Somali Health Care Experience- Prenatal Care, Labor & Delivery

King County Somali Health Board
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Somali experience:

- There's a difference between generations both here and in Somalia. In Somalia they didn't have pregnancy tests. Usually woman would not announce a pregnancy until the 4th month (after 20 weeks, they would consider it to be a viable pregnancy). Also, women back home were likely to conceal their pregnancy from their husbands until the 4th month, partially due to modesty as well as wanting to confirm the viability. In the US, they may continue this practice.
- In Somali women and men are more separate. Here in the US they are together, and are more isolated from community members of the same gender. In Somalia, men are not part of the birthing process and systems are not set up to incorporate them. There are also taboos about sharing this information with them due to modesty. In the US, men get training for child birth. The taboos need to be changed.
- Women don't tell their husbands about pregnancy because it is an issue of modesty. It is also seen as bad luck before the babies are formed. American women will wait 3 months here as well to announce their pregnancy.
- Here in the US it is recommended that pre-natal care is started before the 1st trimester. It is considered late if started after 3 months. The reason care is started early is to watch for any threats to the baby's health, such as high blood pressure or gestational diabetes. In other cultures, pregnancy is normal. Here in the US we medicalize it. Here it is a medical condition.
- Pregnant women may need to avoid certain medications, this is why it is considered a medical condition
- There is confusion here among Somali women about the date of conception. Sometimes women don't' know the date of their last period. During delivery, Somali women are concerned about C-sections. No one really knows the date of conception because they do not keep track.
- There are also issues with Somali women avoiding prenatal vitamins (gelatin or chewables) because they are considered to include gelatin which is considered haram (forbidden). They need to be educated that there are many forms of vitamins, even some chewable vitamins may be Halal.
- If a woman has a child and is pregnant again right away they feel judged by nurses and doctors or visiting nurses, so they hide it from them. They feel shameful because they have been told about baby spacing. It's hard for them to tell people they are pregnant again, even if this is just their neighbor.
- There's a lot of concern in this community about the very high C-section rate among Somali women.

- Many Somali's will answer "Inshallah" or "god knows" when they are told the sex of the baby or the date of delivery. Provider's need to acknowledge this and say, "Yes. God knows but this is also what we know."
- There are many trust issues with the doctors. A lot of times these women are confused because they count months and not weeks. They also have relationship issues with the doctors because the doctors do not take the time to build proper trust and relationships.
- For doctors its' important to pin point the number of weeks because developmentally a lot of things can change in weeks. Maybe we could use months and weeks, such as "3 months and 1 week"
- Swedish is having issues with Somali women being referred to genetic testing because the doctor sees a problem but they are not explaining the issue properly to the Somali women. The women then become scared because they are not told why they are in genetic testing. As part of the normal procedure they ask if the woman wants to terminate the pregnancy after the ultra sound. This is not culturally acceptable for Somali women. There doesn't seem to be enough time to educate the patients.
- Somali women are concerned about these genetic issues. They don't know any family members with this before and don't remember hearing about this in Somalia. How come then they come to the US they are seeing this? There are already trust issues with doctors and the health care systems. This exacerbates the trust issues. The women are scared of the genetic counseling. They sometimes think they are brought in there to convince them to terminate the baby, because maybe the woman already has had 9 babies. Some Somali women think the government is trying to limit the amount of children they can have.
- There is continued education for providers but often times it can be done online. There is an issue with providers not having enough time. Most are working all day and then delivering at night.
- Providers need to know that education takes time. This cannot be done in 10 mins when you are facing issues like explaining why diabetes medication makes sense when they never took it in Somalia. Also, if you are using an interpreter you need more time for the visit. It takes more time to interpret information.
- More education needs to be done with mothers before C-sections come up in the delivery room. An option can be to do birth plans with clients. If mothers are ready with questions for their doctors before they are in the room, they will be able to ask the right questions to make their own informed decisions. It's not cultural to take notes as a Somali person. Maybe the women don't even know how to read and write. Here we have to educate people so they can advocate for themselves.
- Swedish sees that many patients who are afraid of C-sections stop coming at 7 months and then they come to the hospital when they are in labor and the baby is distressed.

- C-sections do happen back home, so it's not like they don't have any concept of it. It's the distrust. Women mostly don't want to do C-sections because then they have to heal and they cannot take care of their children.
- Providers are also seeing affects of malnutrition in the refugee camps, and FGC (female genital circumcision). The hips are smaller because of malnutrition and this can cause the babies' oxygen to get cut off and then they have to decide between the baby or the mother. Providers have had the family say that they want to save the baby that they could get another wife and they have to honor what the patient says. Women have died from not getting C-sections. Nurses have to go through counseling after experiences like this.
- There is a lack of trust with the doctors around C-sections. One woman called on a family member who told her not to get a C-section and her baby died and she went into a coma. The providers need to build trust with their patients and help patients come up with a plan before so they don't have to call random family members to make important decisions like this.
- There is also an issue with having a good relationship with a doctor but then the woman is in labor and a different doctor is on-call.
- Men need to be at the table. They need to talk to their wives about this even if this is taboo back home. Men should be informed from the beginning, especially if women are high-risk.
- Patients need to know why they had a C-section. Some have no idea.
- Some Somali community members think C-sections are done to make the hospital money.

Potential Next steps:

- Somali's need more education around: gestational diabetes, genetic screenings, fistulas, FGM/FGC (FGC preferred term), C-sections. We should bring together the Somali community leaders and have Somali health professionals educate the community on these issues.
- Approach health systems and community clinics to put in place education for prenatal care.
- Identify doctors locally who have worked in refugee camps (Kathleen To has contacts) who know how to deliver natural births for women with FGC.
- We should coordinate education for health systems. We can identify Somali nurses or health professionals to educate providers. Kathleen To will check to see if Swedish can host a "grand rounds" and invite clinicians for their continuing education credits.
- Ethnomed has a Somali perinatal report that can be used in conjunction with educating healthcare providers. Yetta requested Somali community members help in reviewing, since it is 4 years old. She requested updates and any additions. Robin will send out a link to this with the notes.
- We should engage retired or non-practicing Somali doctors and midwives that live in our community to support our women. Midwives could even be in the birth room. There are many women who also were doulas in the refugee camps.