Executive Director of the East Africa Health Project and former Director of the Community Health Department of the Somalia Ministry of Health, who is also a Somali immigrant with a background in pediatric medicine and tropical diseases. All of the Somali interview questionnaires were reviewed with both organizations before submitting them to the IRBPHS for approval. The Minnesota Department of Health also suggested a few clinics and physicians to contact for the maternal health care provider interviews who have a long history of working with Somali immigrants.

The goals of the Somali interview questions with women were to: 1) understand the cultural traditions that influenced their pregnancy, childbirth and child spacing experiences; 2) identify gaps in maternal health care treatment and programs that could be improved by increasing cultural sensitivity; and 3) determine the information and education that would best introduce Somalis to Western reproductive health practices.

¹⁰ Written consent was obtained to include Fartun Weli’s name in this thesis.

¹¹ Verbal consent was obtained to include Dr. Osman Ahmed’s name in this thesis.

The primary goal of the Somali interview questions with men was to understand family beliefs and practices surrounding pregnancy, childbirth and child spacing. The interview questions with the Imams were designed in order to understand their religious beliefs, and in particular, their interpretations of the Quran as it relates to having children, family size and acceptable child spacing practices.

Finally, the goals of the Western maternal health care providers were to: 1) solicit their perceptions of the cultural differences between Somali immigrants and their U.S.-born counterparts; and 2) identify best practices of clinics/hospitals who have been working in reproductive health with Somali women for over a decade, with the intent to share these culturally supportive strategies and programs regarding pregnancy, childbirth and child spacing with other health care providers in the community, around the United States, and longer-term in Somalia and its surrounding regions where refugees reside.

The participants were sampled in the following manner. For the Somali women, Isuroon maintains a demographic database of approximately 250 Somali women, which was used to randomly select one participant who met the demographic criteria for each focus group. After the first participant was selected, the research utilized the snowball methodology to identify remaining participants for each group. For the Somali men, soliciting the participation of a random Somali man who was a member of the East Africa Health Project identified the initial participant for each focus group. After the first participant was selected, the snowball methodology was used to identify the remaining participants for each group. The Imams were recruited based on Dr. Osman's relationship with the Imams in the Minneapolis area, identifying those who had the richest knowledge of the Quran in my areas of reproductive health interest, who were the Imams from the Dar Al-Hijrah Mosque. The

initial Western health care participants were suggested by the Minnesota Department of Health, and then I networked my way to identifying other doctors, nurses and midwives based on those initial recommendations.

An important 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 that at any time during the process they could choose not to answer a question or stop. It was also explained that the information they provide in the interviews would remain confidential. Importantly, the interviews were completely anonymous and no personal identifying information was collected. The informed consent was translated into the Somali language for all Somali-speaking participants to sign at the beginning of the interviews and was written in English for all medical staff to sign.

Based on the strong recommendation of the Minnesota Department of Health and both NGO partners, I believed it was important to provide all Somali participants with a small cash reimbursement as a thank you for their time invested. The Minnesota Department of Health also provided me with ranges of cash incentives that have been provided in recent research projects. At the end of the interviews, each Somali individual was provided with a cash envelope, but they clearly understood that should they decide to stop the interview at any time, that their reimbursement would be provided to them regardless of the length of their participation.

I completed the research project with the support of Isuroon and the East Africa Health Project over three consecutive weeks between August 21, 2012 and September 7, 2012. Interviews were typically conducted with the Somali community on evenings and weekends,

due to work schedules and childcare needs. The interviews were typically conducted with medical staff during weekday clinic hours. A total of 25 Somali women, 12 Somali men, three Imams, and seven Western health care providers were interviewed.

Project Methodology

The following qualitative research methodology was utilized for each of the above-mentioned participant groups. First, focus groups were conducted with Somali women in partnership with Isuroon. Four focus groups of approximately six women each (for a total of 25 women) were conducted in the Somali language with the support of the Isuroon moderator/translator.

The focus group methodology was considered superior to conducting individual interviews with the Somali community for several reasons. First, it was determined that the childbirth stories women were being asked to share could be quite painful, and the questions highly personal and sensitive to answer. In a focus group environment, there was a spirit of supportiveness among the women, and therefore, they became increasingly more comfortable sharing their experiences during the two hours allotted. Second, given the generally supportive nature of Somali women, there was tremendous synergy that resulted from the use of this approach, and the participants tended to build on each other's responses. Third, it was decided that using individual interviews for such sensitive research could be quite isolating for the women in particular, and the desired richness of information would not be obtained utilizing a one-on-one method versus that which could be gathered through focus groups.

From a demographic standpoint, most importantly, Isuroon sought to recruit women who had given birth first in Somalia/or refugee camps, and more recently, to children in the United States. Next, Isuroon sought to recruit young women ages 18 to 30 and older women

ages 31 to 45, divided into two focus groups for each age range. Because of the challenges of satisfying the critical birthing requirement, it was more difficult to recruit two groups of younger women. As a result, we recruited one group of younger women and three groups of older women. This was acceptable to me, because it is known in Somali culture that older women are treated as respected elders, and therefore, as long as we separated the age groups, we did not risk biasing the responses of the younger women in deference to the older women's responses.

Second, the men were divided into two focus groups of six participants each (for a total of 12 men) and conducted in the Somali language with the support of Dr. Osman's translator. Similarly, we benefitted from the synergistic and supportive nature of the Somali focus group method in order to understand the personal, sensitive family beliefs surrounding pregnancy, childbirth and child spacing. The interviews also were structured along age splits (ages 35 and under and ages 36 to 50) to determine if different, less traditional attitudes prevailed among the younger generation. To note, the recruiting of slightly older men was deemed to be essential, as Somali men typically do not marry as young as the women do. We also conducted a small focus group of three Imams in order to fully understand each of their religious beliefs and interpretations of the Quran as it relates to reproductive health.

Third, one-on-one interviews were conducted with seven Western maternal health care providers including obstetricians, nurses and midwives. The health care providers worked at three clinics/hospitals where many Minneapolis-based Somali women go for maternal health care. The purpose of conducting these interviews separately is to gain maximum input in a short period of time (approximately 45 minutes each) and to ensure that the opinions of each medical participant were sufficiently documented given the smaller sample size.

In order to obtain in-depth narratives regarding pregnancy, childbirth and child spacing, and cultural beliefs and attitudes toward Western medical practices, I used a semi-structured interview process with the Somali women and men's focus groups. Several core questions were asked of each group, and these questions served as jumping off points for better understanding Somali culture regarding reproductive health. Given that I was not intimately familiar with Somali culture, a non-directive style was used for the interviews. Further, because qualitative data cannot be aggregated, it made sense to focus my efforts on obtaining the detailed narratives that are missing in the literature.

With respect to the Imams, in an attempt to maximize information collection in a short one-and-a-half hour time span, and because interviews focused primarily on questions of religious beliefs and Quran interpretations surrounding childbirth, family size and acceptable child spacing practices, a structured interview process was used. Finally, with the Western medical professionals, a structured set of questions was asked of each participant and a more directive style was used, given the lack of cultural differences between the participants and myself.

Limitations

Given that this is a research project and not a thesis, I focused a significant amount of time upfront anticipating problems that might emerge in the context of the empirical research, and devising solutions to these challenges to the extent possible. Below is a summary of the potential challenges and the ultimate solutions that were utilized for each of the participant groups interviewed during my time in Minneapolis.

I anticipated that the biggest challenge I would have with the Somali women was getting them to "open up" and share their thoughts on what are very sensitive and personal topics

related to their cultural beliefs. While this did not ultimately turn out to be true, it was likely because I was working in partnership with two Somali women who were implicitly trusted, as well as the multi-faceted solutions to this problem that were devised. First, though my stay in Minneapolis was limited, I spent as much time as possible up front immersing myself in the Somali culture. Fartun Weli helped introduce me to the Somali culture through the following activities: 1) she invited me to join her at a typical Somali mall where we shopped and walked around; 2) I was able to observe women in one of their five daily prayer sessions after which I purchased an English version of the Quran; 3) I spent time in Minneapolis suburbs where most of the Somali population resides; 4) I joined Fartun in visiting a Somali woman's home for one of the focus groups to better understand how they live; and 5) we were able to enjoy several Somali meals together. Second, and extremely important, because the women I interviewed deeply trusted Fartun and her research assistant (who acted as moderator and translator), I believe that having them as active partners throughout the research enabled the women to feel more comfortable in my presence. Third, as previously stated in the methodology section, interviewing the women in focus groups and in the Somali language helped the women feel more comfortable talking about sensitive subjects with their peers. Fourth, every participant had the option not to answer any question they did not wish to give personal information about or to stop at any time, although this was never an issue. I also never asked for any participant's name as to ensure their complete anonymity throughout the process. Finally, and also significant to both the Somali and the Western medical communities, Fartun and I are in the process of planning a large Somali celebration and event, where Somali families and Western health care providers will be invited to hear the results of the research, in an effort to "give back to the Somali community" and help build increased trust between the two populations.

The biggest problem that I anticipated in the focus group discussions with Somali men and the Imams was that what men say about these sensitive topics and religious questions, respectively, in the presence of a Westerner could be different from what they would say in the presence of their peers. My solution, which was quite satisfactory, was that partnering with Dr. Osman (who is extremely well respected in the Somali community) and conducting these groups in the Somali language helped mitigate this problem. I also attempted to present myself appropriately by dressing in a manner that is culturally acceptable to Somali men, which in turn, helped them feel more comfortable with me. Finally, as stated with the Somali women's interviews, every Somali male participant had the option not to answer any question they did not wish to give personal information about or to stop at any time, although this was never the case. I never asked for any participant's name as to ensure their complete anonymity throughout the process.

Lastly, the major challenge that I anticipated with the Western medical professional interviews was that these providers might feel because they have worked with Somali women for many years, that they already have adequately bridged the cultural divide. My solution in this situation was to look to them as experts. I used the interviews as an opportunity to understand their best practices for working with the Somali population. Given that most of the participants had worked with Somali families for over a decade, this turned out to be an ideal solution and one that resulted in excellent strategies to be shared with other health care practitioners. The only other challenge that I anticipated was that some of the staff could worry their superiors might see or hear the answers to their questions given that they were occasionally discussing clinic/staff opportunities for improvement. I conducted all one-on-one interviews in a private area away from other staff members. I explained to participants that I

would be the only person to see the raw information to protect their identities. As with all other interview subjects, every participant had the option to not answer any question that they did not wish to give information about or to stop at any time, although this was never an issue. Finally, I did not document any participant's name as to ensure their anonymity throughout the process.

If the research project is successful, it will be a major step forward in respectfully supporting the cultural traditions of a large refugee population in the Horn of Africa and a sizable immigrant population in the United States through the identification and subsequent development of culturally sensitive pregnancy, childbirth and child spacing programs for Somali women. Importantly, with the completion of this research and programs that enable these communities to “meet halfway” and build trust, it will, in turn, reduce the rate of maternal morbidity and mortality among Somali women.

Chapter Four Childbirth Journeys

Introduction

Childbirth is a universal journey shared by women across the world. It connects us; it bonds us in unique and unexpected ways. As a warm-up activity in my focus group research, I asked the Somali women – strangers to each other, and strangers especially to me as a white Westerner – to share their experiences of childbirth as they made the transnational journey from Somalia, to neighboring refugee camps, and finally to the United States.

As each woman shared her respective journey, once she started to talk, the memories came flooding out of her. The women laughed; they cried; they held hands; they hugged each other in expressions of support. Just a few short moments ago, they were complete strangers, now forever connected through the stories of their 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.

But I'm getting ahead of myself. I will start where the women themselves started – in their home country of Somalia during the war – in the comfort of their own childbirth traditions.

Somalia: The Journey Begins

The women began talking one by one – telling the stories of their own childbirth journeys. Though the memories are mostly painful, there is solace that comes from being surrounded by women who have shared a similar experience. They speak in their native language – Somali – and though I do not understand a word that is spoken, I can see the pain in their eyes and the way they use their hands and bodies to express themselves as they act out their stories. The room is hot and airless, but the women remain fully covered in their

hijabs, seemingly unfazed by the stifling heat. They are in a different place; they are in a different time. It is Somalia during the war, before their journeys across the Horn of Africa began.

Childbirth in Somalia is rich in culture and religious traditions, and the tremendous strength and courage of its mothers. Women for generations, particularly those who live in rural or remote parts of the country, and marry as young as 13 years of age, have given birth to their first child in the privacy of their homes. When their “time comes” and labor begins, the women in the extended family gather around – mothers, mothers-in-law, sisters, and cousins – providing emotional, physical, and moral support to the young wife getting ready to give birth. Sometimes, if she is fortunate a traditional birth attendant or midwife joins the gathering. The young girl in labor walks around in circles, praying through the worst of her pain and contractions. She does not ask for drugs to manage the pain because there are no drugs available for her.

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. Somalis don't believe in interventions – Allah will take care of the mother and unborn child and 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, and approximately 80 percent are infibulated as very young girls. But the midwife knows how Somali girls need to be cut –“side to side”– to avoid the “cut to the bottom” [fistula] and help the baby come out.

At the end of five, six or sometimes even seven days the young Somali girl labors on, physically and emotionally exhausted from the never-ending pain of her labor – but at last

Allah provides – and the midwife or one of the female elders with experience delivering babies, holds the expectant young mother from the bottom, puts her hand inside the young woman's body, pushes the baby up and carefully guides the baby out. After a cleaning of the nose and throat, and a gentle slap on the buttocks, the baby begins to cry. The young girl's husband, who has not been permitted in the room because Somali culture forbids it, waits patiently outside with the other men. He hears the cry and now knows the baby is alive. His young wife, too, has survived. It is a good day in Somalia... a day for celebration.

As a Westerner, these cultural traditions are completely foreign to me – no hospital, no doctors or nurses, no fetal monitor, no epidural – 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 unnecessary, preventable deaths. As my Somali research partner begins to explain, there are many factors that contribute to Somalia having one of the highest maternal and infant mortality rates in the world.

Even for women who are fortunate enough to 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 birthing experience during the war, where a midwife's error had a bad outcome for a brand-new mother.

I had my first child in Somalia during the war when I was 14 years old. [I was at home] and the midwife cut me up when I had 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 had to cut the stitches and sew me up again. [After all that], my son died.

This story brought a wave of tragic childbirth journeys to the surface – the women patted each other's hands and shook their heads – growing closer as they told of their own

first childbirth experiences. Even in the cities or urban centers, where hospitals, clinics, and doctors were available, many women still preferred the use of midwives and traditional healers. The next story of a young mother's multiple, sequential infant deaths brought tears to my eyes as well.

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 that I consulted with the doctor who told me it was because of my husband's blood type that the babies are dead at birth.

After listening to these childbirth journeys involving midwives and healers – I felt compelled to inquire if these infant deaths and labor challenges led the women to seek out a doctor or go to a hospital. I had enough previous work experience at international NGOs with expectant mothers in developing nations being referred to hospitals to know that even in cultures with rich birthing traditions, women will seek out emergency obstetric care in life-saving situations.

The women told me that in the case of what appears to be severely prolonged or obstructed labor, which continues for days on end with no relief, they will go to the nearest hospital. Of course this depends on being fortunate enough to find the necessary transport – an ambulance, a truck, or even a wheelbarrow – whatever it takes to get the mother and her unborn child safely over the hot, dusty, unpaved dirt roads of Somalia to her destination.

The following childbirth journey also ended badly, this time because of the cultural tradition that suggests cesarean sections should only be considered in cases where the life of the mother or child is in obvious danger. In the words of one mother:

I was in labor for three-to-four days. Finally we went to the hospital. The doctor said I

needed surgery [cesarean section] because the lengthy labor made the child breech and there is no chance of straightening him out. The family took me home because they didn't want a C-section – it is against our culture. They thought the surgery might cause me not to have other babies. They were not sure how the surgery worked. After the fourth day of continuous labor I gave birth to a dead child.

We shook our heads in sorrow for this woman's loss. As I was to learn over the course of the three weeks I spent in Minneapolis with these brave women – there is much that they fear about cesarean sections. Among the myriad reasons, in a culture where the community considers the family “wealthy” if they have 10 children, the thought of surgery resulting in not being able to bear additional children is an unbearable tragedy to most Somalis. There is much more to be said on the topic of cesarean sections, which will follow in the next chapter.

The final story of Somalia childbirth that I have chosen to share speaks to the subject of referrals. Even for those Somali women who sought out doctors and hospitals after experiencing prior infant deaths – the outcomes are not necessarily positive. In an oral culture characterized by storytelling, unfortunately these negative childbirth experiences get told hundreds of times in the community, and can have a strong influence on how women choose to give birth. In the opinion of this mother whose words dripped out of her like water from an empty village spigot, an experienced midwife could have saved her unborn child. The story is one of probable incompetence, but opinions notwithstanding, it compelled this woman to want 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 then left for a nearby bar and started drinking alcohol. [He came back] and told me it was a girl but she had her feet [coming out first]. The nurses said you cannot have the baby here and they transferred me to another hospital while the baby's legs were out of me. Her chin got stuck in my cervix, 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

As has been noted elsewhere in this report, the Somalis who fled the death, devastation and destruction of the civil war from 1991 to the current day, walked for weeks on end – with little to no food or water to sustain them – in the hopes of surviving long enough to evade the bandits and reach refugee camps in the bordering countries of Kenya, Ethiopia, and Djibouti. Given that 20 percent of women in these crisis situations are typically pregnant – it was not surprising to hear the stories of many Somali women in our focus group discussions who gave birth to several of their children in these neighboring, foreign lands.

It is another sweltering day in Minneapolis, and this time, we sit together in the intimacy of the home of one of the participants, on ornate couches, large pillows, and plush carpets purchased at one of the local Somali malls. With the graciousness typical of a Somali woman greeting guests in her home, she passes piping hot, honey-sweetened tea with milk around the room. We all partake despite the 90-degree heat and sip slowly as the women’s voices fill the room. These women are generally older, more experienced mothers than the prior groups – some of them have given birth to as many as 10 children. As they start to share their childbirth journeys, graphic tales of life in the refugee camps emerge.

The conditions in the camps, particularly in the early days after the war broke out were horrific. Imagine more than 100,000 people stuck in a place where there is literally 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 civil war in Somalia broke out, and most will be there until peace is restored to Somalia once again.

Many of the Somali women speak expressively, sharing horror stories about maternal

and child deaths in the camp clinics and how those stories spread through the camps like wildfire. They 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 that Somalis would consider a successful childbirth journey.

I had a girl Kakuma Camp [in Kenya]. I was 15 when I had her. This was 1999, and there were not many Somalis. They told me horror stories about having a child at the hospital. They told me a girl died there while having a baby. They do not like Muslim girls. I told my mother that I would have the baby at home; we had a neighbor that was a traditional midwife. When the labor came, I had the baby without many complications, although there was some blood that I lost through the delivery and the labor took long.

Another refugee story would be considered challenging to most Westerners, but it was neither worrisome nor stressful for the mother who shared it with us:

My second child was [born] at the refugee camp in Utange [Mombasa, Kenya]. I went into labor and a Somali lady helped me. She slept next to me and when the labor intensified, I woke her up and I delivered my daughter without any problem.

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 parts of the camp. Once again, 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 my 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 long and terrifying story, another woman told us about her childbirth journey at an Ethiopian camp. In her opinion, the camp doctors and nurses don't transfer you to the hospitals until you're almost dying, and even once

you're transferred if you need surgery, the doctors force you to decide on the spot whether you want to save your unborn child or save yourself. It is harsh and inhumane; it is also common.

I almost died giving birth to my sixth child. I was held for 21 nights at the refugee hospital. When I had no strength left in me [from the labor] and was almost dead they transferred me to the city 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. So 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.

As these stories indicate, many of the Somali women who fled the war became refugees in Kenya. While Kenya had a relatively sophisticated national health care system, including doctors and modern hospitals for childbirth, this care was only available for the small percentage of upscale families who had the money to pay for these services. For most refugees, this level of care was far out of reach and therefore unimaginable. A soft-spoken Somali woman with seven children told us about her journey through her tears. After five uneventful, successful childbirth experiences in Somalia thanks to family support, she had a tragic birth experience as a refugee in Kenya.

The child I had in Kenya was my most difficult birth. One day [when I was at 7 months] I went unconscious. A pharmacist came to look at me and said my relatives should take me to a hospital. Instead they took me to a Somali midwife but when she saw [I was in a coma] she said she could only help with deliveries for healthy women having babies, and that I needed to see a doctor before things got worse. But we did not have any money so they brought me back home and put me in a room [still in a coma]. One day everyone was outside having tea and one of the girls came into my room and saw blood all over the floor – it was the baby coming. The girl ran to get the pharmacist and when they came, the baby was out and lying next to me but the umbilical cord was still attached. The pharmacist cut the cord, put me on an IV and gave me injections and other medications that brought me back. My son was not moving at all, so they just wrapped him up and put him aside. After 10 days I was able to hold my son but I was still hallucinating and asking people how they got the baby out. Now my son just turned 15 years old – he does not talk, he does not walk and I have to help him eat.

United States: The Journey Ends

All of the women I met made heroic journeys from Somalia to neighboring border countries, sometimes immigrating to the Middle East or Europe before finally settling in the United States. While Minneapolis, Minnesota is currently home to an estimated 100,000 Somalis, it is frequently the second or third stop in the United States in these Somalis' nomadic, transcontinental journeys to resettlement.

While Minneapolis offers families a chance at a new life with decent jobs, good schools for their children, and sophisticated health care, while they are embraced by a large Somali community that shares their culture and religion, years later there is still much about Minneapolis life that is foreign and uncomfortable – particularly when it comes to the childbirth experience – and especially for Somali women who have not experienced childbirth in a Western hospital supported by a white physician.

What follows is a typical Somali woman's childbirth experience in a Minnesota hospital, as told to me by the women in our focus group discussions. By the time she has made the long, arduous 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 and lost to her forever. To begin with, 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". She isn't yet comfortable with the English language and her Somali interpreter just does not seem to have a good grasp of the medical terminology that matters. At 39 weeks, this woman is officially "past due" according to Western standards, and her doctor wants to induce labor. But this experienced Somali woman knows her tired body well and is sure it isn't her time

yet, plus all Somali women know that 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 cultural tradition. Finally, after a couple of days, she feels inside her womb that it is her time and her husband drives her to the hospital. She wishes she had all of her women elders, sisters, and cousins around her for moral and emotional support, but the woman and her husband are just a nuclear family now, as their relatives sadly were left behind in Somalia and the refugee camps, so her husband alone accompanies her to the hospital.

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 back home in Somalia, but she cannot. Instead, they tie her down, surrounded by all of this “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 to Allah. 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!” And the Somali women all laughed.

It seems that no matter what your tenure in the United States, once an immigrant, always an immigrant. One Somali women with eight children, six born in Africa and the last two in the United States had a very unfortunate, somewhat atypical experience, which she felt was largely driven by her immigrant status.

In the United States, as long as you're an immigrant, [the doctors] do not give you

proper care. I was pregnant and my child had his umbilical cord wrapped around his neck. The doctor saw it, but they did not care about it. When I had the ultrasound they 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 still has a disability from that birth.

After that negative journey, this woman had only one more child – and the problems she suffered this time, in her opinion, happened despite giving birth with one of the city's best doctors according to the Somali community.

I went [to the hospital] at night after I have labor, but they checked me in and said the baby will come the next day, but after 30 minutes I had another strong labor [contraction]. I alerted the nurses and they all came, so during the delivery they pulled the baby inappropriately and broke his shoulder. And this is supposed to be one of the best doctors in Minneapolis!

The topic of cesarean sections came up in all of the Somali interviews – with the Somali women, the Somali men, and the Imams. According to the Imams, the English word “surgery” translated into the Somali language means “slaughter,” so they suggested that perhaps when physicians and providers use this word it creates instant dread among the Somali population. I make a note of this for my interviews with the Western maternal health care providers.

Though Somali men aren't going through the multiple childbirth journeys of their wives, they had much to say about why cesarean sections are problematic – most of which will be analyzed in the next chapter. Suffice it to say that emotionally they experience their wives' pain and suffer their own “complications” from these unnatural births – as it impedes their ability to have as many children as they would like to have.

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 the pain. The other thing is that my father had 10 kids and I would like to have that many kids but now my wife is frightened to have many kids, because she is afraid of having many surgeries. My wife says she might die when having kids. Now my wife is ill all the time from the complications from those births.

Conclusion

As I learned so well from this memorable time spent with the Somali community – joy, terror, tragedy and everything in-between is in the eye of the beholder. These childbirth journeys – even those I might consider to be the more 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.

Without these vivid depictions of transcontinental childbirth, I would have never been able to successfully encourage the Somali community to so freely share their concerns about Western medicine. Moreover, the Somali women’s comfort with me after we experienced their “childbirth journeys” together put them at ease for the more personal discussion of Somali cultural and religious traditions that followed. An analysis and comparison of both topics can be found in Chapter Five.

Chapter Five Analysis

Introduction

In-depth analysis of the Somali focus group discussions with 25 women, 12 men, and three Imams and the one-on-one interviews with seven Western maternal health care providers revealed substantive differences in reproductive health care between Western medicine and Somali cultural traditions. Overall, while many Somali women and men felt that reproductive health care in the United States was superior to Somalia and the refugee camps based on its advanced healthcare system, technology and high-quality providers, a large number of those interviewed had serious concerns about Western medicine and preferred the comfort of their own cultural and religious practices.

As the summary chart on the next page and the following analysis indicate, there is a large gap between Western medical practices and Somali culture, which reinforces the need for more culturally sensitive reproductive health care. That said, there are a number of Minneapolis-based hospitals and clinics that have been providing reproductive health care for the Somali community since they began arriving in the early 1990s. From these providers, a collection of best practices for culturally sensitive care has emerged which are outlined at the end of this chapter.

Description	Western Medicine	Somali Cultural Traditions
Medical Model	Preventive	Curative
Preferred Caregiver	Physician	Traditional Healer/Midwife
Finding Physicians	Complex Referral System	Community Stories/WOM
Antenatal Care	Every 2 Weeks	Little to None
Childbirth	Hospital	Home
Gestation Period	38-40 Weeks	42+ Weeks
Post-Date	Induce Labor	No Interventions
Labor	Lying Down w/Fetal Monitor	Walking Around
Pain Management	Epidural	Prayer
Cesarean Section	Myriad Reasons	Life-Saving Only
Female Circumcision	Illegal	Infibulation
Episiotomy	Midline	Medio-lateral
Delivery	Mother Pushes Out	Midwife Pushes Up and Out
Modesty	Male or Female Physician	Female Physician/Midwife
Husband Participation	Husband in Delivery Room	Women in Delivery Room
Postpartum	2 Days in Hospital	40 Days at Home
Support System	Nuclear Family	Extended Family/Neighbors
Family Size	Couple Decides	Allah Decides/Peer Pressure
Child Spacing	Modern Birth Control	Breastfeeding Only (2 Years)
Marriage	Monogamy	Polygamy Accepted
Language	English or Somali Interpreter	Somali

Medical Models and Prenatal Care

One of the fundamental differences between Western medicine and Somali cultural tradition is the respective medical model. Western medicine follows a preventive, long-term 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 gets worse.

These differential medical models directly relate to the practice of prenatal care. In Western medicine, when a woman is pregnant, her prenatal care usually begins around eight

to 10 weeks with her first pregnancy exam 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, “The difference between Somalia and here is that here when you get pregnant, you see a doctor, but in Somalia, you have to hide your pregnancy.” Frequently prenatal care wasn't available in Somalia, or if it was, they may not have had the money to pay for it. Either way, for experienced Somali mothers who gave birth to large numbers of children in Africa, the recommended level of Western antenatal care is viewed as inconvenient or women don't see the value in it. As one Somali woman told her obstetrics and gynecology physician (OB/GYN), “I've had eight children and everything turned out fine. I know my baby is healthy because it is moving. Why do I have to be measured every two weeks?” The implication of this difference in prenatal care leads some experienced mothers to come in once at 20+ weeks for an ultrasound, and after that, women don't return until they are in labor.

Two types of critical prenatal testing are also worth noting here. U.S.-born women generally want antenatal genetic testing – which can identify a range of major birth defects or chromosomal problems such as Down syndrome. This testing is found to be offensive by many Somali women – they believe that God has given them the gift of this baby and don't understand why physicians are trying to interfere. Moreover, Somali women are concerned that Western physicians who do prenatal genetic testing are looking for reasons to terminate the pregnancy, which is strictly forbidden according to Islamic tradition. The second form of antenatal screening, for gestational diabetes, if left untreated can result in a very large baby and a difficult birth. As an OB/GYN described, “For a Somali woman in a new country with four toddlers at home, the way we are asking her to monitor her sugars and change her diet

can be overwhelming.” One of the Somali women reinforced this notion, adding, “Even the diabetes screening appointment is too long, not to mention all the changes the doctor asks her to make. That woman is just going to come home stressed out afterwards and have a big lunch of goat and rice.”

Caregivers

The all-important question of who provides a woman's reproductive health care revealed several key differences between Western medicine and Somali culture. For women who believe in Western medicine, their preferred provider is a physician. For Somali women, their preferred provider in the United States and Somalia is a midwife, and possibly even a traditional healer if she still lives in a remote or rural part of Somalia. Finding a reproductive health care provider in the West often involves a very complex referral process through a woman's primary care physician. In the Somali community, what matters is word-of-mouth. The stories of unsuccessful childbirth are told hundreds of times over as are the names of good physicians or midwives who tend to end up caring for very large numbers of Somali women.

Another critical aspect of caregiver selection has to do with a Somali woman's modesty. All women clearly want the best for their babies, yet American women are generally comfortable with male or female physicians, and Somali women have a very strong preference for female doctors and midwives. As noted in the previous chapter, Muslim 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.” One Somali woman reiterated this notion, “I was so afraid a man would help with my delivery.” Another Somali women added, “If all doctors are women, then I can share anything with them and be comfortable.”

Childbirth

Given that a significant portion of the research had to do with the subject of medically assisted versus natural childbirth, it is not surprising that a number of critical differences emerged related to this topic. For nearly all women, both Americans and Somalis, childbirth in the United States takes place in hospitals. As we've seen in previous chapters, it is Somali cultural tradition in their native country for childbirth to take place at home, and in hospitals in the case of an emergency or when the woman is about to give birth. A range of other childbirth-related factors follows.

The typical gestation period (the duration of pregnancy) for most women is 38 to 40 weeks. In contrast, Somali women uniformly 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 general reluctance to do post-dates testing past 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. We could all take a lesson from their ability to accept that death is a part of life.”

This question of post-term pregnancy (or a baby that has not yet been born after 42 weeks of gestation) is directly related to the Western medical practice of inducing labor.

After 42 weeks of gestation, the placenta, which supplies the baby with nutrients and oxygen from the mother, starts aging and will eventually fail. Post-term babies may be larger than the average baby, increasing the length of labor and difficulty of a vaginal delivery as the baby's head may be too big to pass through the mother's pelvis. Two of the most common methods of inducing labor are breaking the mother's water and giving women the synthetic hormone Pitocin. Somalis are culturally “anti-intervention” and their aversion to inducing labor was expressed by Somali women, men, and Western health care providers alike. One of the nurses described a Somali mother's response, “It is in Allah’s hands and I'll deal with that whatever happens.” A Somali husband shared his regret that the couple agreed to induce, stating, “The doctors induced labor and my wife still has back problems from it – we should have waited for the natural birth.” Finally, several Somali women commented that they had refused inducing labor because they believed that it “burns the womb,” meaning that the uterus ruptures or tears and women won't be able to carry additional children, which is a tragedy in Somali culture.

The interviews with Somali women consistently surfaced their discomfort at being “tied down” during labor, or attached to a fetal heart monitor, versus their culture of freely 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 maternal health care providers or they were not understood.

The issue of pain management during labor was also a popular topic in the Somali interviews. A number of Somali men whose wives had been given epidurals claimed that it had caused their wives residual back pain, which continued long after their children were

born. 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 lack of pain during labor in the West is "...a piece of heaven."

When the time comes for the babies to be delivered, there was quite a bit of discussion from the Somali women about the Western medical practice of the mother pushing the baby out versus the Somali practice of midwives holding the delivering woman's buttocks up and helping guide the baby out. In many instances, the midwife will put her hand up 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, "In Somalia they say don't push hard to avoid injuries, but here they ask you to push whether the baby is big or small. My friend sustained an injury from pushing her baby out and still has pain. I don't understand where this culture of pushing comes from when it causes injuries."

Another woman reinforced the benefit of the Somali way of giving birth, "At home, the midwife gives you support from the bottom; it is normal 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]."

Obstetric fistula is a severe medical condition in which a hole develops between the rectum and vagina or the bladder and vagina after prolonged labor because the unborn child presses tightly against the birth canal causing the surrounding tissues to disintegrate and rot away. Women suffering from this disorder are subject to severe social stigma due to the odor of their urinary or fecal incontinence, perceptions of uncleanness, and in some cases, the inability to have children.

One of the interesting discussions that had clear generational differences among the

Somali population was the husband's participation in the delivery room. As we saw in the Childbirth Journeys chapter, when women give birth in Somalia, according to cultural tradition, the men are not allowed in the delivery room – this experience is culturally appropriate only for the mother, mother-in-law, sisters and female cousins. In the United States, however, much to the dismay of the older Somali women (over age 30), their husbands are frequently with them in the delivery room. As one woman definitively stated, “I don't want my husband to see my vagina when it is swollen, ugly and bleeding.” One of the younger women countered, “It is not fair that he only sees it when it looks beautiful.” The Somali men shed some interesting light on this topic. Many of them explained that in the United States, they are a nuclear family, and therefore, 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.

The last difference that was noted during the childbirth discussion (but applies to reproductive health in general) related to language difficulties. In the United States, Somali women either struggle to speak English with their maternal health care providers, or preferably, use a Somali interpreter. This is compared to conversing with a care provider in one's native language – which results in clearer communication and less misunderstandings. While Somalis and Western health care providers both deemed interpreters essential, the two communities expressed frustration and concern with important information being lost in translation.

Cesarean Sections

Without question the most heated discussions centered on what the Somali community described as “Western doctors' rush to cesarean sections.” This is a major dilemma for the

Somali community who does not understand why doctors don't give women more time in labor in order to have natural births. Further, there is a broad perception that doctors are harsh and insensitive of this Somali cultural tradition. They have been known to come to women in labor and say, "Either sign for this surgical procedure or sign that you won't give consent and you are responsible for the consequences." This is not much of an option for Somalis to consider.

According to Somalis, cesarean sections aren't part of their culture, and are acceptable only if the life of the mother or her child is in danger. In the West, there are myriad medical reasons for performing cesarean sections, including: post-term babies, women whose pelvises are too small for their baby's head to pass through, breech babies, umbilical cords wrapped around babies' necks, premature babies in fetal distress, and the mother or infant's life in imminent danger.

Somali fears and apprehensions about cesarean sections are well documented in the literature. As the Imams explained, the English word "surgery" in Somali means "slaughter," which they believe contributes to the fear a woman has of dying or losing her child during cesarean sections. Other fears noted by the Somali women were suffering from a disability, difficulty caring for their children after surgery, and most significant – the inability to have additional children. When pressed about *why* the inability to bear more children created such fear in Somali women, their consistent reason was illustrated in the following story told by an OB/GYN, "I had a patient who had given birth by C-section seven times. During the last one, 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.' Her husband

responded, ‘She is convinced that if she stopped having children, that I’ll leave her. Her father left her mother for just that reason. But I’ll never leave her.’” Many Somali women confirmed the validity of this fear and revealed that this was one of the major reasons that they tended to give birth to children on an annual basis. One Somali man told the story of a friend's divorce because his former wife refused to get pregnant because she was afraid of having another surgery.

While this was not a quantitative study and as such, the data does not exist to validate these figures, the Somali men perceive that as many as 70 percent of Somali women in the United States give birth by cesarean section. Of note, it would be extremely interesting for the United States Department of Health and Human Services to research the percentage of Somali women who have cesarean sections versus the percentage of American women who have cesarean births. In particular, the Somali men have strong opinions on why doctors do so many cesarean sections, which ranged from doctors’ ability to make more money from surgery versus natural births, to cesarean sections making their jobs easier and more efficient because the birth timing can be planned, to doctors using this opportunity to train residents, and much to the dismay of the Somali men, to prevent Somali women from having more children.

One Somali man summed up many of these concerns, “In Somalia, only 1 percent to 2 percent of births are by C-section, but we see here maybe 50 percent to 70 percent of deliveries are done by surgeries. So we think because of this high number of surgeries, the doctors want to make money from the surgeries; they will make less if the child was born naturally. They also want for the mothers to have fewer children. They tell mothers after three surgeries that she will be responsible for herself and her unborn children from here on if

she has problems. That is what makes us fear C-sections.”

A related topic covers the decision-making process for cesarean sections. When the Imams were asked if the Quran gives any guidance on whether or not women should have a cesarean section they provided this counsel, “The Quran says ‘ask the scholars’ which means it is always wise to ask knowledgeable people. One of the five basic rights to be preserved is life. Therefore, if lives are endangered it is wise to seek advice of knowledgeable people – in this case doctors – to find the best outcome. If the doctor says there is danger to the mother’s health, it is mandatory to accept that doctor’s advice.”

That said, the Somali community often had difficulty accepting the advice of the physician. For example, 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 recommendation and risk the consequences. One man’s story reinforced the community’s frustration with not understanding the rationale for doing cesarean sections, “One day, my wife went to her routine appointment, she drove by herself and when she got there they checked her vitals and after that the doctors went outside and sounded an alarm; they came back with their surgery gowns and said she will have a C-section. I came over and a female interpreter was there too. I asked how could she have surgery when she came all by herself. They said we checked her in and realized that she was has to have a C-section and asked me to sign papers. I told them I was not going to sign and they left and went ahead with the surgery. The mother and child, they were not in danger.” Clearly, in this case either the reasons for surgery and risks to the mother and/or unborn child were not clearly explained or something important was lost in the translation.

As noted in the previous chapters, in Somalia, it is typically the men in the family who make decisions about cesarean sections, often to the detriment of the mother or her baby. In the United States, younger couples who don't have a large extended family here to support them generally make these decisions together. When the extended family lives in the same city as the expecting couple, custom still dictates their involvement in the decision-making process. Many relatives are against cesarean sections, and believe women should have babies naturally as cesarean births can cause the inability to have other children. “The milk jar and its cover are not comparable” is a phrase commonly used in Somalia, which means the woman's life is more valuable and should not be risked, and at other times means it is easier to give birth naturally than by surgery.

Female Circumcision

In the United States, female circumcision is against the law. In Somalia, as previously cited, 98 percent of women and girls are circumcised, and approximately 80 percent of them go through infibulation, which is the most severe form of circumcision that is practiced. Much has been written on this topic as well, which both the Somali women and Western maternal health care providers addressed during their interviews. Most physicians are unfamiliar with circumcised women, and as a result, 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,” yet at this stage the women have difficulty concentrating on the question at hand. In one woman's words, “There was no discussion whatsoever. The doctor decided on her own during labor to cut me.” On the other hand, hospitals and clinics with extensive experience caring for the Somali community tend to show more sensitivity to circumcised 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 let us know what you want to do after birth in terms of repair.” A Somali woman reinforced this idea of developing a plan and taking action before labor begins, “Personally, I think it is better to get cut during pregnancy, and there will be nothing pushing you later and the child will come out normally.”

Aside from these examples of sensitivity and advance planning, many Somali women felt that their doctors didn't “know how to cut,” referring to the practice of doing an episiotomy to help the women give birth naturally. One woman stated, “In the United States 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 that the biggest issue they have 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 United States as a result of the midline episiotomy, instead of being cut medio-laterally or in their words “side-to-side,” as they are cut in Somalia. This Somali woman's point of view summarized these opinions, “Since I had two vaginal births, they didn't cut me at all, and I ended up with a cut to the bottom [obstetric fistula].”

One of the final challenges with women's circumcisions has to do with the Fircooni circumcision style in Somalia where girls are sewn afterwards. These circumcisions tend to heal after they are cut for births, so as a result women need to be de-infibulated and repaired each time. Given this particular challenge, one of the maternal health care providers was asked what U.S. law indicates regarding de-infibulation and repair, and she replied, “We can repair it if we undid it.” She continued to say, however, that there are others 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 Americans consider to be a human rights violation with such sensitivity.

Postpartum Phase

After Somali mothers give birth, there are major differences in the care that the woman receives in the United States and back home in Somalia. In the West, mothers typically stay in the hospital for two days at most 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 especially true 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 made the group laugh but was 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.”

This Western practice is compared to the much-loved Somali tradition of the ummul (new mother). It was vividly 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 around the clock, keeping you company, watching your children, and bringing you meals, including the best meat, porridge and soup to restore your energy. At the end of the 40-day period there is a small celebration – a “coming out” with the baby. The mother looks beautiful and rested.

Many women reminisced about this cultural practice and dearly missed the company and support of their extended family in the postpartum period. In one woman's words, "Everyone in America is so conscious of their time – they have some kind of work going on, and you will not find anyone to stay with you after the baby is born like in Africa." Another woman clearly preferred the support that mothers were provided in Somalia despite the challenges of fleeing from the war and the high levels of maternal and infant mortality, "Somalia childbirth was a better experience for me overall – I felt I had moral support, physical support and emotional support."

Child Spacing

The first research question that came up related to child spacing was, "How do Somali couples determine family size?" This would not be an unusual question in the West because the husband and wife generally decide how many children they would like to have and when to have them. Yet for the Somali community this is a strange question. As one Somali man firmly stated, "Man and wife do not talk about these things." Another chimed in, "We believe that God provides, so we don't limit the children we have."

As a result, the counsel of the Imams was sought, who provided the following information about children and family size according to the Quran, "One of the three purposes of marriage is to bring about children and populate the Earth. Islamic faith says that having more children is good because the Prophet encouraged his followers to have many children to show he had more followers in the next life. The Quran says in many places the children are gift from Allah. The Prophets all pray for children, as they are one of three sightings that the Prophet enjoyed."

With this cultural and religious practice of having large families in mind, the Somali

women and men both spoke of family 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 coming from her mother to bear as many children as possible. Another woman shared her views, “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.” A third woman recited a well-known Somali saying that summed up this familial pressure, “The baby camels go after the big camels.” This means that today's Somali men are doing what their fathers and grandfathers did, suggesting that Somali culture still has many disadvantages for women as it can be very difficult to have as many children as their husbands and relatives desire.

The term “child spacing” tends to be used exclusively with the Somali community. It refers to the practice of spacing out the birth of one's children by exclusively breast-feeding a child for two or more years for the health of the mother, the health of the new baby, and the future babies that 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 their children. This is compared to the more commonly used term of “family planning” and Western methods of contraception or birth control such as the pill, condoms, intrauterine device (IUD), tying a woman's fallopian tubes, and more.

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. Interestingly, these particular Imams stated that pills, condoms and other “medical child spacing methods” are not against their religion if contraception is used for child spacing purposes. However, they said that Western birth control methods are not part of Somali culture and that their women

and men are ashamed to use these modern techniques. Even the term “birth control” assumes that people are in charge, and all good Somalis know that God is in charge. If a mother doesn't get pregnant for a while people will start asking whether she “locked” herself [had her tubes tied]; therefore, from the Imams perspective there is tremendous guilt among mothers using birth control.

The Somali men unanimously agreed that child spacing is consistent with their religious beliefs. However, most of the men commented that as Muslims, they believe that families should not space their children for too long, because God provides. Men whose wives gave birth every year were especially proud of their large families and they were the envy of others in the Somali community. Many Somali women described the paradox of couples wanting to comply with their religion which calls for two-year child spacing, yet Somali custom results in husbands pressuring their wives to have babies every year.

There was a moderate amount of disagreement and confusion among the men as to whether Western methods of birth control are allowed. One Somali man definitively 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. A third Somali men explained, “Western child spacing is only disapproved of if families say we are having two or three kids and we're going to stop there – that idea is against our religion.”

The Somali women also agreed that their religion permits child spacing through breastfeeding until the baby turns two, that those two years should be dedicated solely to the new baby, and then it is time to think about having another child. Many of the women also noted that men can “pull out of the woman before ejaculating,” but said that it wasn't foolproof.

One woman commented that Somalis who use Western birth control typically hide it because if other Somalis found out they would say, “Don't you know God can get rid of your other children too – why deny what God has given you.”

Consistent with the men, there was confusion among the women who felt that they didn't have full knowledge of what their religion permits. For example, one woman inquired of the 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 answered, “It is true for some others but I was having babies every year and I was breast-feeding.” One of the woman's Imams advised that the Muslim religion says in order to use drugs to space children, there has to be a sick mother or a sick child. An opportunity exists to provide consistent education to the Somali community about what the Islamic faith allows, and explain why some women can get pregnant while breast-feeding.

Many of the maternal health providers commented that their U.S.-born Somali patients tend to be more knowledgeable about family planning options and are more willing to consider birth control than their Somalia-born mothers. Despite this knowledge and growing use of birth control, one nurse talked about a Somali patient who had four children over the last four years and while she does not want to be pregnant again, she didn't feel she could use Western birth control methods because of her religion. Others spoke of Somali women who had IUDs put in without their husbands' approval, and then returned only to have the IUDs taken out again. One of the OB/GYNs confirmed that she hears much about the two-year child spacing window, but if women go much longer then the husband has the right to find a new wife, which is why some Somali men have multiple families. Finally, an OB/GYN clarified that breast-feeding works well as a method of birth control for about six

months, but that as soon as the woman begins giving the child solid food or when the woman begins supplementing breast-feeding with formula, she can begin ovulating and get pregnant again. In addition to the previously noted pressure coming from the Somali husbands, this could help explain why many Somali women have babies every year.

Overall Quality of Care

When Somali women were asked about the overall care they received by their providers, the sentiment was generally positive. That said, a sizable number of women felt that they were discriminated against because they are immigrants. One woman shared her experience of being in excruciating pain and the nurses were just standing outside laughing and telling stories. Another woman said that some hospitals get a reputation for being racist against Somali immigrants, and that once word-of-mouth spreads in the community, no Somali women will give birth there.

There are perceptions of experimentation among the Somali community and that they are being “practiced on as guinea pigs.” The use of medical residents perpetuates this feeling of experimentation because “student doctors” are treating them. Clearly, it has not been explained to this community that all patients in teaching hospitals and clinics have residents working with them. One gentleman even stated his belief that providers experiment with new drugs on the Somali community.

Many Somalis believe that their Western providers are insensitive with them and use an overly directive communication style. When doctors say things like, “If you don't want to have a cesarean section, then find another doctor,” women feel abandoned. What the Somali community is asking for is very simple – they want to be given options and they want to have an open discussion about those options with their providers. The words of one Somali man

summed up this sentiment, “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 for Culturally Sensitive Reproductive Healthcare

As this chapter suggests, there is a clear lack of trust and a gap between the cultural beliefs of Somali families and Western reproductive health care practices. Yet, 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 are the ones that were interviewed for this research and they were proud to share their best practices for culturally sensitive reproductive health care. From those interviews, a set of the top 12 best practices was derived, which are summarized in the chart below. An overview of each of these practices follows.

#	Best Practices
1	Build 1:1 Relationships
2	Respect Culture/Religion as Part of RH Care
3	Provide Options/Consult with Families
4	Hire Somali Staff and/or Speak Somali
5	Offer Female Providers
6	Make Midwives Available
7	Contract with Competent Interpreters
8	Understand Female Circumcision
9	Learn Somali Life Stories
10	Lecture Staff on Somalia History
11	Respect Somali Calendar/Holidays
12	Do Community Outreach

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.” She continued to explain that doctors can't understand individual beliefs

from projecting general belief systems. Another physician reinforced this message, stressing that you can't generalize the population – 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 that 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. This level of broad clinic-wide respect, kindness and sensitivity is something that should be practiced by every provider working with the Somali community.

3. Provide Options and Consult with Families

The providers who were interviewed 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 that I interviewed had a wonderful practice of hiring Somali staff – in the front office and as practicing residents to help make the Somali families feel supported

and able to communicate more easily in their native language. Several staff, including physicians in this practice, also went to classes to learn basic Somali and embraced key aspects of Somali culture to make the women and also their husbands comfortable. For instance, they don't shake hands with the husbands if they are female providers. 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.” Imagine how much more comfortable those patients must be as the result of these efforts.

5. Offer Female Providers

All of the hospitals and clinics interviewed understood Somali women's discomfort with male providers. As such, they made an effort whenever possible 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. Of note, as you might expect, the cesarean section rate is lower in the midwife unit (at a record low of 12 percent) versus the doctors' average cesarean section rate of 16 percent to 20 percent in the main hospital.

7. Contract with Competent Interpreters

The need for competent interpreters is essential both for the Somali women, their families, and the maternal 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 in particular noted the importance of continuity and availability of the interpreters not only for appointments but also for phone consultations throughout the pregnancy.

8. Understand Female Circumcision

One of the midwives combines sensitivity and respect for women's circumcisions with the opportunity to educate women on the different types of circumcision and their options for repair postpartum. She uses laminated pictures of a non-circumcised vulva, all the way through a Type III infibulation and lets women decide with their relatives what they'd like to do in terms of repair. She commented, “I place a high value on women's desire to have her circumcision the way she wants it.” In addition, an OB/GYN who participated in the research is well known in the community for her lectures to medical students on female circumcision. Given that 98 percent of Somali women are circumcised, respecting their sexual identity, supporting women’s preferences for medio-lateral episiotomies, and discussing options for repair are all important areas of collaboration for the medical community who treat Somali women in major cities across the United States.

9. Learn Somali Life Stories

As one OB/GYN explained, “Understanding the journey these women have made –

from Somalia, to Kenya, to Northern Europe, to various cities in the United States – all influences our discussions regarding reproductive health.” Another OB/GYN has created a unique 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 (since many are missing)? 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 best evidence she has gathered, she provides an overview of the Somalia Civil War, what it means to be a refugee, what the refugee camps are like, introduces Somali culture, differences between Somalia and United States medical systems, and more. This presentation is provided to all incoming residents and is an excellent tool for understanding the context and prior lives of the Somali patient before she comes in for a visit. This is another best practice that should be shared across the nation for more culturally sensitive reproductive health care.

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 right after the holidays above-mentioned.

12. Do Community Outreach

A couple of the clinics and several 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. As she stated, “It is all about coming from different directions and trying to find common ground.” 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.

Overall, these best practices are but a sampling of many of the ways that these well-attuned providers are giving culturally sensitive reproductive health care to Somali families. Unfortunately, according to the Somali population, a gap still exists between most providers' medical practices and the Somali communities' cultural and religious belief systems. As one Somali woman rightly stated, “It's all about how much interaction there is between people to understand each other's culture. If there is a gap, there will be misunderstandings.” There is an opportunity for a central party, such as the Minnesota Department of Health in the Minneapolis area, to act as a convener in partnership with NGOs, to spotlight these best practices and encourage other providers in the community and across the country to adopt them in their own work as the Somali community grows. These and other recommendations will be addressed in the final chapter.

Chapter Six Conclusion and Recommendations

Conclusion

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 immigrants and refugees. The previous two chapters in particular were designed to give maternal health care providers rich descriptions and information about the Somali community's preferred cultural traditions related to pregnancy, childbirth and child spacing. Bottom line, the research demonstrates that there is a way to provide safe, culturally sensitive reproductive health care experiences for Somali mothers.

This study originally proposed that more research was required to address the following limitations in the existing literature. First, this research could provide guidance on how the Western health care community should integrate Somali customs and religious traditions into Western pregnancy, childbirth and child spacing experiences. Second, this research could enable Western health care providers to deliver relevant education for the Somali community to help them better manage women's reproductive health within a Western preventive medical model. Lastly, this project marked the first time that the full complement of actors – from Somali women, men, and Imams, to Western physicians, nurses and midwives – were included in a single research initiative in an attempt to best address the above-mentioned objectives.

The information gathered from this research, based on a highly supportive and synergistic focus group methodology, effectively gave a voice to Somali women experiencing childbirth – in Somalia, refugee camps, and the United States. It shed a light on Somali attitudes, beliefs and concerns regarding Western health care practices. Importantly,

this project also was a means to gather best practices of Western health care providers who were working with the Somali community using culturally sensitive birthing and child spacing approaches. The net result is that this small-scale research project represents a critical first step toward the broad provision of culturally sensitive reproductive health programs in Somali communities across the United States and internationally.

There were two key themes in the literature that should be reviewed in closing:

1) Western medicine defines Somali women's cultural traditions as a problem; and 2) Somali women have a general distrust for Western medicine. As was proven through the best practices of the Western maternal health care providers, Somali women's cultural and religious traditions can be respected and embraced as part of an effective, culturally appropriate reproductive health care program. While many Somali women, particularly those who suffered from negative childbirth experiences, do tend to distrust Western providers – many had successful pregnancy and childbirth experiences and found Western medicine to be superior to the care they received back home in Somalia.

Finally, the project proposed that there must be a way to provide reproductive health care that doesn't require Somali women to sever their cultural and religious ties. Supported by the research analysis both within the Somali and Western health care communities, there is a way for both communities to “meet in the middle,” based on safe and effective pregnancy, birthing, and child spacing experiences that integrate some of the most important cultural and religious traditions related to Somali reproductive health.

Recommendations

The recommendations which follow are organized into three key audience groupings:

1) Western maternal health care providers, 2) the Somali population, and

3) conveners or agencies in a position to act as central coordinating bodies. The Western maternal health care population includes doctors (OB/GYNs and family practitioners), nurses and midwives in the United States and Somali refugee camps. The Somali population includes women, men, Imams and interpreters. The list of convening agencies includes governmental bodies, development organizations ranging from local to national to international NGOs, and humanitarian relief agencies.

One of the primary goals of this research project was to make it actionable by providing both analytic and programmatic guidance to the interview participants. The recommendations, which flow directly from the analysis, are organized in terms of programs that should be implemented by audience group. Following the recommendations, limitations and suggestions for additional research are outlined at the close of this chapter.

Western Maternal Health Care Providers

1. Maternal health care providers could benefit significantly from cultural sensitivity training in order to provide “culturally competent” care. The Culturally and Linguistically Appropriate Services (CLAS) Standards of the United States 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 individual or collective health professionals. Based on the research, and in particular the generally negative feedback from Somali women and men, Western health care providers need to better understand Somali culture, traditions and beliefs systems related to reproductive health care. This training should cover the entire spectrum from pregnancy, to childbirth (including cesarean sections and female circumcision), to postpartum care and child spacing. Potential formats for this training could

include: training classes, online training modules, pamphlets, webinars and podcasts, and published articles.

2. Minneapolis-based clinics/hospitals who see large numbers of Somali patients should share best practices for culturally sensitive reproductive health care. Beginning locally with Minneapolis-based providers interviewed in this research and expanding to include other metropolitan areas and states with large numbers of Somali immigrants (such as Ohio, Washington, and California), sharing best practices with other providers would substantially help expand culturally sensitive reproductive health care across the country. In addition, there is no reason why these best practices could not be adapted to international providers in both refugee camps and urban areas that practice Western medicine. Potential formats for sharing best practices could include national/international conferences and published articles in medical journals.

3. Maternal health workers need to embrace culturally sensitive childbirth options as long as they provide no danger to the expectant mother or her unborn child. Based on this research, the U.S.-based midwives are currently providing the most culturally sensitive child birthing options – based on their less “medicalized” philosophy of childbearing. In order to accomplish this in other settings, midwives could offer local tours of their facilities, provide train-the-trainer sessions at national/international midwife association conferences, create videotapes of their best practices, and publish articles in midwife journals.

4. Western maternal health care providers need to provide education to the Somali community on why cesarean sections are sometimes required. Given the tremendous 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. Potential formats include: videos, pamphlets, and local community days addressing this topic. In addition, a media outreach campaign could also be implemented on Somali television with an educational series on cesarean sections produced for the Somali general public.

5. Western maternal health care providers need education and training on female circumcision – ranging from general sensitivity to de-infibulation, episiotomy style, and repair. Based on the research, United States OB/GYNs need to be educated on the critical aspects of Somali circumcision, including: the four main types (according to the WHO), learning what female circumcision means to the identity of a Somali woman, planning for de-infibulation during a Somali woman's pregnancy, performing the preferred medio-lateral episiotomies, and asking for the woman's desired level of repair after childbirth. These sensitivities are well understood by a group of physicians, nurses and midwives who have been caring for circumcised Somali women since the immigrant influx began in the 1990s. As the Somali community grows across the United States, providers with circumcised patients need to embrace and understand these issues. Further, it is important that maternal health care providers separate their own personal views on circumcision as a potential human rights violation from Somali women's need for culturally sensitive care. Recommended formats for this education include: speaking opportunities at regional/national medical conferences, train-the-trainer sessions, videoconferencing sessions, consulting services, and articles published in medical journals.

6. Maternal 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 are insensitive and 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. Two-way communication and general sensitivity to adherence versus compliance is being taught to upcoming medical students, interns and residents across the country. This modified style of communication can either be included in cultural competency trainings or addressed in periodic trainings, orientation, and staff meetings for specific clinics and hospitals.

7. Cross-cultural understanding is required to bridge the gap that exists between maternal health care providers and the Somali community. One of the central themes in the research is the broad gap and lack of trust that exists between the Somali community and Western maternal health care providers. All efforts should be made to identify strategies and programs to bridge this gap and engender increased trust. Community outreach workshops featuring joint panel discussions are recommended which bring both populations together. In addition, a cross-cultural, bi-lingual video could go a long way in educating both communities. Finally, a bi-lingual pamphlet could also be produced to enable cross-cultural understanding.

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 comprehensive reproductive health education on why Western medicine and the preventive

model is critical to the health of the mother and her children. While this is a common recommendation in the literature, it is important to accomplish this in a culturally sensitive way. Possible formats for this education include videos in the Somali language, media campaigns on Somali TV and radio, community health days, and pamphlets in the Somali language.

2. The Somali community needs education on the value of prenatal care to the health of mothers and their unborn children. As this research and the literature have shown, 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 a woman's pregnancy. The information should be provided to women in a Somali leaflet when they come in for their pregnancy test or first prenatal appointment.

3. Imams need education on natural child spacing methods and Western birth control in order to help influence the Somali community. The research suggested that it would be beneficial to educate the Imams on the full range of child spacing options – from the Quran-blessed exclusive 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 their Somali congregation. The best format for providing this information would be community lectures for Imams by Somali physicians, and a pamphlet in the Somali language.

4. The Somali community needs clarity from Imams regarding which methods of child spacing the Quran supports. The Somali men and women participating in the research 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 child spacing methods that are available, Somali families need to better understand which methods they can use. Given the significant influence that that Imams yield in the community, they could help discourage the Somali practice of bearing children every year – which is unhealthy for the mother, the children, and the economic condition of the family as a whole. This information could be made available to Somali communities across the country via pamphlets distributed by the North American Council of Somali Imams, and locally in Minneapolis through the Council of Somali Imams. In addition, this information could be shared on Somali TV and radio stations in cities where they exist.

5. U.S.-based Somali communities should organize to provide postpartum care during the 40-day ummul period. Nearly all of the Somali women fondly recalled their memories of being an ummul, and dearly miss the care they were provided by their extended family and neighbors back in Somalia. Given that this tradition is missing in Western culture, the 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 immigrant resettlement and acculturation or as part of a mosque-led effort.

6. Gender equality training is needed for Somali men in the United States. Given that the traditional 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. This training should take the form of workshops offered to men in Somali communities by respected male elders who embrace the more equal gender norms appearing in Western society.

7. Somali interpreters should be trained in reproductive health/medical terminology to enable improved provider-patient communication. The U.S. Department of Health and Human Services Office of Minority Health's Language Access Services Standards focus on facilitating communication during all points of contact during a patient's health experience. One of its core strategies is to assess the knowledge of medical terminology among all interpreter candidates. The research revealed frustration on the part of the Somali community and maternal health care providers that much of the communication was lost in translation. Therefore, a certification 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. It could be offered as a course for individual interpreters or as a train-the-trainers course for interpreter services organizations.

Conveners

1. The Minnesota Department of Health should act as a convener in cross-cultural education to bridge the gap between the Somali community and maternal health care 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 and the requirement that a central party coordinate the above-mentioned approaches to bridging the gap, it seems that the Minnesota Department of Health, and specifically the Maternal and Child Health Section of the Division of Community and Family Health, the Refugee Unit, or both groups in tandem should play a convening role.

2. The Minnesota Department of Health should help fund recommended programs for maternal health worker cultural competency and Somali community education. The myriad programs recommended in this chapter will require funders to ensure their proper development and implementation. The two Minnesota Department of Health departments noted above would be excellent funding candidates given their respective charters. Any support they can provide to help secure additional funding would be most useful.

3. The appropriate state governmental organization should lobby for U.S. Department of Health and Human Services Office of Minority Health CLAS legislation to be passed in Minnesota and other states with large Somali communities. Currently the Cultural Competency State Legislation has not been signed into law or referred to committee in the state of Minnesota, which has the largest number of Somali immigrants in the nation. Legislation has been passed in California and Washington, two states with significant-sized Somali populations, and is under consideration in Ohio, which accommodates the second-largest Somali community in the United States. It is critical that the appropriate governmental body begins to lobby for this invaluable legislation in Minnesota to support the 100,000+ Somali population in the Minneapolis metropolitan area alone.

4. NGOs specializing in reproductive health should develop programs for culturally appropriate reproductive health care. As has been noted throughout this thesis in both the literature and the research, the provision of culturally sensitive 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 NGOs can help develop training programs for culturally sensitive reproductive health care – specializing in culturally appropriate pregnancy, childbirth, and child spacing experiences for Somali mothers.

5. The U.S. Department of Health and Human Services Office of Minority Health should conduct a quantitative research study on the percent of cesarean births among different ethnic groups versus American women. In an attempt to either dispel or support the perception among Somali men that as many as 70 percent of pregnant Somali women have cesarean births, a national study should be conducted. This quantitative study would compare the number of cesarean births among different ethnic populations, including Somalis, to the American-born population.

6. Clinics/staff in Somali refugee camps should be trained in culturally sensitive reproductive health care. The poignant stories of childbirth in Somali refugee camps that were shared in this research indicate an opportunity for humanitarian relief 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 the Western methods practiced in the camp clinics. Humanitarian relief agencies such as the International Refugee Committee, Doctors Without Borders, and others who are currently operating clinics for reproductive health care are excellent candidates for this training. If the UNHCR as the convening global refugee agency advocated or mandated this training for on-the-ground humanitarian agencies providing such services, it could go a long way toward the provision of culturally competent care. In the short-term, a “field-friendly” guide of best

practices based on this research will be made available to the humanitarian relief community.

7. Refugee camps need to make community health workers and midwives available to support Somali home births. For Somali women who are 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 such as the International Confederation of Midwives or others who support the use of midwives and community health workers should be involved in the development of these programs and the staffing of such personnel needs in the Somali refugee camps.

8. Somalia's Ministry of Health needs to secure funding to support the reestablishment of the maternal/child health clinics that were destroyed or closed during the war. Now that Somalia has elected a new Somali president for the first time since the civil war began in 1991, the Ministry of Health is finally 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, such as USAID or UNICEF. This is a long-term initiative that will take years to complete, so the time to begin planning is at hand.

9. Development agencies working in Somalia or the Horn of Africa must train new midwives to support home births. As stated in the introduction to this thesis, the vast majority of births in Somalia take place at home. Given this fact and the sky high rates of maternal mortality in Somalia, new midwives must be hired, trained and deployed, especially in rural, remote areas where it is virtually impossible to travel the distances required to reach local clinics or hospitals. International development agencies like the International Confederation

of Midwives who operates over 100 member associations in countries in every part of the globe (including the Horn of Africa), and UNICEF who promotes safe motherhood programs in Somalia are strong candidates for this critical work if Somalia is to succeed in reducing the number of mothers who die in childbirth.

Limitations and Additional Research Required

As stated in Chapter Three (The Project), there were a number of potential limitations to this research, the majority of which were sufficiently addressed during the implementation of the project. That said, three specific limitations suggest opportunities for additional research, which are noted below and on the following page.

1. Conduct a follow-up study with a larger sample size. This qualitative study had a relatively small sample size of less than 50 participants across the various audiences given the short period of time that was available to complete the research. It would be beneficial to attempt to replicate the study with a much larger sample size, and consider including a quantitative survey for Western health care workers to better understand their reproductive health care practices, as well as a short survey to obtain more detailed demographic data from the Somali population.

2. Study both refugee camp and immigrant populations. It would be extremely beneficial to study the reproductive health experiences of both refugees in camps and immigrants in Western nations to better understand Somali cultural traditions related to reproductive health among these distinctive groups. As indicated in the opening chapter, given the instability of Somali refugee camps due to Al-Shabaab attacks, it was not possible to study refugee populations at this time. As a result, the research methodology was limited to studying Somali immigrants in a highly stable community, and asking them to recall their refugee

experiences, which for some women occurred several years to as long as a decade ago.

3. Replicate study in multiple Somali communities across the United States. It would be very interesting to replicate the study in multiple Somali communities such as Columbus, Ohio; Seattle, Washington; San Diego, California; and others where large numbers of Somalis reside. This would help eliminate any potential bias that may exist among Somali immigrants living in Minneapolis – the largest Somali community in the U.S. – that for many women and men was not their first immigrant experience in the United States.

The many recommendations made in this chapter are all supported by the research project findings. Culturally sensitive care is a consistent goal for the Somalis who shared their traditions and concerns, a reality for the medical professionals who were interviewed as part of this project, and could be an integral part of reproductive health care for Somali refugees and immigrants everywhere. It would go a long way to ensuring that Somalis uniformly embrace Western medicine wherever it is available, and could be a major step forward in saving the lives of many Somali mothers and their unborn children who die needlessly on both sides of the globe.

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