Mama AMMAAN (Safe Mother):

A Community-Based Participatory Action Approach to Bridging Perinatal Care Gaps in the Seattle Somali Community

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Abstract

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The Mama AMMAAN (Safe Mother) Project is a community-based participatory research project that was created to test the feasibility of a culturally adapted service model. It is based on extensive formative research with the Somali community to uncover existing barriers, gaps and needed supports for women seeking access to perinatal services in the greater Seattle area. Research has found that Somali women have a strained relationship with the healthcare system resulting from the disconnect present between themselves and healthcare providers as well as the lack of cultural congruence in their care. They believe the cultural, financial and racial barriers they face are the root of their negative experiences and poor health outcomes. In order to combat these disparities, the participants in the project wish to be better equipped with the tools necessary to navigate the healthcare system.

INTRODUCTION

Somali women in the greater Seattle area face adversities in Western medicine as a result of their intersecting identities that directly impact their pregnancy, labor and delivery experience. This group primarily identifies as Black, African, Muslim and immigrant and when it comes to their health and wellbeing, they are constantly battling systems that are not catered to their background often leading to increased morbidity and mortality. The poor health outcomes can be attributed to the barriers hindering them from receiving adequate healthcare. Understanding these barriers can lead to solutions that will aid Somali women in attaining optimal perinatal care. The immigrant status of this group has an effect on the adversities they face with the healthcare system.

The migration of Somalis was a result of political unrest that led to this community living in low-income areas of greater Seattle. In the early 1990's, Somalia was at the height of its civil war which caused the displacement of millions of Somali men, women and children across the world (CDC, 2019). Seattle has embraced the third greatest number of Somalis in the United States behind Columbus, OH and Minneapolis, MN. According to databases, roughly 31,000 Somalis live in the Greater Seattle Area (Ott, 2010). Many refugees were placed in pockets around southern King County such as Seattle, Kent, Tukwila and Renton where there were low income housing options available. According to the article 'Nativity, Ethnicity, and Residential Relocation: The Experience of Hmong Refugees and African Americans Displaced from Public Housing,' most "refugees, or immigrants that leave their countries of origin because they face some form of persecution or the threat of persecution, come to the United States with fewer financial resources and lower human capital levels compared to other immigrant [and] are more likely to need government services than other immigrants (Allen and Goetz, 2010)." South Seattle in particular has the largest number of Somali settlers as well as other refugee communities like the Vietnamese,

Ethiopian and Cham communities. This area, zip code 98118, was once revered as one of the most diverse zip codes in the country (Ran, 2010). County data shows that the largest concentration of Black people, including Somalis, is in this area with about 36% of the population (Yoon et al., 2017). While this area is ethnically and racially diverse, it is also home to one of the county's greatest maternal health disparities.

Black women in the greater Seattle area, particularly Somali women, face disparities in perinatal care that leave them suffering more than their non-black counterparts. South Seattle has among the highest rates of preterm and low birthweight babies, cesarean section rates, and women experiencing less than adequate prenatal care in the state (*KCCHNA*, 2018). These inequities are directly related to the social determinants of health such as race, housing and education (Anachebe and Sutton, 2003). According to the King County Community Health Needs Assessment, "Black mothers were less likely than Asian and white mothers to receive early and adequate prenatal care." Racial disparities are extremely prevalent in maternal health and have been largely spoken about in present research. The data also states that "the probability of mothers receiving early, and adequate prenatal care was lowest in high-poverty neighborhoods and highest in the most prosperous neighborhoods (*KCCHNA*, 2018)." This shows that the lack of prenatal care disproportionately affects those living in these low-income areas which are primarily Black and Brown individuals. Research shows that barriers to care and socio-economic risk factors lead to high rates of maternal stress, which has been linked to poor birth outcomes, particularly for minority women (*National Partnership*, 2018). While we know that there is a clear disconnect between those attaining adequate care and optimal health outcomes and those who are not, it is unclear how Somali women with refugee/immigrant backgrounds are impacted by these statistics.

This group is relatively 'new' to this 'old' Western healthcare system and the barriers they face are more dynamic than data shows.

By understanding why Somali women are receiving less than adequate care and the specific barriers they face, we are able to better serve this community. Many projects utilize community-based participatory research (CPBR) as a way to achieve outcomes that are yielded from the community themselves through their active involvement in the entire process. Research shows that CBPR research "has resulted in an exciting and longstanding history of work that has explored community needs and strengths in order to ultimately influence community action and change across a wide range of issues and settings (Jason and Glenwick, 2016)." By listening to the needs and perspectives of Somali women on perinatal risks, resources and resilience in their own lives and neighborhoods, we are able to have a true model of community-based participatory research that will give this community the tools to bridge the gaps present in their navigation of the healthcare system. Data derived from this method can help inform innovative, culturally congruent approaches to perinatal services that better address and positively influence the experiences and outcomes for vulnerable communities. Cultural congruence can allow for "providers and clients [to] create an appropriate fit between professional practice and what patients and families need and want in the context of relevant cultural domains (Schim and Doorenbos, 2010)." In order to achieve this goal, a group of researchers created a community-based intervention which is able to act as a catalyst for such outcomes.

The Mama AMMAAN (Safe Mother in Somali) Project: African Mother to Mother Antenatal Assistance Network (AMMAAN) was a feasibility pilot study funded by the Royalty Research Fund led by a group of Somali professionals and University of Washington faculty. This formative research project based in the greater Seattle area was a collaboration between the Somali

Health Board, Health Alliance International and the UW. The aims of the project were to 1) identify the barriers that prevent Somali women from receiving quality perinatal care, 2) to identify the motivators that encourage Somali women to receive quality perinatal care, 3) to understand the context in which the community operates which addresses the health disparities present and 4) to understand the needs, wants and desires of Somali women in the community. This project relied on the community-based participatory approach to collect the data that eventually led to the development of culturally-congruent interventions.

METHODS:

Study Participants

This study intended to include and encompass a wide range of experience among Somali women and their relationship with the healthcare system. The participants of this study were Somali mothers (birthed at least one child) or soon-to-be mothers (pregnant with their first child). The ages of the women ranged from 18 to 65. The participants lived in areas around Seattle/South King County and frequented healthcare facilities in the area (Swedish, Kaiser Permanente, Harborview, NeighborCare). The women were able to give accounts of their experiences, obstacles and desires to provide information on a potential intervention. The study also included healthcare providers who worked directly with the participants (doulas, interpreters and nurses) and fathers (who have at least one child with a woman). These secondary participants were able to give insights that enriched and contextualized the data collected from mothers by providing other perspectives from the wider community.

Site Description

This study was conducted in South Seattle/King County in locations the participants primarily resided close to or had easy access to. As a community, Somalis mostly gather in areas such as the local mosque, libraries and community centers. The project team made it a point to meet moms where they are thus choosing sites for the convenience and comfort of the participants. Members of the research team that shared background with the participants chose the following locations based on experience and observation.

- Abu Bakr Masjid (Tukwila, WA)
- Somali Health Board Office (Tukwila, WA)
- Tukwila Library (Tukwila, WA)
- New Holly Neighborhood Campus (Seattle, WA)
- Rainier Beach Library (Seattle, WA)
- Somali Community Center (Seattle, WA)

Study Design

The Mama AMAAN Project was a qualitative research project that utilized the community-based participatory approach in gathering information to create a culturally competent intervention for the participants (Minkler and Wallerstein, 2003). This project also served as a feasibility study to see the potential of an even greater intervention that could further address the disparities the participants face.

There were five phases of the project that lead to the final implementation of the culturally congruent intervention that addressed the disparities in the community.

1. Documenting the perceptions, preferences, practices of perinatal health-seeking, forms of resilience and resources among women in five populations carrying heaviest burdens of negative reproductive outcomes in Seattle's most diverse and underserved neighborhoods;

and identify barriers and facilitators to perinatal and birth care-seeking and service-utilization.

2. Training doulas, midwives and nurses in culturally congruent peri-natal care, birth education and doula care, and train doulas to mobilize and sustain pop-up group perinatal mother-to-mother care.
3. Drawing on formative research and adapted group perinatal, birth educator, and doula training curricula to develop core components for community-based East African pop-up group, mother-to mother perinatal care services, including modified mental health screening tool.
4. Implementing interventions, convening and monitoring monthly pop-up group perinatal mother-to mother care and education in 5-6 community settings.
5. Tracking project indicators to evaluate the impact, acceptability and feasibility of the group perinatal intervention components (Pfeiffer and Chapman, 2020). The formative data collection in phase one was the most critical aspect of the project, because it informed the direction in which the intervention would go.

The data for the project were collected by means of focus group discussions (FGDs) and individual interviews with mothers and providers. Focus group discussions are used in group settings to stimulate discussions that would not occur in simple two-person interactions and encourages people to explore similarities and differences of opinion (Bernard and Ryan, 2010). The project utilized this approach to encourage semi-structured conversation that allows for the participants to speak on the research project in a less formal environment. The sampling/ recruitment selections for the focus group discussion participants were primarily achieved through network sampling, specifically snowball sampling. In this method, you start with a few people you have a relationship with or those who respond to your callout. That starting group then begins to

recommend one or two other people who fit the criteria and you eventually find more and more participants growing the sampling size (Bernard and Ryan, 2010).

For focus group recruitment, the Mama AMMAAN team members that were well-connected in the Somali community first approached potential participants from their own networks or in locations frequently gathered by the Somali community such as the mosque and library. This sampling method was appropriate for data collection, because it allowed the participants to feel comfortable in the interviews/ discussions due to being recruited by their peers. On the other hand, this sampling method could lead to a possible bias in the participants recruited. For example, snowball sampling may have tended to include women/men who spend their free time in the mosque and those connected to them and exclude those who were working, stay-at-home mothers/fathers or non-religious men/women. This project had a total of 4 focus groups, three groups were all mothers and one was all fathers. All four groups were recruited in the same way, through network/ snowball sampling. Each focus group had from 5 to 25 people, and they were conducted at the Somali Health Board office, Tukwila Library, Abu Bakr Masjid, Rainier Beach Library and the Somali Community Center. For the individual interviews, there were eight providers and four mothers that were recruited to join the study. The participants for these interviews were selected through purposive (or judgment) sampling which is where interviewers choose their own participants through their own set of criteria (Bernard, 2010). The criteria for the including providers were that they had to work directly with the Somali community in reproductive and maternal/ child health. These criteria could include doctors, nurses, medical assistants, doulas, midwives, interpreters and public health professionals. The criteria for the individual interviews of the mothers were that they had to be Somali and a mother. While there was already a focus group discussion that included Somali mothers, the purpose of the additional individual interviews

was to dig deeper and cover topics that were less likely to be spoken about in a larger group. All the participants for the individual interviews were selected by the Mama AMMAAN team through their groups' collective network.

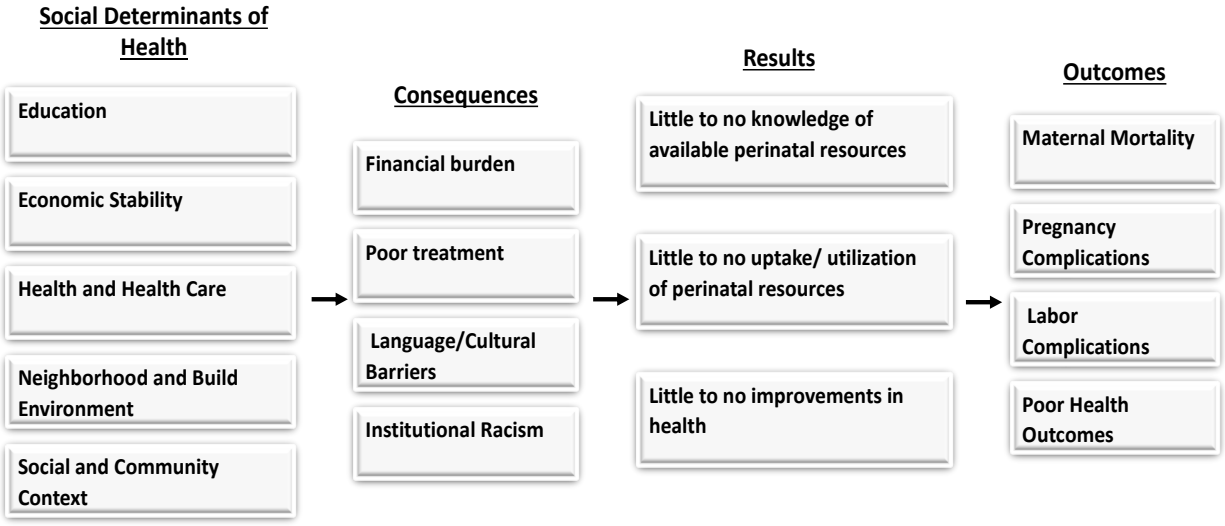
Interview Guidelines

The interviews for the data collection were designed to capture the conversations around perinatal care in a larger scale through focus group discussions and at a smaller scale through individual interviews. All the interviews were semi-structured meaning that some topics are chosen before beginning the interview based on research, but when and how the topics were presented was not structured (Corbin and Strauss, 2015). This allowed for a natural flow of conversation that was centered around a specific topic. With a questionnaire created by the research team, the moderator kept the conversation related to the pregnancy and birthing experience. Considering the participants and their religious preferences, there were deliberate choices made. When conducting the interviews, we made sure that women were interviewed by women, and the men were interviewed by men. This was done to maintain privacy and modesty among these groups in accordance to their culture (Global Affairs Canada, 2018). These conversations are sensitive, so making sure the participants are comfortable is imperative to the richness of the data. According to studies, women speaking about their infertility, health complications and birthing experiences are more comfortable in the presence of other women who share similar experiences (Krueger, 1994). By keeping the groups separate, conversations are able to be centered around respective experiences.

Data Analysis:

Before initiating data analysis, I created a conceptual framework to ground my approach to the project. Figure 1 shows the relationship between the social determinants of health and the poor health outcomes that exist in this community. To address the outcomes, it was beneficial to visualize why these outcomes occur in order to narrow the scope of the research. After the interviews and focus groups were complete, the team came up with several open codes that connected to our grounded theory in order to condense the data. According to textbooks, "the act of discovering themes is what grounded theorists call open coding, and what classic content analysts call qualitative analysis (Bernard and Ryan, 2010)." The transcripts were coded through a software called Atlas.ti.

Table 1: A Conceptual Framework of Determinants of Poor Maternal Health Outcomes



RESULTS

Theme 1: Ideal Birth

Participants used these interviews as a time to openly discuss what they needed in order to have an ideal birth. This topic allowed for the women to use their own words to describe their needs that are in-tune with their cultural beliefs and personal desires. They discussed wanting stability, financial leeway and optimal health.

Here is a mother from an individual interview speaking on what she views as the best birthing outcome for her and her family.

> *"I would ideally want a healthy baby, that I am healthy and that I have enough food to raise my kids and take care of them and myself with no worries in my heart."*

The hope for this mother is not having to worry about basic necessities. She wants to be able to give birth to a baby that she is able to take care of. Food security is a topic she highlighted which is making sure there is food for the child to eat at all times. To be able to feed her child is to be able to take care of them. The Somali community is primarily comprised of low-income refugee families, so food insecurity is not out of the norm. While some may not even think about the food they eat on a daily basis, it is clear that this a concern for this mother and others in this community.

This mother from another individual interview described her ideal birth as not having any financial stress.

> *"I would not work -- so I wouldn't have any financial stress. I wouldn't have to worry about anything, and -- I wouldn't have to worry about medical coverage -- or anything that*

has to do with premiums. I would have full coverage of everything, I wouldn't have to worry about any of that business."

The idea of an optimal birthing experience for this mother is having insurance and financial comfort. She did not speak about the labor and delivery itself, but the fees associated with it. She would preferably deliver a baby in a situation where she does not have to worry about the finances. This brings attention to the larger issue of insurance in the United States healthcare system. To give birth without any insurance is to give birth with financial burden. According to research, "charges for vaginal births ranged from $3,296 to $37,227, and charges for caesarean sections ranged from $8,312 to $70,908 (Hsia et al., 2014)." The concern this mother has for insurance is fueled by the existing systems that burden patients with outrageous bills.

While the other mothers spoke primarily of food and financial security, this mother spoke on her dreams of the actual birthing experience itself.

"I would, if I could I would have a shorter labor where I would not necessarily [use] pain medication. [I'm] just gonna say no pain."

This mother is interested in having a quick, painless and natural birthing experience rather than a long, medicated one. This is a perfect situation most mothers dream for however; it is not a realistic outcome. Studies show that, "labor pain is ranked high on the pain rating scale when compared to other painful life experiences (Labor and Maguire, 2008)." To desire a painless labor and delivery without medication are conflicting desires because the remedy of pain is medication. Somali women come from a rural background where they typically do not have access to the same technologies and medications as the West. Therefore, their reliance and comfortability with drugs

in labor and delivery differs culturally which is why this mother brought attention to not wanting to rely on pain medications.

Theme 2: Support/Advocacy/Autonomy

Participants highlighted their need for support when it comes to the whole process of being pregnant, giving birth and taking care of a newborn. They desired familial and community support as well the ability to support themselves.

This mother in an individual interview spoke on the importance of having support.

> *"I think a healthy pregnancy is having a lot of support. Especially with existing children. I think sometimes it's not the pregnancy itself. It's the existing children. Also the other demands of a mother becoming a mother again. Simple things like naps, not having to cook when you're really nauseous. It's kind of... making you-- sicker."*

The mother recognizes that being able to have back up when you are pregnant makes a significant difference in your ability to have a healthy pregnancy. Having extra support is not only helpful for your health but also for your existing children. This mother highlighted the difficulty of being able to balance a household while being pregnant. This is a topic many other mothers spoke on as well. Many women in Somalia believe "6 or more children to be the ideal family size (SHDS, 2020)." To be supported in your pregnancy is crucial to the mental and physical wellbeing.

A public health nurse in an individual interview spoke on the importance of educating and advocating for yourself when it comes to your health.

"In recent news reading about not necessarily just infant but maternal mortality lately, it is a scary thing. But -- acknowledging that it is there and -- the more knowledge you have about these things, the more you will be empowered to speak up for yourself. So, what I do is I use my experience and I totally relate that to my clients, and I empower them to speak up [and be] the best advocate for your own health and for your children"

This provider highlighted the harsh reality of infant and maternal mortality in this demographic. They want their clients to be educated on these daunting statistics and use them as a tool to advocate for themselves. By being aware of the way the healthcare system fails Black women, clients are able to pay more attention to their own health and speak up when things are wrong. This provider encourages her clients to be autonomous and alert when it comes to their own health and the health of their baby.

Theme 3: Resources That Meet Mothers Where They Are

Participants were hopeful for changes and brought forth many ideas that will allow for a more positive experience when it comes to accessing perinatal resources. They wanted cultural competency in the healthcare field, more Somali people in positions of power and more initiatives that can allow for easy access for Somalis by Somalis.

This mother spoke on the lack of representation for this community in terms of overall healthcare.

"They need support and their community, to find a Somali speaking nurse, midwife, doctor or pharmacist that helps a lot. If a person needs help they can ask them to explain it. It would be great if there was an office with all these resources."

The idea of having healthcare providers that are also Somali is a common dream for many participants in the study. To have providers that are already familiar with their background and beliefs would allow for women to best utilize the resources provided without much hesitation. Participants believe that having an office where the community is able to access the resources tailored to their needs would break down barriers they have previously faced. The language barrier that participants face would also not be a concern because they would be able to have community members aid in their understanding of the resource materials.

Another mother addressed the lack of individualized intervention and education when it comes to Somali mothers in their perinatal health.

> *"Somali mothers here work and also take care of their children so they don't get any time for themselves. You would see a woman with young children and her teeth have fallen out or are broken because she has not taken care of herself. They need to be educated on nutrition and what her needs are."*

To this mother, meeting mothers where they are not only means meeting them physically but also meeting them at their own journey. This participant brought attention to treating each mother as their own individual person rather than a collective. In the example brought forth in the quote, the provider stated that if a mother requires attention in certain areas such as nutrition and self-care then they should be educated on just that. Some mothers require different interventions and it is important to be mindful of that instead of using the same approach for every person. Meeting mothers where they are physically, mentally and emotionally is important to the utilization of resources.

Theme 4: Navigating Medical Care

Participants were very vocal about wanting to learn various aspects of the healthcare system and take matters into their own hands. They wanted to learn how to know how to best interact with their providers and how to determine if they are trustworthy. They wanted to be educated on their individual rights and how to deal with discrimination, abuse and mistrust. They wanted to understand the different medical terminology and procedures they encounter so they are equipped to make the right decisions. In order to successfully navigate medical care, they are cognizant of the fact that they must be able to advocate for themselves through education.

A provider suggested that it would be helpful to offer this community language tools to encourage participants to speak up for themselves.

> *"It would be nice if there was an emphasis on providing resources to non-English speakers so that they can be better equipped to learn the language."*

Since this community is primarily comprised of refugee and immigrant individuals, English is not their first language. To be able to speak the English language, the community members are able to bridge the communication and cultural gap present when navigating medical care. Most resources are written in the English language and having it translated to Somali is arduous. To be able to advocate for themselves and attain resources, learning English would be helpful.

This mother highlighted her struggles of not being able to access healthcare due to the financial, language and cultural obstacles in her way.

> *"I struggled because I didn't know English, was homeless and on a waiting list for housing. I barely had any money and didn't live near a hospital so I would taxi everywhere. I*

couldn't find any doctors who would take me during my last trimester of pregnancy and went to many hospitals. The hospital I wanted to give birth in the doctor didn't want me as a patient because I wasn't with them throughout my whole pregnancy."

This account of a mother's battles to find a doctor to care for her during her pregnancy showcases the difficulty of navigating healthcare. Financial, language and cultural barriers can present obstacles that stop women from attaining optimal healthcare. Many women said they were not able to utilize perinatal resources because they were not able to due to extenuating circumstances. By understanding that this is a struggle many Somali women face, it can be a point of intervention for the research project.

Theme 5: Provider/ Patient Disconnect

The participants spoke on the disconnect present between providers and patients which limit effective communication in terms of their perinatal healthcare. They expressed how they were not fully understood by providers and they were not able advocate for themselves due to the language and cultural barriers present.

This interpreter discussed the tools used in the medical field are not compatible with all patients which adds to the disconnect between provider and patient.

"When I'm interpreting the tools providers use tend to frustrate mothers who just had their babies, the tools weren't made with our community in mind. It may make sense for a westerner for instance, but not for us. For example, a question may be "does your child play peek a boo?" that doesn't exist in our culture so that question doesn't relate even if you translate it."

The interpreter highlighted that using the right tools to assess patients is crucial to understanding them. Using tools that do not relate to the patient is unhelpful and leaves room for misunderstandings. This point focuses on the importance of having culturally congruence in assessment tools, so patients are able to be understood.

A nurse practitioner spoke on the lack of understanding between healthcare providers and patients.

> *"I know they've been in a war [and] they came from camps. Every situation is unique. So trust is a big one they want to know the intentions, they want to question everything you tell them, sometimes they don't follow the direction you give them."*

The lack of trust between provider and patient is evident throughout the whole project. Women spoke about how they do not believe that the doctors want the best for them. Sometimes, patients ignore the suggestions of the provider due to that disconnect between the two groups. This is a huge issue because this disconnect can be fatal when the patient and provider are not listening to each other.

Theme 6: Institutional Racism

Participants voiced their dissatisfaction with healthcare providers and the institutions. They shared their personal experiences with their office visits, labor, and delivery. They spoke of racism, islamophobia, xenophobia and misogyny that impacted the quality of their care.

A provider in an individual interview accounts a time where a colleague spoke condescendingly to a patient not following their advice.

"I vividly remember after the woman whose twin died being at a debrief with all the people that were involved and a physician looked at me and said very angrily to me. 'Why can't you make them do with what we want them to do?'"

This remark by the provider highlights the issue of racism where the provider who was white was angered by "they/them" not listening to them. The US vs THEM used in this quote upholds the ideologies of white supremacy and institutional racism where the patients who are out of line are viewed as wrong. Many women in the study also spoke about how they felt providers were forcing them to do things in the way they wanted rather than a plan that is culturally acceptable. They often feel disregarded and less than, which further strains their relationship with the healthcare system.

This Somali provider highlighted an experience they had with a different healthcare provider that showed the prejudgment she faced.

"Just like any brand-new mother I was not sure what to do, but when I did come in the nurse just assumed that, ah, you know I kinda had it together, I feel like did not check on me quiet as often as she should, I feel I was dismissed in certain cases, I was offered interpreters when I very well spoke English, so I guess just that bias deep and rooted and existing within the staff members, I guess is just racism in itself, right?"

Providers labeling patients a certain way before them saying a word upholds the detrimental effects of institutional racism. Healthcare providers having the power to make assumptions about their patients can affect their health negatively. According to research, "actions that stem from biases compromise quality of care through error, miscommunication, no referral or inappropriate referral to specialty care or medical procedures, and misdiagnosis of medical conditions (King and Redwood, 2016)." Bringing attention to institutional racism is critical to the care of this population.

Theme 7: Reproductive Decision Making

The participants included in the study spoke on how they use their cultural and religious practices to guide their choices in pregnancy and delivery. They spoke on how being Muslim and Somali contributed to their poor treatment at healthcare facilities.

This participant spoke on how their view of children differed from Western views which ultimately led to *their choices being judged by healthcare providers.*

> *"Doctors pressuring women to stop having kids when the women want to continue having children. It is part of our culture to have as many kids as possible. We believe that children are the most prized gifts that God has given us and we believe that."*

While some cultures believe that having a few children is better, this participant highlighted the beauty of having as many kids as you can. Having more than the average number of children in the United States, which in 2019 is 1.93 children per family, is unfamiliar and judged (Duffin, 2020). A mother's decision to have more children is fueled by cultural beliefs even when it may affect their own personal health.

Two mothers discussed how their faith plays a major role in the resilience strategies and health seeking patterns. They expressed how they stayed firm in their choices although providers may have advised them otherwise.

> *"[Doctor] kept mentioning how I shouldn't have been pregnant and how all this was affecting my health and could even lead to death. I told her that I would have fifteen let alone ten children if God willed it. I told her that I as a Muslim believe in God and that life and death comes from him and I would be happy with all that He decrees for me."*

"God is a huge, huge Factor like we believe, you know, you might tell me my baby's going to die and it might it might be right now what you see but God has power to alter that to change that to give me a healthy baby because it's not dead yet, right."

By leaving their health and well-being to the hands of God, this community is able to rationalize and accept their outcomes. Religion plays a large role in the fate they accept, positive or negative. This can pose as a frustration to non-Muslim/non-Somali providers because this mentality can lead to stagnancy at crucial points in their pregnancy and delivery. Just accepting the potential negative outcomes instead of being proactive to make changes suggested by health providers can be fatal. However, this rationale is a form of resilience in terms being able to feel comfort when bad news is delivered. Keeping faith alive is possible by trusting God.

DISCUSSION

This project was able to explore the views of Somali women on their perinatal health options, health-seeking beliefs and practices, needs and experiences with various healthcare facilities and providers. Black women have faced poorer health outcomes in comparison to their non-Black counterparts which has led to higher maternal and infant mortality rates. The results have provided insight on the various systemic and cultural barriers this community faces while also bringing forth solutions. The participants of this research were in search of a better relationship with the healthcare system. One that connected with their Blackness, Somali culture and religion.

Barriers

Through the various focus group discussions and individual interviews, there have been recurring barriers mentioned when it comes to accessing perinatal resources. The largest of the themes was systemic and institutional racism. The obstacles this community faces are linked to

the lack of representation in the healthcare field and the subsequent maltreatment they encounter. The Somali community is relatively new to the United States thus having adequate resources and support in these institutions is difficult. They are faced with providers who look down on them, incompatible assessment tools, and opposing views. All the points brought up by the participants highlighted the cultural and religious differences they experience and how it led to their lack of trust in the system. The intersecting identities of this community also plays a role in their lack of utilization of resources. As a refugee community with Islamic roots, they are immediately othered which causes difficulty in attaining optimal care. Participants ultimately desire cultural competency in order for their community to feel comfortable and confident with healthcare providers. The lack of support systemically can have a detrimental effect on health and wellness for this community therefore breaking down this barrier is crucial.

Motivators

The participants of this project highlighted the ways they would feel the most comfortable utilizing perinatal resources to aid with relationship with the healthcare system. The main motivators that would allow women to be more open to accessing these resources were said to be education, community and empowerment. They wanted to be at the forefront of their own health and wellness by having the tools to make decisions for themselves. Somali women are primarily stay-at-home mothers who do not speak the English language so having control over their own health despite the obstacles they face is important to them. Many of these women are proud to be mothers and birth many children so being able to provide the best outcome for their family is desirable. They state that they would be able to do this through governmental, community and familial support.

Implications for Intervention Development

The Mama AMMAAN (Safe Mother) Project is a research project with the intent of testing its feasibility and developing further interventions to address the health disparities this community faces. By creating the pilot intervention stemming from the data analysis, the research team was able to provide initial resources that addressed a few of the concerns of the mothers such as educational material and advocacy (Pfeiffer and Chapman, 2020). This project was informed by the formative research which allowed researchers to create a culturally congruent, community-based intervention. There are four core components of the project created address the needs of the community: 1) to create culturally congruent pop-up peri-natal ed classes, 2) establishing workshops for fathers that would them how to best support their partners during pregnancy, labor and delivery, 3) connecting mothers with doulas for perinatal and Ummul (the forty days following delivery or postpartum) Care, and finally, 4) provider education to allow for cultural competence and congruence in the medical field. On top of these four core components, participants will simultaneously be engaged in social media platforms to keep the communities connected instantly in mediums they feel most comfortable with, which are Whatsapp, Facebook and Snapchat. Table 2 details how the intervention components will yield the project outcomes as well as the ultimate outcome of greater health and wellness. These components of the Mama AMMAAN project will aid in addressing the barriers and cultivating a better relationship with the healthcare system for the patients. This project was designed to make Somali women feel empowered and supported in environments made specifically for them, by them.

Table 2: A logic model of The Mama AMMAAN (Safe Mother) Project

Intervention Component	Inputs	Outputs	Project Outcome	Ultimate Outcome
9 Education Modules • Rights • Knowledge • Resources • Doula education • Materials	Knowledge and awareness	Provider choice	Prenatal Care • # of visits • Quality ○ Cultural congruence ○ Language ○ Resources	Improved birth outcomes in Somali community of Seattle
Doula (umuulo) Home Visits • Pre-labor • During labor • Post partum	Understanding and implementing Doula services	Adherence to visits	Maternal Services (Labor and delivery) • Quality • Socio-medically appropriate c-section decision making (negotiation)	Improved overall maternal and perinatal health in Somali community of Seattle
Social Media • Facebook • Snapchat • Whatsapp	Social support • Doula support • Peer support • Partner support	Trust the providers	Post Natal Services • Quality • # of visits • Home visits • Immediate visits	Improved awareness of perinatal and maternal services
Consistent Program • Meets mothers where THEY are	Continued, ongoing access to information	Reduce loss to follow-up	Maternal Empowerment • # continued all modules	Improved trust of community interventions
Holistic **person-centered** integrated services • Mother's receiving services and knowledge THEY want	Connecting mothers to resources and answering questions they may have	Empowered Informed Decision Makers	Individual Autonomy and Empowerment • Quality • # connected to resources	More accountable and responsive healthcare systems

Limitations

The project did not include other voices such as caretakers of mothers and social services specialists. Caretakes of mothers are those who are there for the patient through their appointments and health journey. Those who are educated on the patient's health and well-being. This could be a daughter or son who serves as an interpreter and educator for their mother who does not speak the language. This perspective would provide supplemental information which would further enrich the data. This project also did not include social services specialist or personnel who would be able to speak on the uptake of resources and why they are or are not being utilized.

Recommendations

Further Research:

The recommendation for further research on this topic would be addressing the effects of chronic illness on perinatal health. Women that have health concerns such as HIV, diabetes and

high blood sugar may have a different relationship with the healthcare system than women without chronic illnesses.

Further Intervention:

The recommendation for further intervention would be addressing nutrition and its effects on pregnancy in the Somali community. Nutrition and diet have a lasting impact on pregnancy thus having it as a point of intervention would allow for participants to have the tools to educate themselves and self-regulate throughout their pregnancy.

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