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Somali Immigrant Women's Health Care Experiences and Beliefs Regarding Pregnancy and Birth in the United States

Nancy Hill, BSN, RN[1], Emmy Hunt, MSN, MSW, RN[1], and Kristiina Hyrkäs, PhD, MNSc, RN[1]

Abstract

Purpose: To describe Somali immigrant women's health care experiences and beliefs regarding pregnancy and birth. **Design:** Four focus group interviews were conducted using a convenience sample of Somali women who were pregnant or had recently delivered. Qualitative thematic content analysis was used. **Findings:** Six major themes emerged: pregnancy as a natural experience for women, value and relevance of prenatal care, lack of control and familiarity with delivery in the United States, balancing the desire to breastfeed with practical concerns and barriers, discomfort with mental health issues, and challenges in the healthcare system. **Discussion and Conclusions:** Somali immigrant women perceive, interpret, and react to Western health practices from a perspective that includes their cultural, religious, and "scientific" beliefs. **Implications for Practice and Research:** Implications include cultural competency workshops. Educational materials and prenatal education sessions that support the women's needs have been developed for this population and should be a focus of future research.

Keywords

prenatal care, focus group interview, cultural sensitivity, Somali women's health, maternal/child

Background

Many cities in the United States, Canada, and around the world have experienced an influx of Somali immigrants (Office of the United Nations High Commissioner for Refugees, 2010a). The UN Refugee Agency (Office of the United Nations High Commissioner for Refugees, 2010c) statistics show that today Somalis constitute the third largest of the increasing refugee groups. This is a result of the deteriorating security, the lack of humanitarian conditions, and the unstable political situation. In 2009, there were more than 1.5 million Somali refugees, asylum seekers, and internally displaced persons, 38% to 51% being women (Office of the United Nations High Commissioner for Refugees, 2010b). Many Somalis suffer from posttraumatic stress disorder arising from the experience of famine, torture, and war trauma, including violent death of family members (Jaranson et al., 2004; Robertson et al., 2006). Refugee women who have lost or left family behind are especially vulnerable during their childbearing years since traditionally extended family and community provided critical support during pregnancy, childbirth, and child rearing.

In Somali culture, women marry young and value the ability to have many children, which they view as gifts from God. Up to 98% of Somali women have been circumcised predominantly by infibulation, raising the issue of deinfibulation for facilitation of vaginal delivery (Lewis, 2009). There is very limited prenatal health care, and women often rely on others within their community to act as midwives during home births. The infant mortality rate is one of the highest, at 120 per 1,000 live births, when compared with 6.7 per 1,000 live births in the United States (World Bank, 2010). The average (global) infant mortality rate is 46 deaths per 1,000 live births (World Bank, 2010). According to World Health Organization (2010) statistics, the maternal mortality ratio in Somalia is estimated to be 1,200 per 100,000 live births, making Somali women one of the highest risk groups in the world.

A study of Somali refugee women in six receiving countries has identified that multiple factors can lead to adverse perinatal outcomes (Small et al., 2008). Research conducted by Vangen, Stoltenberg, Johansen, Sundby, and Stray-Pedersen (2002) revealed that Somali women in modern obstetric settings in Norway had a higher incidence of fetal

[1]Maine Medical Center, Portland, ME, USA

Corresponding Author:
Kristiina Hyrkäs, Center for Nursing Research & Quality Outcomes, Maine Medical Center, 22 Bramhall Street, Portland, ME 04102, USA
Email: hyrkak@mmc.org

death, fetal distress, and prolonged second stage of labor requiring operative delivery compared with non-Somali women. They concluded that circumcision (most often infibulation), low social status, suboptimal perinatal care, mental stress, poor nutrition, and intercurrent diseases such as tuberculosis, hepatitis, and parasitic infections all contribute to adverse outcomes. In addition, Johnson, Reed, Hitti, and Batra (2005) cited a higher incidence of gestational diabetes and perineal lacerations compared with U.S.-born Black and White women.

Essen et al. (2000) have reported that even after migration to Sweden, Somali immigrants seem to maintain their cultural attitudes, strategies, and habits during pregnancy and childbirth and that these may contribute to a higher incidence of perinatal mortality and morbidity. Essen et al. (2000) also argue that as long as health care providers are unaware of cultural differences that may lead to adverse perinatal outcomes, it is doubtful that women will change their beliefs and behaviors. When Johnson et al. (2005) compared U.S.-born Black or White women with those born in Somalia, Somali women were nine times more likely to deliver at or beyond 42 weeks, and thereby the risk of adverse sequelae, such as oligohydramnios and fetal distress requiring cesarean delivery, was increased.

A study by Wissink, Jones-Webb, Dubois, Krinke, and Ibrahim (2005) found that health care providers' lack of knowledge and understanding of differences in practices, beliefs, preferences, and expectations regarding pregnancy and childbirth were a barrier to improving refugee women's care in the United States. Herrel et al. (2004) described perceptions of diminished staff sensitivity to Somali women's individuality and care needs as a result of racial discrimination and stereotyping. The women also reported apprehension about cesarean birth and concern about the competence of medical interpreters.

The findings of this study will be important to the health of future generations of Somali women and girls who will give birth in the United States. The significance lies in the increased need to provide quality health care services to a growing number of female refugees/immigrants, especially Somali women who have a high risk of adverse events during pregnancy and delivery. To develop and improve health care services and outcomes, it is important to focus on exploring these women's beliefs and experiences in a health care system that is new and different for them. The findings of this study will also be important from a national perspective because one measure of the health of a nation is its maternal and infant mortality and morbidity rates.

Aim of the study

The purpose of this study was to describe and better understand Somali immigrant women's health care experiences and beliefs regarding pregnancy and birth in the Unites States.

Table 1. Eight Open-Ended Questions Used in the Focus Groups

1. What is pregnancy care like in your country?
2. What factors make it hard or easy to get seen by a medical provider in OB clinic?
3. What are your beliefs about nutrition during pregnancy?
4. What behaviors in a provider show respect, caring, and cultural sensitivity toward you?
5. What are the most upsetting or irritating aspects of a clinic visit?
6. What are your special requests?
7. Do you have any particular fears?
8. What learning needs do you have regarding pregnancy and having a baby in Maine or the United States of America?

Method

Since Somalia has a strong oral tradition and an adult literacy rate of 13% for women (World Health Organization, 2002), we selected focus groups as the interview method for gathering information from this patient population (Hollis, Openshaw, & Goble, 2002). Two of the authors are clinical nurses with 18 years of experience working with Somali and other refugee populations. They prepared for this qualitative study by reading articles on focus group process and facilitation with vulnerable and diverse populations. The third author has expertise in qualitative research and data analysis from focus group interviews. We reviewed the interview questions, discussed potential issues with group dynamics, and emphasized the goal of maximizing safety and participation in the groups with our formally trained medical interpreter. We also stressed the importance of the interpreter's role as culture broker.

The participants' English proficiency varied from none to fluent, and therefore, the questions were asked in English, translated into Somali, and the responses translated back into English. The interviews, guided by eight open-ended questions (see Table 1), were audio taped with the participants' written consent. Permission to conduct the focus group interviews was granted by the hospital institutional review board.

Procedures

Participants were selected by convenience sampling. Inclusion criteria were Somali women aged 18 years and older who were greater than 20 weeks pregnant and currently receiving prenatal health care or who had experienced prenatal care and delivery within the past 2 years. The nurses and a Somali community outreach worker recruited a core group of women from an obstetrics and gynecology clinic in the Northeastern United States. The recruited women, in turn, identified friends and family from the local Somali community as additional participants. Two focus groups were conducted at a community center and one in a hospital classroom. Attempts were made to support attendance by

Table 2. Participants' Demographic Information: Age, Length of Stay in the United States, Gestational Age, and Obstetric History ($N = 18$)[c]

Background Variables	Age (Years)	Number of Years in United States	GA at First Prenatal Visit (Weeks)	Current GA (Weeks)	Gravida[a]	Para[b]
Mean	30.28	6.09	9.83	20.75	4.50	3.56
Median	27	6.5	9.3	21.5	4	3
Max	42	12	16	30	10	10
Min	23	1.5	5	8	2	1
SD	6.07	2.83	2.72	6.94	2.43	2.23

Note: GA = gestational age.
a. Gravida indicates that a woman has been pregnant, regardless of whether these pregnancies were carried to term. A current pregnancy, if any, is included in this count.
b. Para indicates births of over 20 weeks gestation. Pregnancies consisting of multiples, such as twins or triplets, count as one birth for the purpose of this notation.
c. Half of the interviewed women (n = 9) had given birth and half (n = 9) were pregnant at the time of the focus group interviews.

offering child care, arranging for a convenient venue, paying cab fare, and making reminder phone calls.

Group Dynamics

The nurses chose to be more actively engaged in the discussions than is customary in a focus group technique (Krueger & Casey, 2000; Owen, 2001). Because they had experience working with Somali women, they were able to develop trust and comfort in the groups with a relaxed and conversational approach. This was consistent with normal social exchange among Somali women as had been seen in the clinic setting.

In all the groups, the women were lively, enthusiastic, often interrupting each other, laughing, and appearing to have fun. There were no major interruptions or distractions from outside of the group(s). Despite the availability of child care, most participants chose not to bring their children with them.

Participants

Each focus group consisted of four to seven pregnant and postpartum Somali women for a total of 18. Basic demographic data (Table 2) were collected from medical records. The participants were between 27 and 42 years old ($SD = 6.07$) and had spent an average of 6 years in the United States.

Data Analysis Method and Process

Content analysis is a method of analyzing written, oral, or visual communication. It is a research method that is a systematic and objective means of describing phenomena. Thematic content analysis is by definition a descriptive presentation of qualitative data used to create themes that link underlying meanings together (Burnard, 1991; Cavanagh, 1997; Graneheim & Lundman, 2004; Hickey & Kipping, 1996; Napoles-Springer & Stewart, 2006).

The audio tapes were transcribed by an experienced independent transcriber and then analyzed using the thematic content analysis method. The two nurses who facilitated the interviews read the transcriptions and carefully listened to the tapes to verify equivalence between text and tapes. The nurses and the third author then read the text repeatedly making notes throughout the reading to gain an overall impression of the general themes within the transcripts. Working together, the three authors then identified words, sentences, and paragraphs as meaningful units of analysis. The data analysis continued by reading the transcripts and writing notes/headings in the text (i.e., open coding) to describe all aspects of the content. The next step was to create a list/table of the headings and categories collected from the transcripts and group these together under broader headings/themes. This phase of the data analysis process required decisions, based on interpretation, as to which content described the same themes and ultimately major themes. During the final phase we named the themes and major themes using content-characteristic words. The data analysis was done manually.

The authors continually discussed the themes, their criteria, and then validated them with the interpreter and a selection of participants. They also showed the summary table of findings (i.e., themes and major themes) to Somali women visiting the clinic and asked if these resonated with them. It was not possible to identify individual participant's statements in the presentation of the findings. The comments were identified only by focus group number (focus group) and the page of the transcript on which the quote appeared (page).

Findings

All the women were Sunni Muslims. Many of these women also had pregnancy and childbirth experiences in refugee camps commonly in Kenya. The participants' marital status remained unknown and was not asked because the question is sensitive and Somali women tend not to be forthcoming regarding their status. Demographic details regarding the participants and their obstetric history are presented in Table 2.

Six major themes emerged from the focus group interviews: (a) pregnancy as a natural experience for women, (b) value and relevance of prenatal care, (c) lack of control and familiarity with delivery in the United States, (d) balancing the desire to breastfeed with practical concerns and barriers, (e) discomfort with mental health issues, and (f) challenges in the health care system.

Pregnancy as a Natural Experience for Women

During the focus groups, the participants presented their thoughts using vivid examples that represented the women's perceptions and beliefs about pregnancy as a natural experience. These beliefs reflected a combination of the participants' culture, religion, and "scientific knowledge" as seen in the examples below.

Part of Somali life. The Somali women expressed that pregnancy was viewed in their culture as a natural part of life and it was a health experience, not a sickness.

> Over there it seems a pregnancy is a very natural experience, it's not like seen as a big, big thing like here. Like a woman has to have a baby and that's natural, their body, can handle it. It's okay so just carry on for the nine months. If you get sick, just go to the hospital for that time. (Focus Group 2, page 4)

In the discussions, the women described differences in experience that depended on the support they had from other people in the community. The participants' thoughts and comments illuminated involvement of extended family and friends as teachers and providers of emotional and physical support that is a major factor in a pregnant woman's health and life.

> In Somalia you have the extended family taking care of you. Like you don't have to do any work. People will come and help you and cook for you. Older women who have children would encourage you about the diet, what you should eat. What you should avoid. So you still have the care but not the hospital care. (Focus Group 2, page 6)

Role of faith. The participants' religious beliefs related to pregnancy and childbearing illustrated that Somali women had more faith in God than in science.

> I think that in American culture you put a lot of trust in science. In the Somali culture, we put our trust in Allah. (Focus Group 2, page 27)

Scientific basis for Western medicine. The participants' comments reflected distrust and doubt regarding the treatment methods of Western medicine. When they trusted the source, however, they were better able to accept procedures and technical aspects of care.

> I had a friend who was going 2 weeks past her due date and she was refusing to deliver. Until a Muslim doctor came, and he talked to her for a long time and he said, you know this is what happened back home, the kids die if they get this age . . . because it's science and it's true. Even the Koran says that. (Focus Group 2, page 28)

Value and Relevance of Prenatal Care

Unfamiliarity with purpose. The participants discussed the differences between health care in Somalia and the United States. Neither prenatal nor preventive care was part of health care in Somalia and therefore was not familiar to the women. The purpose of medicalized prenatal care was difficult to understand, because in their culture women only seek this during pregnancy if they are feeling sick. However, traditional knowledge exists that supports pregnant women's health. Most participants agreed that older women, who had experienced successful pregnancies in Africa, either in Somalia or as refugees in other countries with no prenatal care, do not see the importance of it.

> For me I have experienced in my country aunts and mothers having babies over there, so, even though I was young, I remember them not going to the hospital. It's not like prenatal care here, I mean it's there but only when you really, really need it. Like there's no monthly (visit). . . . You have to be really sick. (Focus Group 2, page 3)

They also questioned health care providers' recommendations when they differed from their families'. The following example illustrates the different perspective of a family member not familiar with the Western prenatal health care model.

> My mother didn't go to appointments and she said "I didn't do that. How come you do it? Why? You're feeling better. You're not sick. How come you're going to the hospital every day? You just need to have this baby." (Focus Group 3, page 25)

Some women talked about the motivation to keep their prenatal appointments. They identified a need to be reassured and informed by their health care providers.

> Maybe something's wrong with the baby. They tell you like if your blood pressure or blood sugar [is abnormal] or something like that. (Focus Group 2, page 7)

Relevance of medical care. The participants' deep religious devoutness was emphasized throughout the discussions. They thought that regardless of medical care and interventions, outcomes are determined by God.

> I believe Allah makes the baby; nobody [else] can make the baby. Allah gives you that baby. The baby is a gift. (Focus Group 2, page 27)

Advanced technology. During the discussions, the participants integrated their "scientific" beliefs with explanations of their care. The "medical facts" helped the women understand the rationale for interventions during their prenatal care. The value of care was perceived as important if it related to an existing problem, that is, hypertension or diabetes. Vitamin B6 injections were cited as being very helpful for nausea and vomiting despite the need for weekly visits.

> They take your blood, they have to check a lot of things. They take 7 bottles. . . . And your doctor will explain to you how and why. (Focus Group 2, page 24)

Some of the participants had experienced high-risk and complicated pregnancies. These women were more open to the value of advanced technology in maternal care and understood its importance.

> My pregnancy was the worst, worst so I couldn't stay home, I wanted to stay home. If I was in Africa I would die, because the whole nine months I was sick. So, how could I stay at home? It could kill me. I got TPN in the hospital. (Focus Group 2, page 9)

Some of the women seemed to share a concern that vitamins and nutritional recommendations are not at all beneficial for the mother and baby but fatten both and complicate the delivery.

> You know, some of us believe that if you take vitamins, your baby grows big. (Focus Group 2, page 12)

The women described how in Africa care focused on the mother rather than the baby during pregnancy. Some did, however, recognize the potential for fetal death.

> If she was in Africa and she went to the hospital, they would take primary care of her, not of the baby. So, there's not going to be that monitor, the fetal monitoring. It's not going to be there. (Focus Group 2, page 4)

Lack of Control and Familiarity with Delivery in the United States

Home delivery versus hospital care. The women described delivery as a natural process with no need for intervention. Family members were seen as important advocates.

> She said the experience she's had back in Somalia most people there deliver normal, vagina way [discussion of the natural delivery process] (Focus Group 1, page 4)

There were varying opinions about the importance of men's presence at delivery. Most women firmly described themselves as "in charge" during labor and delivery. This was contradicted by labor and delivery staff reports that, in fact, husbands appear to be vigorously vocal regarding decisions in the childbirth process.

> She usually just goes with her husband to the delivery. She doesn't want other people around because when they talk it makes her nervous. (Focus Group 1, page 22)

During the discussions, the women stated that home deliveries were more common in Somalia. Therefore, they were more familiar with that approach.

> A lot of times it's the midwife who delivers the baby at home—Even in big cities. I mean some people do the hospital, but my aunt, for example, had her kid delivered at home. So I mean, it's much different. (Focus Group 2, page 3)

The participants believed C-sections were harmful to the mother's health and impaired her future fertility. They appreciated the risk in repeated C-sections and agreed that four births after a C-section is the limit.

> If a woman is admitted to the hospital, everything (C-section) is done so quickly, they don't wait for the labor to continue . . . as they used to wait back in Somalia. They will just make her stressed with all those monitoring things. Back in Somalia they would let you walk around and move. Here the most they will give you is a ball. And if you are having contractions they will make you lie on the bed. (Focus Group 1, page 2)

God has control. The women believed that God controls the time of delivery, and thus they did not commonly accept induction of labor. There was a consensus that exact due dates are not relevant and therefore not observed. It is considered all right to wait 1 month past a medically imposed due date.

> Maybe she is confused a little bit . . . and she thinks this baby is gonna be fine but the fluid is empty. She doesn't believe (there is a problem because) . . . she had a baby fine before. . . . Allah knows better [discussion of induction] (Focus Group 2, page 27)

Prevention of tearing. The women talked about the implications of their circumcisions and shared experiences of women who did not have deinfibulation prior to delivery. They believed the procedure is necessary to prevent tearing and facilitate delivery because the vaginal opening is tight

and lacks elasticity. However, common medical practice is to assess the need for episiotomy on a case to case basis.

> Most Somali women want to be cut because back home that's what they do. You(r) doctors say "no, the baby will cut itself." That will damage me cause it will crack everywhere, that's what happened. I ripped all the way down to my bottom. (Focus Group 3, page 17)

Balancing the Desire to Breastfeed With Practical Concerns and Barriers

Feeding of the baby. Somali women like to breastfeed and consider themselves good at it. New mothers learn how to breastfeed from family members and health care providers. A new mother most often learned from her own mother.

> We do good at breastfeeding. That's the first thing Somali women like to do. (Focus Group 3, page 33)

Somali women are likely to begin supplementation early, often on postpartum day 1, because they believe that a baby will not grow well on breast milk alone. It is also sometimes easier and necessary when the new mother returns to work for others in the family to feed the baby.

> In our culture if the baby is really fat, they like it and say, "oh, he's cute." (Focus Group 2, page 20)

> They think the baby will not grow [fat enough] on breast milk. (Focus Group 2, page 22)

Optimal duration. The participants discussed how to determine the optimal duration of breastfeeding and they agreed that 2 to 2½ years was a good time span. However, they were not comfortable with pumping and did not believe that it was a viable option.

> Yeah, pumping is not known, it's kind of difficult. I don't like pumping and with pumping, you're not going to breastfeed 2 years. (Focus Group 2, page 21)

Discomfort With Mental Health Issues

Stigma. In spite of the fact that the nurses did not ask about mental health, the women commented on it. There is a clear stigma associated with mental health concerns in Somali culture. Some participants noted the vulnerability caused by the stress of immigration and of feeling somehow different. The participants commented that in Somali culture, people, including women, tend to deny and hide their emotional problems in order to avoid becoming permanently marked as "crazy" and thus rejected by the community.

> We hide our feelings. Expressing them is a sign of weakness. (Focus Group 1, page 17)

Some perceived mental health problems as uniquely American. They believed that there is a lack of help and support for people with mental health issues.

> You can't plan on getting help and that's why we don't say "yes" we have it. (Focus Group 1, page 16)

Depression after delivery. The participants were surprised and slightly uncomfortable when clarifying questions regarding postpartum depression related to harming or jeopardizing a baby's well-being. This scenario was almost impossible to consider or understand for these women who had a very religious perspective. Responding to repeated questioning about postpartum depression by her health care providers, one participant protested with the following comment:

> We have religion; we can't do that (kill our baby) . . . 99% we can't do that. (Focus Group 3, page 30)

Some of the interviewed Somali women acknowledged postpartum depression but at the same time normalized it as stress. One mother (postpartum with second child delivered via C-section) explained,

> Like when my husband comes home from work. I go out and it's snowing but I sit out there without the jacket or nothing because I feel like I'm burning inside. And I talk to the psychologist who said "she's okay," it's just the pressure and all. (Focus Group 3, page 29)

Use of psychotropic medications. One participant noted that a Somali mother threw out medication when she found out that it was for depression. The participants also mentioned that family members often cautioned mothers not to take medication in the belief that it would make them "crazier." Some admitted, however, that taking medication could be effective.

> Medicine might make her sleepy, she'll get more worried because she'll think there's something happening in the house or something's wrong with the children . . . (and she won't notice). (Focus Group 1, page 17)

Challenges in the Health Care System

Experiences with access to health care. The women stated that many Somali women are lay midwives and everyone is familiar with the cultural and religious aspects of pregnancy, delivery, and care after a baby is born, but as stated earlier have little prior experience regarding formalized preventive

medical care. There is typically limited access to physicians and medical technology, especially outside of large cities.

> In Africa you are poor. You don't have enough money. You have to stay at home for hours sleeping (when) you are so sick. (Focus Group 2, page 4)

Getting to appointments and differing perception of time. The women stated that their motivation for keeping routine appointments was to receive reassurance, which is especially important in the absence of support from their extended family. They also reported appreciation for learning new things and viewed this as an expectation of the American system.

> Especially younger women like this girl would come like the same reason why American born women would come. It becomes the culture. Just go there, it's your appointment, it's your monthly. (Focus Group 2, page 6)

A common perception was that new immigrants found access to health care services especially hard. Transportation to the hospital/clinic was a concrete problem, but many women were ready to overcome this and even willing to walk if the weather was good.

> They don't have cars, transportation to get here. I've been seeing lately a lot of the patients finding a way to get here either by asking a neighbor . . . somebody yesterday was outside her door for an hour for her to find someone who was driving by. (Focus Group 3, page 1)

A frequently mentioned barrier to keeping appointments was that these women were busy and had other pressing priorities, including small children at home. Telephoning to make, change, or cancel an appointment was considered difficult to do because of the English language algorithm on the clinic answering machine.

> When you are in checkout and stuff like that, young kids are crying and going everywhere and you can't watch them. (Focus Group 2, page 8)

A common complaint of the participants was the expectation that a patient had to be exactly on time although they very often had to wait for their provider. Some participants considered this disrespectful, but an apology could express fairness and mutual respect.

> When I'm late you don't respect that, you send me back home. Once a late doctor explained that there was a really sick patient that she really needed to finish up with and she apologized . . . (which helped). (Focus Group 3, page 5)

The participants had also noticed that it was possible to spend less time with a provider who already knew the mother, knew the baby, and knew the mother's condition. It was important for the participants to be able to spend less time and get out right away to home responsibilities. The development of trust was also considered very important but some participants did not mind an unfamiliar provider as long as they got what they were seeking in the visit.

> You have confidence with them, so you are more relaxed and don't forget things. You can tell a lot of things about your body. (Focus Group 2, page 7)

Role of many providers. There was considerable dissent on the topic of "expert health care providers." Most participants expressed impatience with having to repeat their histories over and over. An example was cited of a woman who stopped coming to appointments altogether because of her frustration with having providers unfamiliar with her and, therefore (she perceived), wasting her time. There was also a belief that medical students were extraneous to the process and diminished a patient's comfort and sense of modesty.

> I don't want two people looking at me. I hate it. I just got to the point where I felt comfortable with going for a Pap smear. (Focus Group 3, page 20)

Medical students were considered more acceptable if they were female and were accompanied by a doctor. The participants were doubtful regarding these students' skills and knowledge, thought that they made more mistakes, and had only a vague appreciation for their heavy and close supervision. There was also a belief that nurse practitioners were "practicing" (i.e., learning) and not fully competent providers yet. Any touch by male providers, even hand shaking, is seen as forbidden among most of the Somali women, but a few expressed a willingness to be treated by a male who they perceived was helping them. Male providers were unanimously considered acceptable if the mother was in danger.

> Ok woman to woman to hug, shake hand, touch your shoulder. NO men touching. In an emergency, no woman there, we will accept. (Focus Group 3, page 24)

The findings of this study (major themes and themes) are presented in Table 3.

Discussion

In this study exploring Somali women's prenatal needs, we found six major themes: pregnancy as natural experience for

Table 3. The Major Themes and Themes Describing Somali Women's (N = 18) Experiences and Beliefs Regarding Pregnancy and Birth in the United States

Major Theme	Theme
Pregnancy as a Natural Experience for Women	Part of Somali Life
	Role of Faith
	Scientific Basis for Western Medicine
Value and Relevance of Prenatal Care	Unfamiliarity with Purpose
	Relevance of Medical Care
	Advanced Technology
Lack of Control and Familiarity with Delivery in the United States	Home Delivery versus Hospital Care
	God has Control
	Prevention of Tearing
Balancing the Desire to Breastfeed with Practical Concerns and Barriers	Feeding of the Baby
	Optimal Duration
Discomfort with Mental Health Issues	Stigma
	Depression after Delivery
	Use of Psychotropic Medications
Challenges in the Health Care System	Experiences with Access to Health Care
	Getting to Appointments and Differing Perception of Time
	Role of Many Provides

women, value and relevance of prenatal care, lack of control and familiarity with delivery in the United States, balancing the desire to breastfeed with practical concerns and barriers, discomfort with mental health issues, and challenges in the health care system. We also learned that when Somali women were faced with new experiences and information, they perceived, interpreted, and reacted to this information by integrating it with their own cultural, religious, and "scientific" beliefs. This finding is profound and goes beyond clinging to old habits, strategies, and attitudes as described by Essen et al. (2000) and Johnson et al. (2005). In fact, our study suggests that cultural beliefs do not need to be seen as an impediment to adjusting to new health care challenges but, when acknowledged by providers, can be actively used by patients to comfortably incorporate new health experiences.

An interesting and important major theme in this study was the "value and relevance of prenatal care." Carroll, Epstein, and Fiscella's (2007) study focusing on knowledge and beliefs about health promotion and preventive care among Somali women in the United States complements and supports the findings of this study. The research study by Carroll et al. recognized that Somali women have, in fact, many habits and behaviors that support health around diet, exercise, and spirituality. These included avoidance of risky behaviors and integration of traditional remedies or rituals to protect against sickness. That study also revealed that Somali women's knowledge about the importance of preventive care was low.

We found that lack of control in the birth process and unfamiliarity with delivery in the United States emerged as a major theme. Chalmers and Hashi (2000) have described birth experiences of Somali women with female genital cutting and found that their care needs differed and were not being met. The women felt disrespect and insensitivity from health care providers. Davies and Bath (2001) studied Somali women's maternity concerns and found that they perceived insensitive treatment, including negative racial stereotyping, and that they did not feel comfortable asking for information. It was a surprising observation for us that the Somali women did not express any concern about pain during the focus groups. Ness (2009) has studied pain expression in the perioperative period with Somali women and found that there is a strong reliance on Allah, who is the only one who understands their pain, and that the expression of pain may vary greatly from silence to screaming and that the preferred expression of pain is in their native language. Finnström and Söderhamn (2006) have interviewed Somali women regarding perceptions of pain and handling of pain and concluded that pain behavior is culturally based, that it is a natural part of life, and that they accept pain as it is given by Allah. The results also indicated difficulty with expression of pain and suffering, even with an interpreter.

In earlier studies, Carpenter and Vaucher (1999) have reported that Somali women's practices changed after immigration: breast milk supplementation was earlier and the duration of breastfeeding decreased. Rakicioglu, Samur, Topcu, and Ayaz Topcu (2006) found that Ramadan fasting had no significant effect on breastfeeding but that the nutritional status of lactating women was affected by fasting. Our findings regarding the Somali women's breastfeeding practices complemented these results.

The "discomfort with mental health issues" was an interesting and important finding in this study. In the earlier studies, Palmer (2007) had found that Somali people suffering from mental health issues became isolated from the community and made considerably less use of community groups due to stigma. Mental health problems affected their access to and use of health care services. Hammoud, White, and Fetters (2005) have also discussed mental health issues pointing out that these are considered culturally and religiously taboo by Arab Americans and American Muslims, which may decrease receptivity to interventions or medications. Mental health issues are not acknowledged and are seen as a source of shame and weakness. Hammoud et al. (2005) have recognized that this can be a problem for women who experience postpartum depression. The findings of this study, especially regarding stigma and the use of psychotropic medications, have considerable similarities with the earlier studies.

Our study showed that the Somali women faced several challenges within the health care system regarding access, appointments, and providers. Kulwicki, Miller, and Schim (2000) have studied the same type of issues focusing on how to enhance health services for other immigrant populations

such as the Arabic community. The researchers concluded that the American health care system is complex, difficult to navigate, and language barriers and perceptions of disrespect were deemed to be obstacles to care. They also found that obstacles to cultural acceptability affected quality of care.

Simpson and Carter (2008) studied Muslim women's experiences with health care providers in a rural area of the United States. The findings illuminated perceived power of providers, religiously defined gender relations and experiences of being a stranger in the United States health care system. The study recognized the importance of orally providing information about the health care system in a familiar environment with the help of an interpreter. The findings of our study, especially regarding access to health care, adaptation to a new culture, perceptions of provider expertise, and interactions with the opposite gender, have considerable similarities with the findings of earlier studies.

Limitations

The focus group participants in our study were women who already felt comfortable with their health care and who were willing to share their opinions and experiences. These women may not have been representative of their community or all immigrant Somali women, and some had lived several years in the United States. However, the women did share many experiences and opinions of friends and relatives that differed from their own, reflecting their varying levels of cultural assimilation. Another limitation is that the discussions were so rich that they occasionally expanded beyond the open-ended questions. In addition, the tapes were very difficult to understand at times when women were talking simultaneously and more than one conversation was going on at once, resulting in some loss of detail and richness in the translation. In those instances, the interpreter summarized what was being discussed in Somali using her own words, thereby interfering with the integrity of the original discussion.

Conclusions

Somali immigrant women were comfortable with their prenatal, birth, and breastfeeding experiences. The discussions illuminated difficulties in understanding the purpose of prenatal care, because pregnancy was not seen as a reason to seek medical care and delivery was seen as a natural process that did not require a medical intervention. Somali immigrant women described several challenges in navigating the complex health care system. They perceived, interpreted, reacted to, and incorporated Western health care experience and information through a combination of their own cultural, religious, and "scientific" beliefs and worldview.

Implications for Nursing Practice and Future Research

The findings from the research project and learnings from the process have supported the development of Somali-specific cultural competency workshops for health care providers. The findings also demonstrated the importance of involving Somali liaisons as educational assistants, advisors, interpreters, and culture brokers for the development of educational materials and prenatal educational sessions. Importantly, they can promote a mutual valuing of the diverse worldviews and thus the outcomes of health care. The implications of the findings for nursing practice are that providers need to listen to Somali women with increased openness and trust as they talk about their health-related concerns, experiences, and issues. This change in nurse–patient relationship has promoted improved customizing of care to these women's preferences and choices by increasing flexibility, opportunities for shared decision making, and information sharing that pay better consideration to their needs. However, more research is required regarding transcultural elements of interaction between health care providers and Somali women.

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