Maternal Health is a Human Right:

Identifying Gaps and Directions for Policy Improvement in Perinatal Care for Somali-Americans in Minnesota

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I. Perinatal Care for Somali Families in Minnesota

This paper seeks to highlight a critical healthcare issue in Minnesota and to present a comprehensive program with which to address it. Immigration is often a contested issue, but few can argue that immigrants face a disproportionate amount of stresses, including navigating new gender roles, seeking employment, managing family responsibilities, overcoming discrimination, and learning a new language (Pavlish et al., 2010). Unfortunately, these stresses extend to challenges accessing appropriate healthcare: as Pavlish et al. (2010) succinctly stated, "Lack of access to culturally competent health care is one of the most significant barriers to reducing health disparities for minority populations" (p. 354). In addition to the challenges presented by the language barrier, there are often conflicts between health care recommendations and religious beliefs or cultural values (McGraw & McDonald, 2004). Immigrants—particularly refugees—may also confront significant mental health challenges that may be overlooked. Many have experienced or witnessed war, starvation, oppression, or torture, and rates of PTSD and depression are extremely high in these populations (McGraw & McDonald, 2004).

Minnesota is no stranger to these challenges, particularly for immigrants from Somalia: The 1990s saw a large influx of Somalis in Minnesota, where more than half of all Somali refugees in the United States now reside (DeStephano et al., 2010). Of those, 80% live in the Twin Cities (Herrel et al., 2004). Somali refugees in our local

community continue to experience the lack of comprehensive, culturally competent care that plagues our national healthcare system (Morrison et al., 2012). Of particular importance is perinatal care delivery: providing high-level perinatal care is imperative not only for the sake of the mothers' health, but also to ensure that the next generation of Somali-Americans has the best start to life possible.

However, Somali women have reported feeling anxious, fearful, distrustful, and suspicious while receiving perinatal care; they also reported feeling discriminated against (Benza & Liamputtong, 2014; Herrel et al., 2004). Unwelcoming or hostile experiences can leave patients unwilling to seek care again in the future, which can have drastic consequences during pregnancy. Somali patients also reported a need for reproductive education that accommodates their cultural and religious beliefs, specifically in relation to different roles for fathers; education is of little use if learners are not able or willing to engage (Herrel et al., 2004; Wojnar, 2015).

I propose a multipronged healthcare initiative to meet this challenge: a comprehensive, culturally appropriate "Families First" Perinatal Healthcare Program for Somali women and their families. This program would include:

- A Somali midwife or other perinatal healthcare provider to oversee the program and ensure the creation of inclusive and culturally tailored interventions;
- Standard interpreter services;
- Culturally appropriate educational materials that have been well-received by Somali immigrants, such as videos, hospital tours (in Somali), audiotapes, and printed materials;

- A "Focus on Fathers" section to ensure that fathers (or alternative support persons) are included in pre- and postnatal education and their newborn's care;
- A social well-being screening tool to assess current needs and provide referrals to culturally fluent mental health care providers, religious leaders, support groups, or other appropriate services;
- The integration of a public health nurse and/or nurse care coordinator of Somali descent and fluent in the Somali language to facilitate communication and advocate for the patient's needs;
- A social work liaison to provide reminder telephone calls about appointments and coordinate transportation and childcare as needed;
- Free or subsidized English classes for parents, as desired; and
- Mandatory immigrant health training courses focusing on cross-cultural sensitivity and communication for all maternal-child health workers.

While this program is specifically focused on Somali immigrants, it could easily be altered and extended to serve other immigrant populations throughout the United States.

II. Women's Health: A Human Right

The United Nations' Sustainable Development Goal (SDG) 5, Gender Equality, includes the following among its targets:

-End all forms of discrimination against all women and girls everywhere

-Ensure universal access to sexual and reproductive health and reproductive rights as agreed to in accordance with the Programme of Action of the International

> Conference on Population and Development and the Beijing Platform for Action and the outcome documents and their review conferences
>
> -Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls (UN Women, 2020)

In addition, UN Women (2020) stated that, "Women's equality and empowerment is one of the 17 Sustainable Development Goals, but also integral to all dimensions of inclusive and sustainable development. In short, all the SDGs depend of the achievement of Goal 5."

The United Nations' Sustainable Development Goal (SDG) 3 is to "ensure healthy lives and promote well-being for all at all ages" (United Nations, 2020). The World Health Organization elaborated, defining universal health care as the state in which "all people and communities can use the promotive, preventive, curative, rehabilitative, and palliative health services they need, or sufficient quality to be effective" (Mukherjee, 2018, p. 234). Mukherjee (2018) further emphasized that implicit in the concept of "universal" is the promise of equity, which denotes a commitment to provide care for the most vulnerable and marginalized individuals in particular: "Many international groups, including the World Bank…have advocated for measuring the achievement of UHC by evaluating the access to health care and health outcomes of the poorest segments of the population" (p. 236).

As noted by Small et al. (2017), the UN Millennium Development Goals (MDGs) and post-2015 SGDs "aim to place women's health [in] the context of health equity/women's rights." UN Women (2020) also stated that sexual and reproductive

rights are "critical in their own right," pointing out that gaps in these areas exacerbate other forms of inequity. Mukherjee (2018) further articulated that in its drafting of the SDGs, particularly those related to the provision of universal health care, the UN General Assembly called for "the highest attainable standard of physical and mental health," in addition to a focus on the social determinants of health (p. 235). As Small et al. bluntly wrote, "The fact that maternal mortalities are largely preventable events places these events in a human rights context as violations of women's reproductive rights. Women's rights to education, access to quality health care, and health equity are essential; UN sustainable development goals continue this focus" (Small et al., 2017).

III. Critical Nature of Maternal Health Specifically

Focusing on women's healthcare is of paramount importance because women often bear much of the responsibility for not only their own healthcare, but that of their entire family. Moreover, healthcare during pregnancy has lifelong effects for the unborn child, in addition to the mother. Unfortunately, maternal mortality rates in the United States are steadily increasing, despite the fact that the U.S. remains the world's richest country. Indeed, one 2016 study showed that while deaths during childbirth were decreasing worldwide from 2000 to 2014, they were increasing drastically in the U.S. (Discenza, 2018). Discenza (2018) also noted that while the average maternal mortality rate for advanced industrialized countries overall is only 12 deaths per 100,000 live births, the U.S. has a rate of 19.9. Squires (2020) concurred: "To be sure, the United States is way behind its developed counterparts for maternal and infant health. Regardless of race, women in the U.S. are twice as likely to die in childbirth than Canadian women, and the

U.S. is usually at the bottom of the list for infant death risk, ranking 33 out of 36 nations in the Organization for Economic Development and Cooperation."

However, it is essential to bear in mind that increased attention on maternal health must focus not only on reducing *poor* maternal outcomes, but on increasing *good* ones. As Melberg et al. (2018) wrote, "These global initiatives [SDGs and MDGs] have mobilized attention and funds. At the same time, they have narrowed the field of reproductive health and influenced national health system through a myopic focus on averting maternal *mortality*—rather than improving maternal *health*—in policies and interventions." It is not enough simply to eliminate worst-case scenarios in healthcare; policies that work to *prevent* adverse outcomes and *proactively improve* women's health are crucial. Such policies are even more imperative when they address the needs of fetal and neonatal patients, who cannot advocate for themselves in the policy-making process. As Chervenak & McCullough (2016) mused, "making 'women and children first' was a defining moment in the history of world civilizations and therefore has direct relevance for healthcare today."

Finally, not only are gender equality and universal healthcare fundamental human rights, but improving maternal health is likely to have repercussions that extend far beyond women themselves: allocating healthcare resources to pregnant mothers and, by extension, to their unborn fetuses, may actually be cost-saving in the long run due to improved outcomes of pregnancy and infancy. Simply put, healthier children are more likely to become healthy and productive members of society (Chervenak & McCullough, 2016). As UN Women (2020) plainly stated, "Gender equality by 2030 requires urgent

action to eliminate the many root causes of discrimination that still curtail women's rights in private and public spheres."

IV. Literature Review

Background: Somali Immigration to Minnesota

Begun in 1978, the violence and upheaval of the civil war in Somalia led to massive displacement of Somalis, many of whom escaped the country as refugees. Refugees International (2013) has estimated that more than a million Somalis have fled the country, with more than 1.3 million more remaining internally displaced (as cited in Wojnar, 2015). According to UNHCR Global Trends (United Nations High Commissioner for Refugees, 2012), the United States is home to approximately 1,136,100 Somali refugees, making them the second largest refugee group in the country. Indeed, in the nine years from 2005-2014, 64,000 Somali refugees were resettled in the U.S. (Ellis et al., 2016, as cited in Clark et al., 2018). As a result, the United States is now home to the seventh largest Somali population in the world, trailing only Ethiopia, Yemen, Kenya, Djibouti, the Middle East, the United Kingdom, and Canada. In 2017, the most recent year reported on the Department of Homeland Security's (DHS) website, 7,404 immigrant visas were issued to Somalis. In addition, 6,130 Somali refugees were admitted to the United States, which, while notable, was down significantly from the approximately 9,000 refugees admitted the two years prior (Department of Homeland Security, n.d.).

Somalis in the U.S. are most heavily concentrated in Washington, D.C., Columbus, Ohio, New York City, Buffalo, New York, Kansas City, San Diego, San

Francisco, and Seattle, but the largest Somali community resides in the Twin Cities of Minneapolis and St. Paul, Minnesota (Allied Media Corp, n.d.). More than half of all Somali refugees in the United States now reside in Minnesota—more than any other state (DeStephano et al., 2010); of those, 80% live in the Twin Cities (Herrel et al., 2004). While demographers have estimated the Somali population in Minnesota to be around 25,000, unofficial estimates put the number closer to three times that (Minnesota State Demographic Center, 2004, and DeShaw, 2006, as cited in Pavlish et al., 2010). Limitations in census data collection and factors such as secondary migration and new children born in the United States confound efforts to arrive at an accurate number (McGraw & McDonald, 2004).

While frigid Minnesota may seem an unlikely landing place for East Africans, "exceptional economic opportunities, excellent education, and thriving civic and cultural life" proved the state an attractive destination for immigrants looking to establish a new foundation (Heger, et al., 2010, as cited in Clark et al., 2018, p. 185). Furthermore, the strength of Minnesota's voluntary agencies, or VOLAGS (who contract with the State Department) have made Minnesota a welcome home for refugees. Groups such as Lutheran Social Services, Catholic Charities, and World Relief Minnesota provide ample resources to help new arrivals settle in, learn English, find housing and employment, and attain health care. In addition to the support from non-governmental VOLAGS upon arrival, Minnesota offers strong governmental programs to continue to help refugees build a life in the state. As Dr. Ahmed Samatar, who was born in Somalia and is now dean of the Institute for Global Citizenship at Macalester College mused, "there is so much goodness in this state…. As Somalis settle down, find a life, the good news

spreads: 'Hey this is a good place, you can find a life here'" (DeRusha, 2011). As more families settle in Minnesota and begin to put roots down, the Somali population continues to grow.

Current Demographics as Compared with Other Immigrant Groups

Despite the warm welcome in Minnesota, Somalis have continued to struggle nationally when contrasted with other immigrant populations, such as Hispanics and Hmong. For example, in 2017, Somalis were reported to have a much higher rate of poverty: 49.5% for all individuals, compared to only 16.2% for Hmong and 19.4% for Hispanics. Indeed, individual per capita income in 2017 averaged only $10,476 for Somalis, in contrast to $18,001 for Hmong and $19,537 for Hispanics (with the federal poverty level being $12,060). This data makes sense considering data concerning educational attainment: only 61.8% of Somalis have a high school graduate degree or higher, compared to 76.7% and 68.7% for Hmong and Hispanics, respectively. Similarly, only 15.1% of Somalis have obtained a bachelor's degree, compared to 24.4% of Hmong and 16% of Hispanics. In a related vein, for the population 16 and older, the unemployment rate for Somalis is 9.9%, compared to only 6% for both Hmong and Hispanics (United States Census Bureau, 2017).

One explanation for these disparate rates in income, educational attainment, and employment may be English language proficiency: of the population five years old and over, 41.5% of Somalis reported speaking English less than "very well," compared to only 32.9% of Hmong and 29.8% of Hispanics. Furthermore, although rates of English-speaking-only at home were similar for Somalis and Hmong—15.5% and 16.4%, respectively—rates were significantly higher for Hispanic families: 28%. Taking all

these statistics into account, it is not surprising then that home ownership for Somalis is less than for other immigrant groups: 12.5% compared to 49% for Hmong and 47.2% for Hispanics (United States Census Bureau, 2017).

Perinatal Healthcare Challenges for Somali-Americans

Discrimination in Reproductive Healthcare for African Americans. As Squires (2020) soberly remarked, "while all women in the U.S. are at risk due to the overall inequalities in our health care system, Black women are at greater risk because of the legacy and impacts of structural, systemic racism and implicit bias." She continued:

> Statistics show that Black women are three to four times more likely to die in childbirth, and twice as likely to suffer infant loss than white women. Regardless of age, education, wealth, or health care resources, Black women and their babies are dying at alarming rates. Indeed, Black women with PhDs are more likely to die during childbirth or have their infants die than white women with only a high school degree. (Squires, 2020)

Discenza (2018) concurred: she wrote that according to the CDC, in 2011-2013 cardiovascular and other diseases (endocrine, hematologic, immunologic, and renal conditions) caused 30 percent of pregnancy-related deaths. African Americans—who are 1.7 times more likely to suffer from diabetes than non-Hispanic whites and 1.6 times more likely to experience high blood pressure—are disproportionately affected by these conditions during pregnancy.

In addition to the negative effects of systemic racism, health workers' "erroneous racial beliefs" can negatively affect maternal health outcomes: as Squires (2020) wrote,

"Even when Black people have consistent access to health care resources, we are still impacted by the persistent stresses of living in a racially stratified society." She elaborated that research focusing on allostatic load, or the "cumulative wear and tear on the body's systems owing to repeated adaptation to stressors," has repeatedly demonstrated that "exposure to racism (such as micro and macro-aggressions, stereotyping, overt and covert job discrimination) causes earlier markers of health deterioration." Black women, regardless of social status, are at greatest risk of bearing high allostatic loads; this, in turn, increases their risk of experiencing complications in pregnancy that require more medical monitoring, which may be performed by staff who may be racially biased. University of Minnesota Public Health professor Dr. Rachel Hardeman stressed that one of the most critical points to bear in mind is that "implicit bias shows up within the context of systemic and structural racism. A lot of the work I do is helping folks make that connection so that you understand that these unconscious biases…is part of this larger framing and socialization that we are all part of and harmed by" (Squires, 2020). Upon reviewing multiple studies, The Center for American Progress's Maternal and Infant Mortality Report found that women of color consistently describe experiences of bias and discrimination in health care settings, including "feeling invisible or unheard when asking medical providers for help and when expressing issues with pain or discomfort during and after the birthing process." Furthermore, the studies also found correlations between implicit bias and inferior quality of care (Squires, 2020). Similarly, Hardeman and her colleagues discovered that Black women who chose to discontinue prenatal care visits often cited reasons such as not being heard by a provider. Likewise, Black women who elected to refuse a procedure were more likely to report

feeling discriminated against afterwards. Essentially, when Black women choose to ask questions about their care, health practitioners often perceive the women as being difficult, uncooperative, or non-compliant, rather than simply asserting the right to be involved in their own care.

Immigrant women bear an even heavier burden: health disparities have already been identified between Somali women and those native to the United States, which included reproductive health (Wojnar, 2015). Accounting for these disparities is critical, as they may contribute to increased mortality (Morrison et al., 2012). Regarding perinatal healthcare, immigrant women reported experiencing anxiety, fear, distrust, and suspicion, particularly concerning financial needs, unfamiliarity with multiple healthcare providers, and inexperience with the birth process itself (Benza & Liamputtong, 2014). In one study, Somali women questioned the competence of the staff involved during their delivery. Nursing care in particular was perceived negatively; Somali patients stated that nurses discriminated against them based on their race or language differences and were less sensitive to their needs (Herrel et al., 2004). In another study by Clark et al. (2018), however, all of the participants reported positive relationships with nurses and were concerned only with unmet care needs while hospitalized. The authors hypothesized that increased support and education during the prenatal period may help to alleviate concerns during hospitalization. Delap (2019) also noted that immigrants and asylees are "particularly vulnerable to social isolation…. They also experienced particular issues around choice and consent due to a lack of information about what care they could expect" (p. 408).

Low Health Literacy and Language Barriers. Somali refugees have been shown to have low health literacy; as Njeru et al. (2016) speculated, "competing priorities for safety and survival possibly decreased the importance of health education and knowledge acquisition" (p. 4). Additionally, low levels of educational attainment, income, and English language proficiency after resettlement have been shown to be associated with low health literacy overall (Njeru et al., 2016). Morrison et al. (2012) have also suggested that Somali immigrants may suffer from lower rates of adherence with recommended preventive health services, due both to a lack of awareness of said services and also a lack of "a conceptual framework for disease prevention" (p. 972). Indeed:

> For many Somalis, their first experience with a formal healthcare infrastructure (e.g., accessible clinics, emergency services, hospitals) is in the United States. Shaped by cultural values, exposure to war, and the refugee experience, Somali patients may lack a frame of reference for the idea of long-term health management and prevention having been previously focused on issues of immediate survival. This lack of understanding of long-term health goals in the context of limited English proficiency, concerns about patient-physician gender concordance, and low literacy rates likely put this population at risk for low completion of preventive health services. (Morrison et al., 2012, p. 968-9)

Unfortunately, as Murray, et al. (2013) noted, those "with the greatest health care needs have the least ability to comprehend information required to navigate and function in the U.S. health care system" (p. 9). Other studies have emphasized the correlation between limited English proficiency and adverse medical events (Murray et al., 2013). One

immigrant remarked, “You see their faces. You feel it that they think you are stupid and you don’t know anything about the world” (Benza & Liamputtong, 2014, p. 580). Even a physician admitted, “Sometimes we don’t think that Somali women will understand [explanations] so we don’t take the time to explain. I don’t have any idea why we think that because you can’t speak English, you are not intelligent, but that happens all the time” (Pavlish et al., 2010, p. 357). Morrison et al. (2012) found that the use of trained medical interpreter services was significantly associated with an increased rate of completion of all preventive health measures for Somali patients and emphasized that interpreter services should be used “whenever possible” when providing care for patients without “perfectly proficient” English. However, the authors also added that, “it is clear that effective use of a medical interpreter is necessary but not sufficient for completion of preventive health services among Somali patients” (p. 973). Clark et al. (2018) disagree, however, reporting that in their study, “mostly negative, distrustful feelings were expressed about the use of interpreters” (p. 189). Finally, research has noted a “double jeopardy” phenomenon, in which foreign-born persons of color experienced more discrimination from healthcare professionals than did persons of color born in the United States. Disconcertingly, previous experiences of dissatisfaction often led immigrant patients to later delay seeking healthcare (Pavlish et al., 2010).

Differences in Cultural Values and Health Beliefs. Pavlish et al. (2010) found that Somalis’ health beliefs “contrasted sharply with the biological model that drives Western medicine,” which led to dissonant expectations regarding healthcare, frustrations between Somalis and their healthcare providers, and lowered perceived quality of healthcare (p. 353). While Western healthcare is overwhelmingly biomedical and

individualized, Somali culture generally views health much more holistically. As a result, Somalis are more likely to experience psychosomatic illnesses for which no physical cause can be determined, such as body pain, headaches, sleep disturbances, fatigue, decreased appetite, changes in weight, and low energy. Furthermore, Somali culture is much more communal than that of Western countries, which extends to healthcare; Somalis are not accustomed to focusing on the individual in isolation from the family or clan, nor to disclosing problems to outsiders, which can be considered shameful (McGraw & McDonald, 2004). On the part of care providers, many admitted frustration in working with the Somali community due to lack of knowledge regarding the cultural and religious practices and beliefs of this population (Clark et al., 2018). Furthermore, religion has been identified as inextricable from health beliefs and practices, as well as an essential component for incorporation in any health care treatment plans. One study informant summarized it clearly:

> Religion is a huge part of the Somali community. We are Muslims. In general, most Somalis believe that if someone is sick, they don't need to go to the doctor. They need to read the Qur'an, then they will heal. (Wolf et al., 2015, p. 355).

Perinatal care in particular can be especially fraught: as a workgroup out of Kings County, Washington (2013) emphatically emphasized, "In Somalia, pregnancy is considered a normal process not requiring medical intervention" (p.2). The workgroup went on to elaborate that for many Somali women, pregnancy is their first encounter with the western healthcare system, which undoubtedly contributes to hesitancy engaging with interventions and potential misunderstandings regarding care. For example, participants reported a lack of frame of reference for the concept of infant due dates and "why a baby

has to be born a certain time [versus] when Allah wishes (Insha'Allah)," as well as concerns that medical interventions may harm the baby or prevent vaginal delivery (Kings County, 2013). Two other studies found that Somali woman avoid prenatal care due to a lack of trust in the Western health care system (Wojnar, 2015). Specifically, Somali women were fearful of cesarean section (which could impact fertility going forward) and of healthcare providers' lack of knowledge regarding vaginal deliveries for women with female genital cut (FGC). Clark et al. (2018) wrote that Somali women articulated "punishment from God" as one reason for a fear of cesarean delivery and reported avoiding cesarean sections and "attributing their decision to the will of God and their determination not to interfere with God's will" (p. 188). Participants in the Kings County (2013) focus group believed simply that providers were "too quick" to perform cesareans (p. 3). Unfortunately, and paradoxically, although Somali patients have indicated strong aversion towards cesarean deliveries, "medically warranted" cesareans for Somali women occur at a higher rate than for the community at large (Essén et al., 2011, as cited in Clark et al., 2018, p. 188). Regarding providers' lack of facility with patients with FGC, fortunately, awareness of and knowledge regarding FGC has been increasing in recent decades. For example, although Minnesota has had a law banning FGC since 1994, communities have raised concerns that the punitive approach to FGC may discourage women from seeking healthcare at all. As a result, Minnesota Department of Health Refugee and International Health is currently partnering with the International Institute of Minnesota to form the FGC Prevention and Outreach Working Group to provide more inclusive and positive solutions (Minnesota Department of Health, 2018). Missal and Clark (2016) documented one final additional stress for

childbearing Somali immigrant women: their loss of traditional family support during pregnancy and delivery, especially that from mothers. As one Somali patient lamented, "In Somalia, we were one nation and we knew each other. Here women are more isolated" (Pavlish et al., 2010, p. 355).

Lack of Adequate Health Information and Education. Reproductive health information and education was also a health need for Somalis: Somali immigrants expressed a desire for education for male partners, who—as they make new lives in the United States—are beginning to take on supportive roles in pregnancy and childbirth that are not traditional in Somali culture, such as being present for labor and delivery, providing help and support for the mother, and caring for the baby (Herrel et al., 2004; Clark et al., 2018). Involving the family as a whole in perinatal care may be essential, as studies have reported that both family and community members play a role in women's childbearing decisions, although this may becoming less pronounced in immigrant families (Degni et al., 2012; Steinmen et al., 2010; & Textor et al., 2013, as cited in Clark et al., 2018). Abakporo et al. (2018) noted that traditional Somali society is a "male dominated patrilineal and patriarchal society" and that Somali men in the U.S. remain "major decision-makers" in Somali homes (p. 1230-1). Indeed, when the authors questioned Somali men regarding family health care decisions, 70% reported that they had "a lot of influence" in determining whether their partners access preventive health services (p. 1232). Clark et al. (2018) also emphasized that "family is of paramount value for Somalis, more important than the individual" (p. 188). Hence, it remains even more critical to involve male partners in perinatal care practices. However, education

must accommodate religious and cultural beliefs. In Wojnar (2015), when parents' perceptions of prenatal education were assessed, one father stated:

> Our religion doesn't allow us to attend classes with the women learning in the same room as the men. And, we are not allowed to look at naked figures and so on…. Under the prenatal classes I checked "none." The nurse remarked: "not interested, huh?" Well, I was, but I felt it wasn't a good time to educate the nurse why I didn't go. (p. 365)

Lack of culturally appropriate resources—rather than lack of interest—was a notable barrier to full and active participation in prenatal care for Somali men. Additionally, parents expressed a desire for support on adjusting to the parental role and strengthening the parent-child bond in a new country (Osman et al., 2017). One technique that could be helpful in this respect is the use of lay outreach workers who share cultural and language ties with the immigrant community to provide healthcare education (Benza & Liamputtong, 2014). A study by Wolf et al. (2016) supports this hypothesis, reporting that study participants indicated that Somali persons would trust a Somali employee more than a non-Somali individual.

Disparities in Mental Health. Another significant health challenge for Somali immigrants is mental health. As Wolf et al. (2016) wrote, "Even if the acculturation process follows a conventional course, the outcome is complicated by the impact of…adapting to differences in weather, religion, language, clothing, legal principles, and financial pressures, all of which carry substantial mental health implications" (p. 349). A large number of immigrants also confront drastic changes in social status in a new country. Often education and job skills are not easily transferable to a different country,

and immigrants may struggle to support their families, which can lead to another source of guilt, shame, and feelings of worthlessness. In addition, refugees suffer dislocation from family and home that can result in social isolation, which is felt acutely for members of a community that is traditionally communal and family-centered (McGraw & McDonald, 2004). Finally, many refugees have experienced war trauma, malnutrition or famine, political persecution, violence, torture, or rape. If they have not experienced trauma personally, many have witnessed it firsthand or have relatives or close friends who have been traumatized.

> These stressors can be compounded for parents. As Osman et al. (2017) wrote:
>
> Postmigration factors (eg, stress, lack of social capital, social isolation and loss of social network as well as acculturation problems and experiences of discrimination in the host country) affect the mental health of the parents and the children. Moreover, immigrant parents face challenges concerning their role and responsibilities as parents while adjusting to the host country, all of which tend to create stress in parenting. (p. 1)

The authors added that parents' mental health challenges pose a potential problem for their children as well; attachment may be negatively affected, and parents may perceive their parenting competence as low and "lack the ability to employ positive parenting practices" (p. 1). Conversely, the authors reported that increased maternal self-efficacy was correlated with decreased depression in postpartum mothers, and also that parental satisfaction facilitated parents' mental health and positive parenting practices in general.

These factors, among others, have contributed to rates of post-traumatic stress disorder (PTSD) for refugees resettled in western countries that may be ten times that of the general population (Fazel et al., 2005, as cited in Piwowarczyk et al., 2014). McGraw & McDonald (2004) found rates of PTSD ranging from 39 to 100 percent in immigrant and refugee populations (compared to one percent in the general population), as well as rates of depression ranging from 47 to 72 percent. Many Somalis also suffer from flashbacks, severe guilt, anxiety, fatigue, feelings of emptiness and worthlessness, and poor concentration and memory. The severity of symptoms can leave individuals unable to work, which can compound sufferers' feelings of guilt and shame. Given the high potential for trauma exposure and mental health care needs, it is even more imperative to understand beliefs and attitudes surrounding mental health and illness in the Somali community. However, studies in the United States have implied that refugees tend to have low levels of mental health service utilization, and that they do not often seek out mental health care after resettlement, despite high levels of cumulative trauma (Piwowarczyk et al., 2014).

When mental health concerns *are* identified, they are often addressed first in traditional ways, with the assistance of family, friends, and elders in the wider community, and less severe symptoms—such as headaches, frequent crying, or insomnia—are simply accepted as a part of life and not seen as something for which to seek help. There may even be pressure *not* to obtain formal mental health services, as they are not routinely used in Somalia. As one Somali woman stated, "'Africans usually do not seek psychiatric care. We look for other ways. We talk to elders….If mental illness, they will try herbs'" (Piwowarczyk et al., 2014, p. 211). In a study by

Piwowarczyk et al. (2014), a large number of women expressed uncertainty that mental health treatment could help those with illness to lead "normal" lives; furthermore, the women also reported that they would not access mental health services, even if they were "very depressed" (p. 215). There is also hesitancy towards taking medications in the Somali community (Piwowarczyk et al., 2014; Wolf et al., 2016). As one Somali woman bluntly put it, "'Taking medications will not help, only hurts'" (Piwowarczyk et al., 2014, p. 212). Similarly, Wolf et al. (2016) wrote that "to take medications when they are not experiencing symptoms is virtually unintelligible in this population" (p. 356). Unfortunately, while Scuglik et al. (2007) noted that Somalis may not even acknowledge mental health problems, at the same time, common traditional treatments that were previously used to address psychiatric symptoms often prove ineffective in a new country (as cited in Wolf, 2016).

Another critical factor in Somalis' mental health is a focus on respective faith communities and a tendency to seek help from religious leaders (Piwowarczyk et al., 2014). As Wolf et al. (2016) wrote:

> Reading of the Qur'an is the first remedy that a Somali immigrant seeks when he/she begins suffering, and it is of great benefit and value for the culture…. A provider may need to work with a Somali patient in understanding the importance of treatments outside of reading the Qur'an and negotiate other treatments for better outcome. (p. 357)

Scuglik et al. (2007) similarly noted that Somalis may first seek counsel from a sheik healer, and may also look to a traditional healer called a *minga* or *waddad* for guidance

with emotional concerns (as cited in Piwowarczyk et al., 2014). Wolf et al. (2016) provided an eloquent summary of study respondents' views regarding health and religion:

> Being healthy and feeling well is closely tied with religion and being close to God through prayer and Qur'an reading. They also all emphasized that the first line of treatment for any illness involves reading verses from the Qur'an. They asserted that religion tops everything else in their community and that everything circles back around to include their religious beliefs and practices, although they identified that this would be true of all people who practiced the Islamic religion. Their religion influences…how they view health and illness. Sickness is viewed as a test from God, and although it is acceptable to seek medical care when needed, a person cannot be healed unless it is God's will and unless he/she has faith that it will happen. (p. 356)

Unfortunately, there is significant stigma surrounding mental illness and treatment in Somali culture and the true role of mental health providers—especially psychiatrists—may not be clearly understood. Some individuals may even be ostracized for seeking mental health services, which may contribute further to their underutilization. As participants in one study stated, although it was widely known that mental illness was a concern in the Somali community, "no one wants to admit this" (Wolf et al., 2016, p. 355). Furthermore, as Piwowarczyk et al., (2014) wrote, "The idea of talking to a stranger, not from the culture, is difficult to accept and generally frowned upon" (p. 212). Unlike Western culture, in which health and illness are seen as a continuum with biophysical roots, Somalis perceive mental health very differently:

> In Somali culture, concepts of mental health only include perspectives on mental illness: one is crazy (*waali*) or one is not crazy…. Beliefs in the causes of mental illness are predominately spiritual or metaphysical: mental illness comes from God or evil spirits (jin); illness can also be brought on by another person or ones self through curses or bad behavior. Somalis traditionally explain behavioral problems as an expected result of spiritual causes or possession by an evil spirit." (McGraw & McDonald, 2004, p. 2)

Piwowarczyk et al. (2014) added that mental health issues "are identified only in very extreme situations, in which people are engaging in erratic or noticeable behaviors such as 'removing their clothing'; only in these types of situations would help be acquired" (p. 211). The authors found that there was a lack of words to even describe emotional difficulties, as well as a denial of their existence generally, except in the case of extreme mental illness. Boyton, Bentley, Jackson, and Gibbs (2010) concurred, noting:

> there is a cultural unfamiliarity with the concept of mood disorders in the Somali explanatory model of mental illness. For Somalis, the concept of mental health has traditionally been divided into categories of "sanity" and "insanity," and people who demonstrate psychosis and are either violent or have behaviors that cannot be controlled are labeled "insane." (as cited in Wolf et al., 2016, p. 350)

IV. Highlights from Healthcare Provider Interviews

Minnesota is often perceived as a diverse, progressive state that provides a warm welcome to immigrant families, and indeed, some examples of progress in racial equity over the past few decades can be found. However, I wanted to see if what has been

documented in the literature is reflected in the attitudes, behaviors, and practices of healthcare providers currently. In exploring these issues, I was able to speak with a Neonatal Nurse Practitioner (NNP) practicing at a large teaching hospital and a Certified Nurse Midwife (CNM) working at a women's specialty clinic, both serving a number of Somali families. The NNP immediately identified language services as the foremost need of her clients. She clarified that she was referring to not only interpreter services at the hospital, but also English classes, and mused, "When you can't speak English, how really can you do anything??" She added her belief that, "Everyone would be better off if there was more…not assimilation, but integration, because they're [Somali immigrants] very separated from our Western culture. Not that I think they should change to be more like us, but if they're going to live and thrive in this community, they have to be more 'in' it." (NNP, personal communication, March 13, 2019). In contrast, the CNM highlighted the sustained necessity for more "culturally congruent" spaces, providers, and community resources (such as childcare and domestic abuse services), as well as the overall pressing need for universal health care. She continued that needs also include increased educational and employment opportunities, a universal living wage, safe and affordable housing, and the guarantee of legal rights and protections with viable pathways to citizenship (CNM, personal communications, July 19, 2020).

The NNP also remarked on her perceived difficultly in establishing a trusting connection with some of her families: she reported that her Somali patients' families in the clinic did not seem to be "very open….it's rare that they share information about their personal life. They don't engage easily" (NNP, personal communication, March 13, 2019). She offered additional thoughts on the challenges of bridging the cultural gap

with one of her Somali families and of the possible need for more or different forms of psychosocial support for these families:

> Maybe it would be helpful to have a link to a pastor equivalent? Like right now we have a trisomy 18 [genetic condition with poor prognosis; of babies that survive to birth, less than 10% reach one year of age] baby on the ventilator—they think it's a gift from God, but that baby will be ten years old and still on the vent. He has no brain function. It would just be helpful to have somebody to help bridge the gap because their medical understanding is so reliant on "God is in control." They have four other kids in St. Cloud that they haven't seen in three months. So, it's difficult to explain the reality of things when God is in control…yes, but God also gave us knowledge that this isn't curable. (NNP, personal communication, March 13, 2019)

Somewhat in contrast, the CNM argued that patients have the right to disagree with recommendations without judgment, and commented that, "Many people may have had very few interventions in previous pregnancies and may be wary or not interested in your plan." The CNM also offered some perspective on why some patients may be reticent with care providers when she was asked if she thought immigrants generally feel welcomed in Minnesota. She replied:

> Two years ago, I would say that immigrants overall were feeling welcome and had access to services. Since then, the increasing restrictions around immigration and the Trump administration targeting of certain countries has led to many people being here without any means to bring their families here as well. We also have heard about an uptake (sic) in more blatant race-based incidents. …Many of

> our younger patients who are either first-generation Americans or recently immigrated speak about their fears of police violence against Black people in the cities. (CNM, personal communications, July 19, 2020).

She also reiterated that the impetus to understand the meaning and importance of culturally competent care must fall on care providers, and that care providers must find a way to incorporate patients and families in making care plans without feeling "coercive or flippant." Her overall summary was sobering: "Without working to dismantle white supremacy and transform the healthcare delivery system, then new immigrant patients will remain at risk, even as their families stay here over generations" (CNM, personal communications, July 19, 2020).

V. Overview of Efforts: Steps in the Right Direction, but Further Action is Needed

The global community is well aware of the need for improvement in maternal health outcomes:

> In September 2014, WHO issued a statement on the prevention and elimination of disrespect and abuse during facility-based childbirth, emphasizing the rights of every women to dignified, respectful care during childbirth, and the need for greater action, dialogue, research and advocacy by all health stakeholders on this issue. The statement is now endorsed by over 90 organizations and is available in 15 languages. (Vogel et al., 2015)

WHO's new vision of quality of perinatal care defines "good" quality maternal and newborn care as care that is "safe, effective, timely, efficient, equitable and people-

centered" (p. 671). Additionally, the framework specifically takes into account the perspectives of women and their families, particularly regarding their experiences of effective communication, respect, dignity and emotional support. However, work remains to be done. As Vogel at al. (2015) further remarked:

> There is a clear need for a broad and inclusive approach to this issue, one that ensures the active participation of women, communities, healthcare providers, managers, health professional training, education and certification bodies, professional associations, governments and other health systems stakeholders in developing and implementing solutions. (p. 673)

Opportunities for Growth

While increased attention has been paid to the need for improved maternal health policies, challenges still remain. Vogel et al. (2015) pointed out the lack of standardized definitions of what constitutes both respectful maternity care and, conversely, mistreatment during childbirth. The authors wrote that, "mistreatment includes (but is not limited to) experiences of physical, verbal or sexual abuse, stigma and discrimination, failure to meet professional standards of care, ineffective communication, lack of supportive care, detention in facilities, and extortion," and may be unintentional or caused by 'acts of omission' (such a delay in care or a lack of emotional support from a provider). They also further emphasized that certain groups of women may be more vulnerable to mistreatment, such as ethnic minorities, immigrants, and those with limited financial resources.

Additionally, many policies, while successful in some settings, may not be globally applicable: as Melberg et al. (2018) observed, "[p]olicies promoted in the field of

maternal healthcare are often highly standardized, and they constitute…traveling models to be realized in the same format in many countries. The policy texts are presented as culturally neutral and they are expected to be implemented by frontline workers in healthcare institutions with great geographical, political and cultural diversity."

Current Successes

Fortunately, some studies have found perinatal healthcare practices already in place that have been well-received and perceived as beneficial by Somali immigrants. When surveyed on the most desired methods of pregnancy and childbirth education, one study found that Somali women preferred videos, hospital tours (in Somali), audiotapes, and printed materials (Herrel et al., 2004). In corroboration, DeStephano et al. (2010) wrote that "existing literature has established educational videos as improving knowledge and fostering health screening intention among low literacy, minority, and immigrant populations," and found that when six targeted Somali prenatal education videos were shown, all study participants rated the videos as "strongly recommended" and "appropriate for Somali clients." Furthermore, 60% of participants and 72% of healthcare providers found the videos "somewhat" or "extremely helpful," and providers also noted that subsequent appointments were more interactive. In addition to basic education, emphasis on the importance of prenatal care and discussing concerns openly with healthcare providers, the videos incorporated traditional Somali songs and poetry. A narrative method of teaching may be of particular importance in improving health literacy and providing effective education in the Somali community, as there has historically been a strong oral tradition in Somali culture in which important life lessons are passed from one generation to the next in the form of stories—Somali language was not a formally

written script until 1972 (Kings County, 2013; Njeru et al., 2016; Osman et al., 2017). Njeru et al. (2016) also emphasized that experiential knowledge, or "information and wisdom gained from lived experience" may be more important to Somali learners than the traditional archetype of clinic-based education and standard written materials, and Kings County (2013) noted that "awareness of facial expressions and gestures" may be especially important for care providers (p. 21). Experiential knowledge "may be obtained from information and meanings gleaned through participation in a shared activity with members of a group or community, and this may be an important facilitator in molding health-related behavior" (p. 5).

Missal and Clark (2016) also highlighted the important role of nurses, particularly regarding emotional support and teaching. Nurses could ensure that fathers were included in pre- and postnatal teaching, educate patients on postpartum blues and depression and monitor for signs and symptoms, and offer increased time for questions and support as needed. Indeed, a second study by Delap (2019) found that nurse midwives "were seen as 'the key…a way in' to providing wider support to women," and some study participants even indicated that their midwives helped ensure their attendance at appointments. Furthermore, for expectant mothers with complex needs, specialist nurse midwife teams and a focus on continuity of care were helpful, "particularly if clinicians work from a trauma informed perspective" (Delap, 2019, p. 408). Almost all the women in said study were:

> very positive about their experiences, particularly the opportunity to build a relationship of trust and to be better understood as a person. Women who did not have this continuity said they would prefer it: "It's better for you to have just one

> person. It's no good to have different one…explain over and over again." (Delap, 2019, p. 409)

Nurses, on whom the burden often falls for structuring the patient's day, could also prove instrumental in providing the essential time for Somali patients to pray, meditate, and read the Qur'an, as well as facilitate visits with religious leaders when possible (Wolf et al., 2016).

However, particular attention must be paid to education for nurses and other healthcare personnel. As Squires (2020) frankly noted, "Unlearning racial stereotypes and accounting for implicit bias must become part of core medical education." Research by University of Minnesota Public Health professor Dr. Rachel Hardeman has concluded, however, that successful interventions "go beyond the usual implicit bias protocols, which focus on individual beliefs, to integrate anti-racism, historical, and reproductive justice frameworks"; healthcare providers must be supported in creating "culturally sensitive and culturally concordant" healthcare for African-American mothers (Squires, 2020). From a provider perspective, professionals in one study emphasized the need for education and training in trauma-informed care when working with populations with complex needs, particularly for healthcare workers with limited practical experience. These providers verbalized that it could be "'exhausting' holding women's issues and feeling responsible for outcomes," and reiterated the need for support in these roles: in addition to the knowledge, skills, and confidence needed to care for women with complex needs, it is essential that providers possess adequate time in appointments, as well as the tools to respond appropriately when women disclose complex issues (Delap, 2019, p. 408). For Somali women in particular, it may also be helpful to draw healthcare

providers' attention to the primacy that the Somali community places on faith and prayer, and to continue to encourage collaborations between health care providers and faith community leaders, who may greatly influence health care decisions in the community at large (Piwowarczyk et al., 2014). Finally, simple audit and feedback systems, which have been shown to "significantly" improve the professional practices of healthcare workers, may also be effective in improving perinatal care provision (Vogel et al., 2015).

Herrel et al. (2004) found "overall, most women wanted more information about the delivery room experience, pain medications, why prenatal visits are important, how interpreters are used at the hospital, and services and care they can expect hospital nurses and staff to provide" (p. 347). Women also expressed desire for reminder telephone calls prior to prenatal appointments and for transportation to and childcare during appointments. Overall, more programs that promote respectful maternity care need to be developed and documented in the literature, so that they can be disseminated and adapted to varied settings. As Vogel et al. (2015) wrote, "Wherever maternity care is delivered, measures to improve women's experiences and support their autonomy and self-actualization can be prioritized. This includes clear, respectful, culturally sensitive communication with women and their families regarding their care."

Finally, the importance of community-based care has been noted in the literature (Morrison et al., 2012; Piwowarczyk et al., 2014). Morrison et al. (2012) explicitly stated that, "Interventions should couple community-based awareness campaigns with culturally and linguistically tailored healthcare-based programs to introduce patients to the concepts behind preventive health services" (p. 973). One example of a successful comprehensive and culturally competent healthcare program is the Somali C.A.R.E.S. (**C**ulturally

Appropriate & **R**espectful **E**ducation & **S**upport for Somali Women During Pregnancy) program in Minnesota (Dynes, 2008, as cited in Kings County, 2013), which includes the following:

-routine western prenatal care (fetal heart tone, dates, measurements, etc.);

-discussion surrounding Somali-specific topics, including presentation through role play and storytelling;

-discussions addressing cultural norms;

-time for socialization, including food and prayers;

-demonstrations and video presentations; and

-addressing of stress of coping strategies.

VI. Policy Recommendations

For these reasons, I propose the introduction of a "Families First" Perinatal Healthcare Program for Somali women and their families, which would include:

- A Somali midwife or other perinatal healthcare provider to oversee the program and ensure the creation of inclusive and culturally tailored interventions;
- Standard interpreter services;
- Culturally appropriate educational materials that have been well-received by Somali immigrants, such as videos, hospital tours (in Somali), audiotapes, and printed materials;

- A "Focus on Fathers" section to ensure that fathers (or alternative support persons) are included in pre- and postnatal education and their newborn's care;
- A social well-being screening tool to assess current needs and provide referrals to culturally fluent mental health care providers, religious leaders, support groups, or other appropriate services;
- The integration of a public health nurse and/or nurse care coordinator of Somali descent and fluent in the Somali language to facilitate communication and advocate for the patient's needs;
- A social work liaison to provide reminder telephone calls about appointments and coordinate transportation and childcare as needed;
- Free or subsidized English classes for parents, as desired; and
- Mandatory immigrant health training courses focusing on cross-cultural sensitivity and communication for all maternal-child healthcare workers.

Many of these elements—culturally appropriate materials, involvement of support persons, mental health screenings, collaboration with social workers—are often already standard parts of care in the hospital setting, and may need only to be refined and strengthened through policy updates to best meet the sociocultural needs of different immigrant populations. Three other elements—training for a public health nurse or nurse care coordinator, subsidized English classes for parents, and immigrant health training courses for maternal-child healthcare workers—could be achieved through the development of an education program funded with the assistance of a grant from the Department of Health and Human Services. A similar maternal-child immigrant health

training program completed at the Maternity Infant Care Family Planning Centers in New York City showed statistically significant improvements in the knowledge and attitudes of healthcare workers as well as vast improvements in patient care (Gany & Thiel de Bocanegra, 1996). Once trialed and refined in a single hospital system, hospital policy updates and educational programs could be easily rolled out to other healthcare systems throughout the state. Reluctance to fund or implement the program could ideally be addressed by reminding detractors of the focus on family health—a non-partisan issue—and the social and economic benefits of ensuring optimal health for our state's residents from birth onward.

Cultural Appropriateness of Recommendations

Regarding ideal perinatal care, Missal and Clark (2016) emphasized respect for traditional Somali cultural and religious practices throughout, such as allowing time for prayer over the baby at birth, facilitating provision of traditional foods as desired, and recognition of the 40-day postpartum rest period to which many Somali adhere. The provision of culturally appropriate educational materials that have been well-received by Somali immigrants, the "Focus on Fathers" section, the social well-being screening, and the social work liaison are all concrete pieces of the "Families First" Program that seek to respect traditional Somali cultural and religious practices throughout perinatal healthcare provision.

Pavlish et al. (2010) noted that healthcare providers must encourage patients to voice their own beliefs, values, expectations, and concerns regarding their treatment. The authors continued that, "when working across language, healthcare providers need to be particularly aware of non-verbal language and develop deliberate and consistent ways to

demonstrate warmth and welcome" (p. 359). The "Families First" Program not only seeks to give patients a voice—by providing them both language and cultural interpreters, as well as the opportunity to learn English, if desired—but also gives healthcare providers the skills and tools to truly *listen* to their patients, no matter what language might be spoken.

For these reasons, I believe that the "Families First" Program, would be well-received by the Somali-American community. Additionally, since many of the program's initiatives are already at least partially in place in hospital systems, and would only need to be updated or refined, I believe that this program would not place an undue burden on healthcare systems and would be well-received by executives and healthcare leaders. As our population in the United States continues to diversify, the cost of failing to meet immigrants' healthcare needs—particularly those of the smallest and most fragile—will eventually become too large to ignore.

VII. Conclusions

Although healthcare for immigrants has improved in the last few decades, clearly there remains much work to be done. The Somali population—including women of childbearing age—in Minnesota continues to grow, so it is essential that we maintain efforts to meet the unique healthcare needs of this population, particularly during the challenging and exciting period surrounding pregnancy and childbirth. As one immigrant mother remarked:

> Being a mother alone is already difficult and responsibly [sic], so it is extremely hard when you have to be two things, a mother and a migrant, at once. You were

> born and grew up in a country in which the tradition and culture are totally opposite to that of the country in which your children are growing up. (Benza & Liamputtong, 2014, p. 579)

To ensure a strong and vibrant community for generations to come, it is imperative that Minnesota provide the highest level of healthcare for all our residents, regardless of where they were born. In summary, work needs to be done on both ends. While one NNP emphasized that for Somalis "to live and thrive in this community, they have to be more 'in' it," the same could be said of healthcare providers: they may not need to change their medical practices to be more like traditional Somali practices, but to provide effective care, they have to be more "in" the community.

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