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UNIVERSITY OF SAN DIEGO

Hahn School of Nursing and Health Science

DOCTOR OF PHILOSOPHY IN NURSING

LIVED EXPERIENCE: EAST AFRICAN SOMALI SPEAKING WOMEN ACCESSING THE
U.S. HEALTHCARE SYSTEM

by

Shukri Adam

A dissertation presented to the
FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the requirement for the degree
DOCTOR OF PHILOSOPHY IN NURSING

July, 2011

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ABSTRACT

Access to prenatal healthcare for East African Somali Speaking Women (EASSW) who are immigrants to the U.S. has been dependent on the availability of a systematic healthcare treatment model. The purpose of this study was to explore EASSW's lived experiences in accessing prenatal healthcare services in the U.S. A descriptive, qualitative phenomenological approach informed by the work of Husserl was used to explore EASSW's experiences, views, and problems encountered while attempting to access prenatal healthcare services in the U.S. Fifteen EASSW of childbearing age (ages 18-45) were recruited for this study. All participants interviewed privately, beginning with a semi-structured, open-ended question regarding access to prenatal health care services, followed by three more focused questions. Due to cultural a restraint, no digital recorder was used in this study, instead the researcher took pencil, and paper notes during the interviews.

The specific aims of this study were: 1) to describe EASSW's experiences while seeking prenatal healthcare services; 2) to understand EASSW's views towards the American prenatal healthcare services available to them; and 3) to identify any problems participants encountered while obtaining prenatal care, including, if applicable, the reasons for not seeking early prenatal care services.

Examination of participants' narratives revealed four major themes, including cultural barriers, favorable and unfavorable prenatal healthcare experiences, systematic obstacles, and the target population's lack of knowledge of the U.S. healthcare system. The study provided additional sub-theme categories regarding prenatal healthcare services for the EASSW of childbearing age. Further analysis of themes and subthemes identified three major categories of

factors limiting access to prenatal health care in this population, including internal, external, and systematic factors. These factors include health care providers' lack of cultural sensitivity, a lack of quality interpretation services, EASSW's lack of access to resources such as transportation and childcare, and the complexity of the U.S. healthcare system. This study indicates the need for future research to understand more regarding factors currently limiting access to prenatal care.

DEDICATION

This dissertation is dedicated to my dear mother who had no access to prenatal healthcare services and died from childbirth when I was very young. This event is the catalyst for my research study, becoming a nurse, and pursuing higher education in the nursing profession. My study further helps me to understand the factors that contribute to healthcare disparities of the East African women of childbearing age. Given my personal life experiences and academic achievement, I believe it is my responsibility to empower people of my cultural origin to decrease the incidence of healthcare disparities, especially for East African Somali speaking women of childbearing age.

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I would like to express the deepest appreciation for many special people that supported my educational journey for my doctoral studies- my lifetime academic dream.

To my dedicated husband and four children, “I thank you for your encouragement, support, and your understanding during my journey, I love you”. I want to thank all of my siblings, my nieces, and nephews for your support and encouragement. I want to thank my departed father for encouraging me to always be kind and to help others, and who raised me to do great things, and my mother who I feel would have done the same, “I keep my thoughts and prayers for the both of you always”. Special heartfelt thanks to my brother-in-law, who was so important in the beginning efforts of my career, and walked with me through the doors to register into my initial nursing school class.

My thanks go to the three special people who supported my academic journey by writing letters of recommendation for me. I extend to the Director of the PhD Program in Nursing at USD, Dr. Patricia Roth, my appreciation, and thanks for her support. To the two first professors who met me, I extend my appreciation for interviewing and accepting me into the nursing program.

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CHAPTER I

Focus of the Inquiry: Introduction

Providing optimal healthcare depends on creating a system that offers comprehensive health care, which included physical, psychological, social, cultural, and spiritual aspects. Therefore, obtaining a system receptive to patients relies on the communication between the healthcare providers and the patient, which requires careful consideration of the family, social, and community dynamics that can design the path of the patients' treatment process. In addition, health care comes in many forms: social factors such as race, ethnicity, and immigration status as well as family structure, income, education, and health insurance status have impact (Schultz, Chao, & McGinnis, 2009).

The purpose of this study was to explore female East African refugee experiences and feelings regarding access to quality prenatal healthcare services in the U.S. In addition, this research explored disparities to access of quality prenatal healthcare services. East African Somali Speaking Women (EASSWs) of childbearing age in the U.S. are refugees from East Africa who may experience barriers to obtaining quality prenatal care because of their perceptions and health beliefs about obtaining early prenatal healthcare services. This inquiry was undertaken to enhance understanding of East African women's culture and beliefs regarding prenatal care, with the goal of promoting a more integrated holistic approach to prenatal care and decreasing negative health outcomes in this group.

This research used a descriptive, phenomenological approach to describe EASSWs' experiences and feelings in relation to accessing quality prenatal healthcare services in a community of East African persons living in a Southern California city. This dissertation presents the results of in-depth interviews with EASSWs regarding prenatal care, and then

compares and contrasts their responses in order to construct a narrative report of collective statements describing experiences of the EASSWs in accessing quality prenatal healthcare.

Statement of the Problem

Somalia is one of the most political unstable lands in the earth; Somalis women with complicated deliveries have endured lack of access to healthcare. In addition, it is expected that less than 2% of women in Somalia deliver at a healthcare facility with trained and skilled employees (Chu, Ford, & Trelles, 2011). “Many Somali’s live in destitution, vulnerable to the vicissitudes of political violence, global markets, and climate” (Bradbury, Menkhaus, and Marchal, 2001, p.37). According to Chu, Ford, & Trelles (2011), ongoing civil war has created an inconsistent medical response by the international healthcare providers, with a limited data collection. Women in East Africa suffering from lack of access to routine healthcare services, as well as prenatal healthcare, often endure poor health outcomes. A major concern has been the physical and mental well-being of women and their children; however, no research findings currently have been published regarding EASSW’s perceptions of seeking prenatal healthcare services. Most healthcare providers aim to provide holistic healthcare. However, this goal requires knowledge of the client’s previous and present experiences in accessing quality prenatal healthcare services. This inquiry focused on disparities in accessing quality prenatal healthcare services for EASSWs of childbearing age in a community of East African persons living in a Southern California city.

The National Healthcare Disparities Report (NHDR) presents an annual examination of disparities in health within local communities. NHDR argues that eliminating disparities in healthcare is a logical method for reducing related disparities in health status, which is achieved through focused community-based projects. This argument is supported by data demonstrating

that populations that are receiving services are able to successfully address these health disparities (NHDR, 2003).

Most public health services focus on promoting equal access for individuals in the United States by assisting healthcare providers to respond effectively to their clients. Obtaining early prenatal healthcare services for every woman before, during, and after pregnancy can prevent physical and mental health disorders for women and their children. Currently, a barrier to EASSWs ages 15 to 44 accessing early medical attention, including prenatal care, remains unstudied.

Background and Significance

EASSWs of childbearing age have cultural beliefs that the causes and cures of illness or disability are determined by Allah (God), therefore, considering such matters to be out of their control, and cannot be predicted (Greeson, Veach, & LeRoy, 2001). On the other hand, all of the healthcare assessments and interventions used to treat the East African populations in the U.S. are based on Western perceptions that medicine has the power to prevent, control, and cure diseases and/or disabilities. Unfortunately, the healthcare systems in many underdeveloped countries are broken or nonexistent. Therefore, access to health care, specifically early prenatal healthcare, has been severely curtailed in East Africa.

In 1991 and 1992, the crisis in Somalia caused an estimated 1.5 million Somali speaking people to live outside of their native lands, with at least 2.0 million persons internally displaced who were exposed to extreme conditions such as, hunger, homelessness, and abuse (Bradbury, Menkhaus, and Marchal 2001). In the U.S., the East African populations' data is reported as a black non-Hispanic category; therefore, there are no separate statistics for this group (The County of San Diego, 2010). However, according to Bradbury, Menkhaus, and Marchal (2001)

EASSWs of childbearing age have one of the world's highest infant mortality rates. Mortality rates for children under five are staggering: 224 per 1,000 live births. Infant mortality rates are 132 per 1,000 live births. Maternal mortality rates are 1,600 per 100,000 live births because of poor antenatal, delivery, and postnatal care. Very limited studies have been done on EASSWs of childbearing ages particularly targeting prenatal healthcare and their experiences and perceptions. In this author's anecdotal experience, Somali speaking populations often seek access to healthcare services only as a last resort after seeing all the traditional healers.

The recent immigrant and refugee women from East Africa have multiple challenges in accessing quality prenatal healthcare services. For many immigrants and refugees, cultural beliefs, religious practices, limited education, and lack of knowledge about the U.S. healthcare system has limited their perceived access to early prenatal care. These issues are contributing factors to many Somalis not seeking healthcare. Healthcare providers must consider the patients' backgrounds, perceptions, cultural practices, and belief systems (Pachter & Harwood, 1996).

Not seeking healthcare because of systematic barriers is a prevalent public health issue that can prevent a healthy woman from becoming a healthy mother, who, in turn, produces healthy babies. Therefore, the goals of most public health services in the U.S. are to promote equal access for individuals, and to prepare healthcare providers to respond effectively to their clients. In this author's anecdotal experience, many EASSWs ages 15 to 44 are not seeking early medical attention, including prenatal care, resulting in enhanced morbidity and costs to the health care system.

Data from this study documents that access to early prenatal care, adequate insurance coverage, a primary care provider, and resources such as transportation and language familiarity are important issues in this population. Using a qualitative inquiry approach by interviewing

EASSWs was chosen to identify more clearly the barriers to obtaining prenatal healthcare services in this population.

Statement of Purpose

The overall goal of this study was to describe the experiences of East African Somali speaking women of childbearing age in accessing prenatal healthcare services. To do so, this study explored EASSWs' experiences with and timing of prenatal healthcare services, views of healthcare providers and problems encountered with services, and reasons for not seeking early prenatal health care services.

Specific Aims

The specific aims of this study were to: Describe EASSWs' experiences of seeking prenatal healthcare services, including the time in the pregnancy when prenatal care was sought; 2) Describe EASSWs' view of prenatal healthcare services as provided by U.S. healthcare providers; and 3) Describe problems encountered when accessing prenatal healthcare services in the U.S, including (if applicable) reasons for not seeking early prenatal healthcare services.

Research Question

This qualitative, descriptive study used a phenomenological method to collect data and analyze research participants' responses to their experiences of access to prenatal care. This approach was chosen to answer the research question: What is the meaning, structure, and essence of the lived experiences for East African refugee women of childbearing age in accessing quality prenatal healthcare services? The researcher used the semi-structured approach for interviewing participants because this approach is congruent with qualitative research methods that enable the researcher to obtain valuable, in-depth information (Holloway & Wheeler 2010).

CHAPTER II

Review of the Literature

This review of extant literature provides a background for the conduct of this study, and addresses the political and cultural context of East African Somali speaking populations, access to prenatal care, health disparities in prenatal care for EASSWs, summary of gaps in the literature, and the rationale for the study.

Political and Cultural Context of East African Somali Speaking Populations

The East African Somali speaking population's territory is divided into five areas or regions: Somali Italy (Southern Somalia), Somali British (Northern Somalia), Somali French (Djibouti), Somali Ethiopian (Ogaden), and Somali Kenyan (Bradbury, Menkhaus, and Marchal, 2001). The different East African Somali speaking populations share a common ethnicity, religion, language, and culture, but clans are what separate these populations (Menkhaus, 2003).

Somali speaking populations reside in East Africa (Horn of Africa) according to their tribes. Several of the regions are dominated by one tribe, but some of the tribes overlap in certain regions, which makes these populations difficult to separate from one another. For example, Somali British (Northern Somalia), also known as Somaliland, was one of the victims of the Somalia central government president's regime. Somaliland experienced extreme damage by weapons. In 1988, the Somaliland region decided that they would function as an independent country, created a flag, and elected a president. The Somaliland region is seeking recognition from the world to be an independent country (Menkhaus, 2003). There are two major tribes; one supports the separation, one does not. Since the group opposed to the separation resides in both regions (Northern Somalia and Southern Somalia), the separation would weaken their tribes' power so that half would go to the North and the other half would go to the South. The tribe

opposed to separation, supports the federal government and Somaliland to remain an independent region rather than an independent country. These issues were the basis of Somalia civil wars (Menkhaus, 2003).

After the Somalia civil wars, most of the East African Somali speaking populations (EASSPs) started migrating from their native lands. This increase in migration occurred due to the collapse of the Somalia central government in 1991 (Menkhaus, 2007), which resulted from the political structures of post-colonization, the Cold War, ongoing civil wars, and abuses against human rights. The onset of war prevented women from seeking healthcare, while simultaneously destroying the country's infrastructure (Menkhaus, 2003).

In 1991 the Northern (Somaliland) and Northeast (Puntland) Somali populations encountered mistreatment, violence, and torture from the central Somalia government before it collapsed (Menkhaus, 2003). These issues escalated several civil wars that displaced approximately 375, 000 Northern Somali families who were exposed to extreme conditions such as hunger, homelessness, and abuse. According to Bradbury, Menkhaus, and Marchal (2001), the overall level of healthcare in the central and southern regions of Somalia (Somali Italy) was unacceptably poor.

The impact of the civil wars as well as the population's cultural background, beliefs, and norms contributed to their poor health outcomes. It is important for healthcare providers to be aware of these issues and adapt their approach accordingly. One of their beliefs about the causes and cures of physical disorders is that the illnesses are controlled by the religious Allah (God), and therefore, considered to be out of human control, and this cannot be predicted (Greeson, Veach, & LeRoy, 2001). In addition, 60% of the Somali populations are nomadic or semi nomadic.

It is noted that EASSPs often do not seek medical care or prenatal healthcare services until they experience severe pain. Most of the EASSWs of childbearing age and their children have been exposed to many traumas because of wars. According to clinical observations of Somali patients at the Community-University Health Care Clinic (CUHCC), 32.5% of Somali women had a psychotic disorder; many demonstrated mental illness symptoms associated with depression and PTSD (Kroll, Yusuf, & Fujiwara, 2010).

In 2006, the U.S. Department of the State reported that 10,357 Somali refugees arrived in the U.S., many of them settling in Southern California, due to the similarity in climate to East Africa (HOEFER, 2008). However, Somali refugees in the U.S. continue to experience wide disparities in health status from the mainstream U.S. population, due to underlying differences such as social context and cultural differences. These recent refugees and immigrants from East Africa have unequal health treatment due to factors such as language barriers and unfamiliarity with the U.S. healthcare system.

The following figure illustrates that the total number of Somali refugees arriving in the U.S. from 1983-2009 was 87, 910 persons. This number only consists of Somali refugees (persons from refugee camps, brought to the U.S. with governmental intervention), and does not include Somali asylum seekers (those who seek resettlement inside the U.S. without governmental intervention).

Source: U.S. Department of Health and Human Services-the Office of Refugees Resettlement (USDHHS-ORR, 2008).

Somali populations have had a rapid growth rate due to cultural beliefs against contraception. Moreover, U.S born East African children are not included in the illustrated graph as their data falls under the category of black, non-Hispanic or African-American in U.S. census data. Furthermore, Somali Ethiopian refugees are not included in Figure 1, as they enter the U.S. as Ethiopian (USDHHS-ORR, 2008). Therefore, the estimation of 87,910 persons shown in the graph is likely to be an extremely low reflection of the true number of East African refugees who are currently living in the U.S.

Access to Prenatal Healthcare

According to the Center for Disease Control and Prevention (CDC), a healthy woman becomes a healthy mother who produces healthy babies. The Healthy People 2000's objective was that 60% of primary healthcare physicians should offer age appropriate pre-conception care (i.e., *early prenatal healthcare*). The CDC recommended that pre-conception healthcare should

be a part of the primary healthcare and prevention services rather than just an isolated visit.

The CDC's healthcare recommendations for the U.S. population aim to achieve four goals:

1. Improve awareness, knowledge, attitude, and behavior of men and women regarding preconception healthcare.
2. Make it possible for women of childbearing age in the U.S. to obtain pre-conception healthcare services (i.e., evidence-based risk screening, health promotion, and interventions).
3. Decrease risk indicated by previous adverse pregnancy outcomes to reduce health problems for women and their future children.
4. Minimize the health disparities in poor pregnancy outcomes.

The CDC seeks to improve consumer knowledge, clinical practices, public health programs, healthcare financing, data, as well as conduct research activities. CDC recommendations have been implemented by a series of specific action steps leading to expected outcomes within two to five years. The CDC believes the outcomes of these recommendations will increase access to early prenatal healthcare, continuing of care, risk screening, age appropriate delivery of interventions, and change in attitude and health behaviors of men and women of childbearing age. In the first eight weeks of gestational age, an infants' central nervous system (CNS) is completed, yet most women are not aware that they are pregnant. Taking care of a woman's health prior to conception is within the purview of primary care providers, who are key to screening or introducing healthy lifestyles including eating well, physical activities, managing stress, and avoiding substance abuse for women of childbearing age.

Health Disparities in Prenatal Care for EASSWs

According to Aday (2001), “*health disparity*” refers to inequalities in health outcomes among countries, societies, communities, or individuals in obtaining optimal healthcare. Issues contributing to health disparities are lifestyles, socio-economic levels, and access ability to healthcare. Therefore, nationally, and locally, Health and Human Services Agencies (HHS) are working to reduce health disparities through improvement in access to prenatal healthcare. According to the NHDR (2003), access to healthcare is related to a person’s, race, ethnicity, income, education, and place of residence, as well as cultural backgrounds, language barriers, and religious beliefs. In addition, even though diversity is valued as a shared ethic in U.S. society, it also is a major component contributing to health disparities.

There are multiple stressors for EASSWs in the prenatal period. These women may have a lack of understanding of unfamiliar aspects of their new country, bad memories from their native country, lack of relatives or friends, and pregnancy itself as major psychological stressors. The frustration of trying to understand the resettlement process, culture shock, and social isolation also contribute to women’s daily life stress (Silveira & Allebeck, 2001).

Many EASSWs do not seek prenatal health services, as they believe the pregnancy process is a normal physiological change, and there is no need to seek prenatal healthcare. Consequently, not seeking prenatal healthcare contributes to health disparities in this population. The majority of EASSWs have no routine health screenings, because of their beliefs about the causes of physical and mental disability is controlled by the religious Allah (God), and therefore, considered to be out of human control, and this cannot be predicted (Greeson, Veatch, & LeRoy, 2001).

Summary of Gaps in the Literature

There is limited research on Somali-speaking women's health in the U.S., particularly regarding their experiences of seeking prenatal healthcare. Therefore, their understanding of the need to seek prenatal care and routine checkups is of particular concern. Most Somali women do not receive checkups due to habit, lack of resources, unfamiliarity with the healthcare system's processes, and lack of trust in healthcare. While access to prenatal care has been documented as a necessity in optimizing healthy birth outcomes, EASSWs are among the most vulnerable of African immigrant populations and encounter numerous barriers to accessing adequate care. Although barriers to prenatal care such as lack of knowledge and other instrumental barriers have been identified, few data exist regarding the actual experience of EASSWs seeking prenatal care.

Rationale for the Study

This study was conducted as an initial step in establishing a knowledge base of what EASSWs actually experience in accessing prenatal care, with the ultimate goal of planning interventions designed to decrease health disparities in this population. According to Holloway & Wheeler (2010), a descriptive qualitative method refers to human existence, which focuses on meaning, purpose, and direction of life. This type of research inquiry focuses on understanding individuals' experiences to identify feelings and concerns. Such an approach was appropriate in the initial exploration of phenomena such as the experiences of EASSWs seeking prenatal care.

Halabi (2005) recommended a qualitative approach as an initial method of studying refugee populations that are illiterate and have no formal education. In addition, Halabi added that interviews and observations allow those populations to describe their healthcare concerns and create trust that facilitates future researchers to provide intervention and education. Thus, a descriptive, phenomenological approach was an appropriate method to use in examining a

relatively unstudied phenomenon in this particular population. The following chapter contains an explication of descriptive phenomenology and a description of its specific use in this study, as well as a summary of the methods employed in the study.

CHAPTER III

Method

This study utilized a qualitative, descriptive, phenomenological method of inquiry. The purpose of this phenomenological approach was to explore the experiences and feelings of EASSWs of childbearing age in relation to their access to prenatal healthcare services. This method of inquiry was implemented through systematic collection and analysis of participants' experiences of their ability to obtain prenatal healthcare by examining their verbal responses to specific interview questions.

Overall Goal and Specific Aims

This study sought to accomplish the following overall goal of describing the experiences of East African Somali speaking women of childbearing age in accessing prenatal healthcare services. The following specific aims were achieved using a descriptive, phenomenological method of inquiry: 1) To describe EASSWs' experiences of seeking prenatal healthcare services; 2) To describe EASSWs' view of prenatal healthcare services as provided by U.S. healthcare providers; and 3) To describe problems encountered when accessing prenatal healthcare services in the U.S., including, if applicable, reasons for not seeking early prenatal healthcare services.

Research Design

This study was designed to understand the life of participants in relation to their access to prenatal healthcare services. This research design was based on a qualitative, descriptive, phenomenological inquiry to understand human needs from a philosophical approach (Holloway & Wheeler 2010). This descriptive phenomenology approach was selected because it collects personal experiences without making prior assumptions about this lesser-known topic. This philosophical method explored EASSWs of childbearing age in terms of their experiences and

feelings by conducting interviews and using collected, translated, and analyzed data. Data analysis involved extracting major, recurring themes. This design clarifies specific statements and themes that produce a creative synthesis from the interviews (Holloway & Wheeler, 2010).

Descriptive Phenomenology

The choice of descriptive phenomenology as a study method was based on the relative lack of information regarding the phenomenon of interest, i.e., the experiences of EASSWs in seeking prenatal care in the U.S. The use of such an approach is appropriate when little to no information exists regarding a specific phenomenon. This descriptive approach used Edmund Husserl's philosophical elements: intentionality, essences (cognition), and bracketing (phenomenological reaction). According to Husserl (1859-1938), intentionality is the fundamental characteristic of the subject's consciousness toward an object. Cognition is the ability to understand a phenomenon, and bracketing is the logical act of solving problems without judgments and assumptions (Holloway & Wheeler, 2010).

This qualitative study used a phenomenological approach to collect data from East African women of childbearing age residing in an immigrant community in a city in Southern California. As a descriptive phenomenological study, this research project did not attempt to generalize; its purpose was to gain an in-depth perspective describing East African experiences of accessing prenatal healthcare services.

Setting

Participant interviews were conducted in a Somali immigrant community in a Southern California city. The interview setting was in locations within the neighborhood in which privacy could be maintained in a comfortable, and accessible room to the interviewee (e.g, participant's home, or quit area in community building).

Sample

Inclusion criteria for the study were: 1) female; 2) age 18-45; 3) East African ethnicity; 4) born in East Africa; 5) immigrated to the U.S.; and 6) received prenatal care and/or gave birth in the U.S. The exclusion criteria included persons who did not meet one or more of these criteria. The initial participants helped to recruit other interviewees via a snowball effect; after each interview, the researcher asked the interviewees if she knew a woman of childbearing age who might like to participate. Fifteen (15) EASSWs of childbearing age were recruited and interviewed.

Demographic Data and Interview Guide

The researcher collected the following demographic data: age, birth location, years in the U.S., educational level, income source, number of children, number of children born in Somalia, the U.S., or other location. This investigator developed a qualitative interview guide containing four interview questions.

Data Collection Procedure

The interview began with the following introductory question:

- 1) What has been your experience about getting prenatal healthcare services if they are available to you?

This general, introductory question was followed by four prompt questions to expand participants' statements. These questions were:

- a) How do you view prenatal healthcare services as provided by healthcare providers in the US?
- b) Describe any problems that you have found within your experience with the prenatal healthcare system in the U.S. At what point in your pregnancy did you seek prenatal care? (If applicable)

- c) Describe your reasons for not seeking care early in pregnancy.
- d) Are there any other comments you would make about the prenatal healthcare care system in the U.S.A?

The researcher used the semi-structured type of approach for interviewing participants, as tightly structured interviews contradict qualitative research methods and make it more difficult to obtain complete information (Holloway & Wheeler 2010). Semi-structured approaches encompass non-judgmental, open-ended questions followed by prompting questions (Table 2: Interview Guide) for elaboration. The researcher then repeated the answer for more clarity, meaning, or reasoning. Each interview took approximately 60 to 90 minutes. No digital recording was done, due to cultural constraints. The researcher took paper and pencil notes during and after the interview. This process of data collection and analyzing took three months (see timeline). This interview was conducted in English or Somali, which ever was preferred by the interviewees. Participants were not interrupted until they were done. The investigator maintained active listening. After answering each question, a prompt question was used to elaborate on their answer. The researcher then repeated and summarized the answer to reflect the answer for more clarification.

The process of performing the study took seven months. The first month, the researcher considered Somali speaking populations as an oral society; word of mouth from family and friends helped to recruit participants. This study used snowball sampling to identify participants who are invisible in the community and were potential participants for this qualitative study. As the limitations suggest, for most of the refugee and immigrant populations, the study was not a priority. Recruiting them required extra time and effort. The second month consisted of arranging appointments and selecting participants. The third month focused on conducting

interviews and the data entering process. The fourth month consisted of performing the processes of translating, transcribing, and organizing. The fifth month focused on organizing data into categories and subcategories, which were linked into themes and patterns that generate narrative reports. The sixth month focused on developing a draft report that would be sent to the chair and the committee for consultation and review. The seventh month consisted of finalizing draft reports.

Human Subjects

This study received approval from the Institutional Review Board (IRB) of the University of San Diego. No written consent was obtained, due to cultural constraints regarding signing one's name. Instead, the researcher obtained verbal informed consent and she explained the risks, benefits, and confidentiality to the individuals who were voluntary participants. In addition, the participants were aware that they could withdraw at anytime. Participants were informed that there were no direct immediate benefits for interviewees, but there would be indirect benefits from the study in the future (e.g. educating healthcare providers about EASSWs). Participant confidentiality was protected by not using an actual name; each participant was assigned a pseudonym for the purposes of data analysis. The researcher kept study materials stored in a locked location in her home. These data will be stored for a minimum of five years.

Data Management and Analysis

Data from this study provide an enhanced understanding of the EASSWs experiences and perceptions regarding prenatal health services, accessing equal health services, and identification of barriers to care. According to Holloway & Wheeler (2007), data gathering in the qualitative descriptive phenomenological method proceeds from the specific to the general, i.e., using a deductive to inductive approach. In this study, information describing individuals' experiences

within a context specific to EASSWs in exploring their reasons for not seeking early and continuing prenatal health services led to the identification of general themes. A specific to general approach enhances data collection and analysis in gaining an understanding of underlying phenomena.

The phenomenological approach used in the study explored participants' lived experiences without prior assumptions regarding why EASSWs do not seek and continue prenatal health services. According to Creswell (2009), this descriptive phenomenological data analysis proceeds through the methodology of reduction, to describe the specific statements and themes to contribute a creative synthesis of the real problem. Moreover, this data analysis searches for all possible meaningful statements to understand the phenomenon of not seeking medical attention, particularly prenatal healthcare services, and discovering important patterns, themes, and interrelationship without prior judgments and assumptions.

The investigator performed data collection, entry, and translation. According to Creswell (2009), a systematic process for coding data from a phenomenological inquiry leads to the identification of themes from evidence and organizing data into categories to obtain consistent patterns. If the interview had been conducted in Somali, the researcher, who is fluent in both languages, translated the data to English. The researcher transcribed both source interviews and the researcher's notes. The researcher then organized the information by using the qualitative software analysis program *ATLAS.ti*. This software helped categorize and subcategorize to identify theme patterns. Following the identification of thematic patterns, the researcher compiled a merged narrative report.

Strengths and Limitations of the Study

This method's rationale was to discover similarities and differences statements, themes, and patterns to describe the target populations in terms of life experiences and feelings toward phenomena. That the researcher was an East African-American Somali speaking person increased level of the trust, comforted interviewees, and encouraged them to express more. There was no prior published studies that could be located concerning the experiences and perceptions of prenatal healthcare services in this target population. Therefore, a key strength of this study is its initial documentation of a phenomenon that is relatively unexplored. A limitation of the study is that it represents the experiences of a self-selected group of East African women in one particular geographic location of the U.S. However, the goal of phenomenological inquiry is not to generalize, but to enter the world of the speaker, and expand the horizons of understanding the listener.

CHAPTER IV

Findings of the Inquiry

The purpose of this descriptive qualitative phenomenological approach was to explore the East African Somali Speaking women (EASSWs) of childbearing age's experiences and feelings regarding access to quality prenatal healthcare services. The researcher interviewed 15 women from East African who speak Somali and reside in Southern California regarding seeking prenatal healthcare services. Demographic data for participants are contained in Appendix A. According to the participants' narrative, each interviewee provided statements to explain what it is like for refugee and immigrant populations to access quality prenatal healthcare services in the U.S. healthcare system.

The findings of this study identify the many challenges EASSWs face as a result of the complexity the U.S. healthcare system. These challenges are complex and varied. Ultimately, four major themes emerged regarding these challenges: 1) cultural barriers; 2) belief systems; 3) systematic obstacles; and 4) lack of knowledge. Each of these themes and their sub-themes contributed to these participants' perceptions of access to quality prenatal healthcare and are described in this chapter.

The following table summarizes the four major themes of cultural barriers, belief systems, systematic obstacles, and lack of knowledge, with brief descriptions of sub-themes and their components. Subsequently, each of the four major themes is explored in depth with accompanying quotes illustrating each theme.

Table 1: Four Major Themes and Sub-themes

Cultural Barriers	Belief Systems	Systemic Obstacles	Lack of Knowledge
Language Barriers <ul style="list-style-type: none"> ➤ Poor Communication ➤ Lack of or Poor Interpreters ➤ Family Members as Interpreters 	Favorable Experiences <ul style="list-style-type: none"> ➤ Public Health Nurses as Helpful ➤ Healthcare Standards 	Insurance <ul style="list-style-type: none"> ➤ Employer's Health Insurance ➤ Medi-Cal Coverage ➤ Medi-Cal Plans 	EASSWs Education Regarding US Healthcare <ul style="list-style-type: none"> ➤ Complexity of US Healthcare System ➤ Unfamiliarity with System Process and Procedures
Cultural Sensitivity <ul style="list-style-type: none"> ➤ Stereotypes about EASSWs ➤ Inappropriate Messages for Minor Interpreters ➤ Offensive Moments 	Unfavorable Experiences <ul style="list-style-type: none"> ➤ This System Functions as a Business for Profit ➤ Past Negative Experiences ➤ Older, Experienced Women vs. Doctors ➤ Healthcare Providers Perform More C-sections 	Lack of Care Continuity <ul style="list-style-type: none"> ➤ Lack of Comprehensive Healthcare ➤ Having to Wait Too Long for First Prenatal Appointment 	Healthcare Providers' Skills <ul style="list-style-type: none"> ➤ Relationship Between Patients and Doctors ➤ Lack of Cultural Competence
Religion/Personal Preferences <ul style="list-style-type: none"> ➤ Desire for a Female Doctor, Especially for Delivery ➤ Personal Privacy 	Religious Restrictions <ul style="list-style-type: none"> ➤ Meds/Vaccines containing Pork Products ➤ Lack of Access to Kosher/Halal Food ➤ Personal Beliefs 	Doctor's Visit <ul style="list-style-type: none"> ➤ Waiting and allocating Time ➤ A Lot of Paper Work ➤ Transportation Issues 	Interpreters' Training <ul style="list-style-type: none"> ➤ Cultural Brokers and System Navigators

Four Major Themes and Sub-themes

In the report of the interviews that follows, the researcher used pseudonyms as a substitute for participants' actual names to maintain confidentiality and to keep the reader's sense of humanity, rather than using labeled numbers and letters. Western names have been used as pseudonyms instead of East African names. The East African community is an oral society; using common East Africans' names as pseudonyms might have resulted in mistaken identities and potential breaches of confidentiality. For the purpose of this study, the researcher has assigned the participants with the following Western names: Anne, Beda, Cathy, Dana, Ella, Florence, Glenda, Honey, Ivy, Janelle, Kelly, Lana, Melinda, Nancy, and Oriel (Appendix A.) Included statements were extracted from the participants' interviews.

Cultural Barriers

Cultural barrier was one the four major themes reported as contributing to unequal access to prenatal healthcare services. This major theme is composed of the three sub-themes of language barriers, cultural sensitivity, and religion/personal preferences.

Language Barriers

Language barriers, referring to a lack of ability to communicate with health care providers, were identified as a major sub-theme. The components of language barriers as a sub-theme were poor communication, lack of interpreters, and the use of family members as interpreters. All fifteen participants shared that some from of language barrier prevented EASSWs from accessing quality prenatal healthcare. Three women mentioned twice in their interviews that language barriers limited their access to quality prenatal healthcare services. Six interviewees expressed that three times the language barrier was a factor that contributed to their inequality of accessing quality prenatal healthcare services. Some participants expressed many concerns that

included language barriers, cultural differences, and Medi-Cal insurance limitations as the contributing factors to disparities in their prenatal healthcare services. Nancy was unable to read and understand that the document needed to be signed.

Nancy stated:

I feel that I have a language barrier problem, and I think there is a cultural difference. The Medi-Cal insurance is bad because I cannot receive all of the care that I need, and I do not like the interpreters because they share all my information with others or they do not have one. I feel bad when I sign something that I do not understand, and I just have to trust them [healthcare providers] when they tell me to sign; even though, I do not understand any of it.

Janelle reported that she was interpreting for a patient who needed a Caesarian section because of her high blood pressure, and language barriers created a significant problem in this crisis.

Poor Communication. The fear of not having an interpreter at the healthcare facility was the main concern that was expressed by participant Anne. She felt “no hope” because of a lack of interpreter services would have an influence on her ability to access quality prenatal healthcare services. The following participants, Anne, Cathy, Dana, and Ella, felt that their inability to speak the English language was the main contributor to their poor diagnoses and treatment process in the healthcare system. Ella described some of the doctors speaking in loud voices as though she was hard of hearing. She said: “The other thing that I experienced at the doctor’s office is that they speak in a loud voice. I am not hard of hearing; my problem is I am not able to speak English well”.

Dana acknowledged her communication with healthcare providers is limited to hand gestures, therefore, her failure to speak English contributed to not understanding treatments including how to take medicine and their side effects. Dana stated: “I did not understand the U.S. healthcare system, because I do not know English and the healthcare providers do not speak Somali”. Glenda articulated that she was not able to understand any part of the U.S. healthcare system because of her limited English and she said: “I cannot understand any system because of language and culture barriers”. Honey shared her feelings on language barriers and she mentioned this issue twice in this study. Honey said: “Some doctors do not welcome Somalis at their clinic because of language barriers”. Janelle said, “Women who do not speak English have difficulty-accessing healthcare”.

Melinda and Anne articulated how they tried to search for healthcare providers who speak their language. These two women felt their culture and language were the barriers to access quality of prenatal healthcare services. However, when they obtained healthcare services from doctors who knew their language and their culture, they still did not feel satisfied with the services. Melinda explained: “I used some doctors who were speaking a language that I could understand rather than English, and most of my bad experiences were from them”. However, Anne tried to solve her problem by finding a doctor who was familiar with her culture. Anne stated: “I found one doctor who speaks my language and one doctor who knows my culture”.

Lack of or Poor Interpreters. Florence, Dana, and Ella expressed their feelings about their current healthcare providers and prenatal services. These three women encountered a lack of or poor quality interpreters. They shared that they were waiting a longer time than necessary to see a healthcare provider because of unavailability of an interpreter during a doctor’s visit. Florence explained: “If I go on time, I will have to wait there for hours. If there is no interpreter, it causes

me stress because of the difficulty of the U.S. system. Other times I do not arrive at my appointment because I have no interpreter”.

In addition, these participants expressed that they did not trust any paid interpreters, and they believed that some interpreters shared their information with others. Dana articulated her feelings on how lack of communication inhibited her access to quality prenatal healthcare services. Dana shared: “Somalis have a lot of problems not only with prenatal healthcare services, but overall with the healthcare system that exists in the U.S. There are misunderstandings and a lack of communication. I cannot communicate with the Western healthcare provider”.

Ella acknowledged that it is a necessity to have professional interpreters in the waiting room. Honey realized poor communication with healthcare providers, even though they were good doctors, impacted medical decisions. She stated that miscommunication between her mother and her healthcare providers occurred while she was giving birth to her first baby. Honey was the interpreter between her mother and the healthcare providers and she shared that there was a lot of tension between her mother and some doctors. She stated: “My doctor was good, but my mother was with me. I was the interpreter between my mother and the doctor because my mother was making decisions”. Melinda and Oriel shared their stories about lived experiences with interpreters. They expressed their feelings as follows:

Melinda: I had a bad experience with interpreters. One time the interpreter was telling me my son had to get an operation on his nose, and the doctor told the interpreter this operation had a success rate of 95 percent of time and the other five percent could be a failure. Instead, the interpreter said 95 percent failure and 5 percent successful. I told him, I understood English and you got it wrong, it was the other way around. The

interpreter started arguing with me, I told him “Let’s not argue. Why don’t we ask again?” When he asked the doctor to repeat what he had said earlier, I did not know if the interpreter truly did not know English or that he was careless. After that, I never took another interpreter. (Melinda).

Oriel recalled that quality of interpreters is poor and she said:

When I came from Somalia, I was in a clinic and I did not tell the doctor that I was capable of speaking English and they brought an interpreter. The doctor spoke to the interpreter as if they were skilled in the knowledge of medical terms. The interpreter did not know anything, and the interpreter did not mention it because it was shameful to do so in our culture. The doctor glanced at the scan and said, “The scan shows your placenta is low and you may bleed- the baby will be in danger. Therefore, if you have any bleeding be sure to go to the emergency room”. The interpreter told me, “Your son has a disease, and if he bleeds, be sure to go to the emergency room.” At this point, I started to speak English.

Family Members as Interpreters. Some of the participants shared that they used their family members including children. Nancy explained:

My mother used to take me to a Mother and Child Health (MCH) clinic for prenatal care. Very poor conditions, but the good part is the providers were Somalis. I used to express my feelings, which I miss now, because there are no quality interpreters.

Ella expressed that using family members- especially children- cannot solve language barriers because of the family member’s limited Somali language skills. She said: “My husband was not available when she needed him because he was at work. In addition, she expressed the belief that paid interpreters do not keep confidentiality”. Florence, Ivy, Lana, Ella, and Glenda

solved their problem of “language barriers” by using family members, including their children. They acknowledged not speaking English and/or not having interpreters, which made it very difficult to obtain quality prenatal healthcare services. Florence said my challenges: “I do not arrive at my appointment on time because I have no interpreter”. Ivy said:

“Misunderstanding and communication barriers prevented me from accessing quality prenatal healthcare services. Some interpreters share information about the patient’s issues with other people”. Lana highlighted unequal access to prenatal healthcare services and she said: “Having no interpreters is another barrier”. Ella explained:

When we [Somali patients] ask for an interpreter, they make us wait longer than other clients do. They [staff] say, “Wait till this room is empty because it has interpreter equipment”. “What I wish is that the equipment could be available in every room”.

Glenda shared: “What I would like is shorter waiting times and a set of ready interpreters. Most importantly, they have to know we are humans and we have feelings also”. Janelle has a high school diploma from the U.S. She speaks English fluently and has served as an interpreter in a healthcare system. She acknowledged some EASSWs do not speak English; therefore, they had difficulties to access quality prenatal healthcare services. Janelle stated: “I guess the newcomers and people who do not understand English encounter more problems than any other person”.

Anne, Melinda, Ella, Glenda, and Kelly used their family members, including children, as interpreters during doctor’s visit. Anne stated: “My husband interpreted. I only took my husband”. Melinda said: “The doctors’ appointments take too long to schedule”. Ella shared: “When I need to see a doctor I usually take my older children with me because I know these healthcare facilities do not provide interpreters. My son interprets for me and my other children”.

Kelly stated: “My husband interpreted for me and my mother took care of my kids. My husband served as an interpreter and gave me support”. Glenda said:

They cannot depend on their children and she shared: “Our children may know English well, but they do not know Somali and they would not explain everything in Somali.

Some interpreters do not know English as well as interpreters should”.

Cultural Sensitivity

Cultural sensitivity, referring to a perceived lack of understanding of the participant’s culture by health care providers, was identified as the second major sub-theme of the theme of Cultural Barriers. The components of cultural sensitivity as a sub-theme were: stereotypes about EASSWs, inappropriate messages for minor interpreters, and offensive moments.

Stereotypes About EASSWs. Beda graduated from a U.S. University. She shared that some healthcare providers assume that almost every East African woman does not speak good English. Therefore, healthcare providers were not approaching her to speak with them until she mentioned her ability to communicate in English. She was not satisfied with the healthcare providers’ stereotypes. However, Beda liked the diagnoses and standard of treatments that she was receiving while she was giving birth to her babies. Beda expressed:

I hate it when a doctor assumes that all Somalis are limited in speaking the English language and they [healthcare providers] do not talk to me until I approach them and ask them some questions. I feel bad for Somalis who do not speak English and how they are treated. Personally, I have no problem, and I like them [U.S. healthcare providers] because they diagnose me before treatment, not like the country that I used to live in.

Inappropriate Messages for Minor Interpreters. Ella shared that her son encountered an inappropriate message from her doctor.

Ella explained:

I became very upset because I had to take my 13-year-old son to the doctor just to obtain an ultrasound result. As a result, the doctor asked my son “ Ask your mother whether when she is having intercourse, is there any bleeding?” My son couldn’t ask me that question, so then the doctor used her hands gesturing intercourse action and if there is any bleeding during intercourse please come to emergency room as soon as possible. I was furious and embarrassed and thinking that this doctor cannot see this child in front of her. It was very humiliating moment for both of us.

Offensive Moments. Janelle remembered that she was interpreting for a patient who refused to have a Caesarian section. An administrator stated that the patient was “a killer” and her religion “supported killing babies.” Janelle expressed that non-English speaking population could understand some words or phrases even though they do not speak English. Therefore, healthcare providers must be sensitive regarding inadvertently offending their patients. Janelle shared: “She [an administrator] called the woman [a patient] a killer and that her religion supported killing babies. Later on, the administrator said that the woman made it clear that it was not her religion, that it was her own choice”.

Melinda’s doctor accused her of wanting to have more children in order to receive more benefits from the government. She stated: “I had a very traumatic experience with the prenatal health care providers. I had six children and the healthcare provider said, “Would you like to have more babies to receive more benefits from the government?”

Religion and Personal Preferences

Religion and personal preferences were identified as the third major sub-theme of cultural barriers. The components of religion/personal preferences as a sub-theme were a desire for a female doctor, especially for delivery, and personal privacy.

Desire for a Female Doctor, Especially for Delivery. Seven participants expressed their desired to have a female doctor, especially for delivery. These women strongly believed that a female doctor should have conducted the delivery process and a male should not perform any procedure having to do with the reproductive system. Some participants were shocked to see a male doctor who was on shift for delivery. Dana said: “My worry is if there is not a female doctor available when I am delivering”. In addition, other participants stated that the preponderance of male doctors in the U.S. made it difficult to access prenatal healthcare”. Nancy explained: “There was a Somali gynecologist. He used to perform prenatal checkups. It is shameful for a woman to have a man deliver her baby. I wonder how American women accept male doctors to deliver their babies”. Beda explained her experiences:

My main issue is gender. In my culture, a female is responsible for women issues. In the U.S., a male doctor may deliver babies. When I was in labor with my second baby, my doctor’s shift ended, the next shift was a male doctor. I was shocked and asked for a female doctor. I had no choice. I was open seven centimeters. I refused to see a doctor, and refused the plan that was to rupture the membrane to deliver soon. Instead, I waited with labor pain until my doctor became on shift the next day.

Kelly stated: “My access to prenatal healthcare was good, I used to go to my appointments on time, and I was very lucky to be paired with a female doctor who delivered my baby. When I was delivering, my doctor came with me to the hospital and she delivered me”.

Melinda explained: “They both spoke a foreign language rather than English, but they were the worst doctors by far. I used to tolerate her bad treatment because I didn’t want to be paired with a male doctor”. Ivy stated that she believed: “A male [doctor] knows more than a woman doctor, because whenever they [doctors] send me to a specialist it’s a male [doctor]. I still don’t want a man [a doctor], even if I get a woman [doctor] who does not know anything”.

Personal Privacy. A participant shared that when she was giving birth to her baby in the delivery room, many random people entered who observed her delivery process. Ella explained:

What really gets me mad is when I am having a baby and random people, males and females, just walk into my room. When I’m pushing the baby out, there is no privacy; the staff, such as a student doctor, nurses or volunteers- even random people who have no purpose being there- come in. The hospital should have informed me before I was in labor, if the doctors want to invite a new doctor into the delivery room.

Janelle suggested:

When they want to use a student doctors they should hire people who can help us and who can work as navigators, like cultural brokers. In addition, the material should be understandable and provide tapes for the Somali people who cannot read so that they can listen.

Belief Systems

Belief systems were one the four major themes of the study reported as contributing to unequal access to prenatal healthcare services. This theme of belief systems composed of the

three sub-themes of “favorable experiences”, “unfavorable experiences”, and “religious restrictions”.

Favorable experiences

Participants reported that favorable experiences consisted of perceptions of public health nurses as helpful and healthcare standards. Participants stated that public health nurses and U.S. healthcare standards were experienced as favorable components of obtaining access to quality prenatal healthcare services

Public Health Nurses as Helpful. Janelle shared that public health nurses (PHN) are very helpful. She expressed that a PHN made her first pregnancy easy by educating her and the PHN gave her material that could help navigate the prenatal healthcare services. Janelle explained: “My first baby, the doctor sent a public health nurse to do a home visit. She helped me a lot, and gave me a book about the pregnancy process, which helped me throughout my three pregnancies. I never had any prenatal healthcare services elsewhere.

Healthcare Standards. Janelle stated: “Some doctors are a great support and advocate for their patients”. Beda stated: “I trust the U.S healthcare system more and their standards because they have a highly trained staff and the best medical equipment”. Lana mentioned that she has a very good experience with her healthcare providers when she was giving birth to her second baby. According to Oriel, experiences with the U.S. healthcare providers are 100% better here than anywhere else because of advanced equipment. Beda said: “I was very happy to have access to the prenatal health care for my first baby; my doctor was with me until I had my baby”. Janelle articulated: “My other two children I delivered in the hospital and I have a good relationship with my doctor and from time-to-time we talk. For my other two children, I used a different hospital and I did not face any problems”

Unfavorable experiences

This sub-theme contained the components of the U.S. healthcare system functioning as a business for profit; past negative experiences; older, experienced women vs. doctors; and healthcare providers performing more Caesarian sections than are necessary.

The U.S. Healthcare System Functions as a Business for Profit. Four EASSWs identified that the U.S. healthcare system functions as a business for profit and therefore healthcare providers do not consider human needs. They felt that the U.S. healthcare providers do not want to see patients who have no insurance and the physicians earn money by doing some procedures (e.g. Caesarian-section).

Cathy explained:

The U.S healthcare system functions as a business for profit, not considering human needs. The physician's focus is to make a lot of money from patients. As soon as you enter their door, the first questions are, "Why are you here?" and "How will you pay for the services?" If you cannot afford the cost of the treatment, no physician will listen to your problem, and after the doctor makes sure that you are on his patient list, then he/she focuses on the next patient for a few minutes and then he/she moves on to his/her next patient.

Honey said, "My mom said " No, you earned a lot of money from her C-section." Oriel shared: "Human needs should be priority number one and prenatal healthcare services in the U.S. are money oriented with no mercy for their patients, they are [doctors] here for C-sections to earn money". Dana stated: "The U.S. healthcare doctors earn a lot of money from C-sections".

Past Experiences. Four of the participants shared that they never visited a doctor in East Africa unless they could not tolerate the pain. Ivy shared: “I used to not see a doctor if I was not sick, now I have no choice. I have to take a lot of medicine from each healthcare provider”. Florence shared: “As a Somali, I never visit a doctor unless I am sick and I cannot tolerate the pain. I had four children back home and never received prenatal care”. Dana stated: “The only time I visited a doctor was when I am pregnant and when I am sick, and when I could not tolerate the pain. I do not go to doctors unless I feel intolerable pain”. Lana shared: “I did not go to monthly checkups. If I am not sick, I do not have a doctor; that is my culture. I was okay, so, I used to go sometimes only to get medicine from my prenatal doctor”.

Older, Experienced Women vs. Doctors. Florence and Honey shared that an older, experienced woman is better than a doctor as a care provider during the prenatal period. They stated that there was no stress with an older, experienced woman and they were able to deliver normally. Florence expressed: “An older woman (e.g. grandma) used to deliver a healthy baby with no worries and hassles. She was able to deliver me normally”. Honey stated:

In my culture, an experienced woman knows everything. My mother told me that she had ten children and had never been in any doctor’s offices and never delivered at the hospital, only at home. An experienced woman in East Africa is better.

Healthcare Providers Perform More Caesarian-sections. Nine participants believed that some healthcare providers pushed to perform a Caesarian (C-section) to earn more money. Multiple participants shared this belief at least twice during their interviews, and Janelle shared this three times during her interview. These women strongly believed that some doctors perform more C-sections for a profit.

Florence described her feelings:

I had a C-section at a U.S. healthcare facility, because they get more money for doing C-sections. My doctor said, “ This is a big baby because you are a diabetic mother. After the C-section, I was upset, worried, and angry”.

Melinda stated: “I have had four C-sections, which I believe could have been avoided, but they wanted more money”. Kelly shared: “I like to go to the hospital when I am about to deliver, [because] they [doctors] are known to avoid C-sections [then]. If I go late, there is less chance to have a C-section”. Florence felt from her experiences that healthcare providers were pushing to perform C-section for every delivery. Therefore, Florence had four C-sections and she shared:

As soon as you enter the doctors’ office, the doctor advises the patient to have C-section so they would earn more money. In Somali culture, C-section is not viewed as something that is beneficial; instead, it is seen as hurting the patient. In my country, they used to do C-section only to save the mother from dying, but not the baby.

Honey stated she believed that the U.S. healthcare system preferred a C-section rather than normal delivery. Honey’s account involved her mother’s emotional responses to her C-section. She explained:

The doctors who do not know how to deliver; instead, they operate on you and force you to have a C-section. With my first baby I did not listen to my mom, so I had a C-section. My mom was so mad because of the C-section and even the doctor noticed and said, “Your mom looks very angry at me,” but the doctor said, “I was trying to help you and the baby.”

Janelle shared her experiences as an interpreter:

A doctor suggested a C-section to [the patient] because she was having very high blood pressure. He was not ready to lose his job and the hospital administration and staff were very aggressive toward the choice they wanted. The mother was angry, and said; “You just want the baby to stay in the hospital longer, so that you can get more money”.

Moments later, the mother signed all the paperwork and stayed in the hospital without being operated upon. Two weeks later, she had the C-section. I also remember a time when I was also interpreting for another woman, and the doctors said the baby’s heart was not good and that they would have to do C-section. They gave the woman a choice, either be operated on or leave the hospital. She refused the offer of receiving a C-section, and came back after two days and had a natural birth. The baby and the mother were both healthy.

Melinda shared that she had four C-sections and the doctor told her:

She [doctor] ask me to sign here [document] for C-section to earn money. The U.S. healthcare doctors earn a lot of money from C-sections. I hope they [healthcare providers] stop pushing patients for C-section. There should be a mutual understanding between the patient and doctors.

Janelle stated: “I think, that n her experience as an interpreter: The hospital administrator also threatened to close her Medi-Cal Insurance if she refused C-section”.

Religious Restrictions

Religious Restrictions, the third sub-theme of favorable and unfavorable experiences, contained the components of medications and vaccines containing pork products; lack of access to kosher or halal food; and personal beliefs.

Medicines/Vaccines Containing Pork Products. Kelly shared:

Some prenatal vitamins contain pork products, but the one I used to take did not contain any, and the problem is this plan would not cover non-pork product prenatal vitamins. I attend prenatal visits regularly, prenatal vitamins make the fetus grow and I was not able to deliver normal and I ended up having a C-section, which American doctors love to do to gain more money.

Dana expressed:

Last year, I was pregnant and my doctor recommended me to have a flu vaccine against swine flu. My friend told me flu vaccines contained pork product, so I did not receive the shot. I would like to have the vaccine, but my religion does not allow pork products, so that caused me a lot of stress and I was afraid of having the swine flu and leaving my children alone.

Lack of Access to Kosher or Halal Food. In general, EASSWs do not like to eat pork products, regardless of their religion. However, those who are Muslim are forbidden to eat pork. Lana shared: “There should be interpreters, the food should be kosher or halal, and the hospitals should give the menu in different languages like Somali, and if we can’t read there should be someone who can explain it to us”.

Personal Beliefs. Four participants shared that their personal beliefs might have contributed to their inequality in receiving prenatal healthcare services. Anne shared:

I believe, those doctors prescribed medicine whenever I visited their clinic. I believe any illness or disease has to have certain treatments that can wipe it out for good, but in the U.S. there is no time to cure the illness, instead they can control it temporarily (e.g. diabetes), a person may take treatment for the rest of his/ her life.

Florence stated: "As a Somali, I never visit a doctor unless I am sick and I cannot tolerate the pain. I had four children back home and never received prenatal care. Anne stated:

My doctor told me if there is any abnormality, the baby should be aborted. My response was even if the baby is abnormal, I will not kill him. Therefore, taking tests is pointless. If the baby is completely retarded, no problem, I will raise him and accept whatever Allah [God] gives me, so leave me alone.

Nancy stated:

I always thought illnesses and cures were controlled by the hand of Allah [God], but there are also evil eyes. People just seeing the baby and saying "Wow, that's a big baby" could compromise the newborn's health. When I delivered, a nurse entered my room and the nurse said, "Wow, he looks older and so cute and will grow to be tall." Now he is seven years old, he cannot talk, he has autism, but I believe the nurse gave him evil eye [jinx].

Anne said:

I did not like that amniotic fluid aspiration because even if there is abnormality, I am not going to accept any abortion. This test is meaningless. Babies are a gift from Allah and in any condition; we have to accept them and not to kill them.

Glenda shared:

I believe Allah controls diseases and cures as well, but at the hospital, blood is drawn and you drink sweet water. The last time the worker said, "We will see if you have diabetes." I told the technician, "I have no diabetes, but I am afraid the sweet water that I am drinking may cause diabetes".

Oriel stated:

I believe, pregnancy is not a disease, it is natural, and there is no need to see a doctor.

Here, you think the appointments are important. I always came on time to all appointments to avoid an unplanned emergency delivery.

Glenda shared: “I cannot understand this culture. In Somali culture, you have to hide if you are pregnant, and that it is a shame. Even if I were married, I would not share with others”.

Systematic Obstacles

Participants identified systemic obstacles, the third major study theme, as a major contributor to unequal access to prenatal healthcare services. This major theme is compounded of the three sub-themes of health insurance, a lack of care continuity, and challenges surrounding a visit to a doctor.

Health Insurance

Most EASSWs in Southern California have Medi-Cal as health insurance coverage, which is the state Medicaid program for Californians. Medicaid is paid through the federal and state government to assist low-income families. Many physicians do not accept Medi-Cal, and many medications are not covered by it. In addition, approval for eligibility can be a lengthy process. Therefore, in California, most EASSWs may have Medi-Cal but are prevented from accessing certain healthcare options. In addition, lack of interpreters, transportation, and childcare options are barriers in accessing prenatal healthcare in this population.

Health insurance concerns for these participants were centered on employer’s health insurance, Medi-Cal coverage, and the nature of Medi-Cal plans. Each of these components was identified as promoting barriers to obtaining prenatal coverage.

Employer’s Health Insurance. Honey shared her employer limited her work hours purposefully, in order to limit her benefits, including health insurance.

Honey explained:

I used to work and the employer used to limit the employees work time to only 3.5 hour per shift because if they reach 4.0 hours they are entitled to have benefits from the employer. If they work more than 3.5 hours, the employer considers that overtime.

Medi-Cal Coverage. All of the participants had Medi-Cal, which is governmentally administered insurance. Most acknowledged that they were rejected at least once to see a doctor. All qualified for Medi-Cal coverage because of their income and they have children under 21 years old. However, their ability to get comprehensive medical care was limited due to Medi-Cal's limited coverage. Eleven (11) EASSWs shared their experience and how it limited their access to prenatal healthcare services.

Honey explained: "The only problem that I encountered is that not many doctors accept Medi-Cal, and those who accept Medi-Cal give poor treatment". Ivy said: "Many specialists do not accept Medi-Cal, and some medicine is not covered by Medi-Cal. So, I have no choice, I have to pay from my pocket". Lana said: "I believe, my first baby that I delivered here, during an ultrasound the technician did it twice and Medi-Cal only covered once a year. They [Doctors' office] charged me a lot of money and I could not pay, so they sent to me a collection company". Nancy said: "I think, we [EASSWs] are faced here in the U.S. with Medi-Cal with limited coverage". Nancy said: "Doctors do not use it [Medi-Cal] on us because of language barriers". Oriel said: "I speak English, yet I do not have access to quality prenatal healthcare". Beda shared this story:

My second baby, my husband lost his job and health insurance. I liked my previous doctor, so as soon as I realized that I was pregnant again, I visited her. My doctor told me this time you have Medi-Cal and we do not accept it. At that point, I have to search for a

doctor who accepts Medi-Cal, which I found that pushed me to receive prenatal services in the late first trimester of my pregnancy. I was surprised with Medi-Cal. I received low quality [generic] prenatal vitamins, I was not able to deliver in my previous hospital, I had to deliver in a low level hospital, and whoever [doctor] was in the shift would deliver me.

Beda stated: “Healthcare providers do not welcome us, and many doctors do not accept Medi-Cal”. Dana shared: “A lot of healthcare providers do not accept any Medi-Cal”. Glenda stated: “Some clinicians do not give us quality medicine; they give us generic medicine because Medi-Cal would not cover it. Sometimes specialists would not accept patients with Medi-Cal”. Honey stated: “The other thing, the Med-Cal coverage is a hassle and you have to fill out many papers every three months, and it is not translated into Somali”. Cathy said: “I have Med-Cal insurance, and the coverage is limited”. Kelly expressed her belief that: “I think, Med-Cal insurance must be changed so that it can cover the cost of treatment and that most doctors accept it”. Finally, Nancy summarized these participants’ frustrations with insurance and their care. Nancy stated: “We [Somalis] need better insurance, quality interpreters, and more information about our condition”. Two participants shared that some healthcare providers do not accept some Medi-Cal plans. Kelly explained:

The U.S. prenatal healthcare was very good until the Medi-Cal administration assigned me a new plan. This new plan is not helpful because many specialists do not accept it and it does not cover all my prenatal vitamins. I used to have Medi-Cal insurance, which let me see any doctor, but now the Medi-Cal insurance has new policies where you have to be enrolled in a plan. To choose a plan they send you a packet full of papers written in English, and I do not fill it out or return it, because I do not understand English.

Eventually, they [Medi-Cal plan] add me to a plan by default that many doctors do not accept. So my doctor is now helping to find a plan tailored to my needs.

Ivy said:

I have been forced to attend all my prenatal care to be safe for my baby and me. There is no one Med-Cal plan that the people are enrolled in. Different groups are worse than others, and some doctors do not accept some plans. My primary healthcare doctor told me to change my plan because some primary doctors do not want to deal with certain healthcare plans. I cannot do needed tests because of my plan.

Lack of Care Continuity

A lack of continuity of care providers and settings emerged as the second sub-theme under the theme of systemic obstacles. The components of this sub-theme were the lack of comprehensive healthcare and having to wait too long for the first prenatal appointment.

Lack of Comprehensive Healthcare. Participants expressed their experiences of receiving poorly coordinated care. For example, some specialists did not accept Medi-Cal insurance or communicate with each other. Ivy explained: “I have high blood pressure, high cholesterol, and a thyroid problem. I had seven surgeries, including a C-section. I always receive medicine for each visit and I go to different healthcare providers, there is no continuity of care”. Cathy shared:

I feel there is no care continuity when I go to prenatal services. They never ask me about medicine that I took for depression. On the other hand, when I go to a mental illness doctor, they never ask about my pregnancy and what medicine I am on. They have high quality equipment, but the healthcare providers are not honest.

Having to Wait Too Long for the First Prenatal Appointment. A participant shared that she waited at least a month to see a doctor from the time she called her primary doctor. She said

that she called at 45 days into pregnancy, and had to wait an additional month to see a doctor.

These systemic delays contribute to late initiation of prenatal care, because the patient might be at the end of the first trimester before being seen. Janelle shared: “Unfortunately, I had to wait a month to see a doctor. I called my primary doctor to see an Obstetric Gynecologist (OB/GYN) doctor, and the receptionist gives me an appointment after a month”.

Challenges Surrounding a Visit to a Doctor

Challenges surrounding a visit to a doctor emerged as the third sub-theme under the major theme of systemic obstacles. The components of this sub-theme were waiting times/allocating time for the appointment, the large amount of paperwork, and transportation issues.

Waiting and Allocating Time. Some participants described long wait times both in the waiting room and after they entered a doctor’s examination room. The EASSWs described their healthcare providers as spending little time with them. Often, they were required to wait long periods until an interpreter was available for them. Therefore, some participants stated their waiting period was longer than that of other patients not requiring an interpreter. Cathy expressed:

I really hate visiting the healthcare providers on time, and then I end up at the waiting room for about two hours or more doing nothing. After a long time waiting, comes my turn, and I walked in enthusiastically when some nurse calls me in to the patient examining room. Then again, I wait about 30-45 minutes sitting on an uncomfortable examining bed. The only human noise in the clinic is a baby’s cry next door. Then the doctor came in and stayed for less than five minutes.

Oriel shared: If I am late 30 minutes, the doctors will not see me, but if I came on time the doctor will see me at least an hour later. The healthcare providers are flexible for their needs, not

their clients' needs. Beda said: "I hate sitting in the waiting room, two to three hours doing nothing". Ella said: "I hate to wait a long time to see a doctor for 7 minutes or less. One day, I got upset, so I left before seeing the doctor". Cathy requested: "Shorter waiting times, because when it's very long it makes me angry, nervous and makes me forget why I was going to the doctor".

A Lot of Paper Work. Five participants stated that they were given a lot of paper work to sign, but they were not able to read what they were signing. Glenda explained:

I believe, the doctors, nurses, or any healthcare provider always give me many papers to sign, but I do not know what they say, even if it is about something important like a liability issue. Honey stated: "Some doctors do not welcome Somalis at their clinic because of language barriers with a lot of paper work to take prenatal vitamins for every pregnancy". Nancy shared: "A lot of paperwork, to fill out".

Transportation Issues. Transportation issues were identified as a systemic obstacle. Florence explained: "Some hospitals are far from here and I do not like to drive on the freeway. I have no transportation and if I will not go to my appointment, they will have to charge me".

Lack of Knowledge

Participants identified lack of knowledge, the fourth major study theme, as a contributor to unequal access to prenatal healthcare services. This major theme is composed of the three sub-themes; EASSWs' education regarding the healthcare system, healthcare providers' skills, and interpreter training.

EASSWs' Education Regarding the Healthcare System

EASSWs' education regarding the U.S. healthcare system emerged as the first sub-theme under the major theme of lack of knowledge. The composed of this sub-theme were the complexity of the U.S. healthcare system and unfamiliarity with its process and procedures.

Complexity of the U.S. Healthcare System. Three participants shared that they felt the U.S. healthcare system is 100% better than the healthcare in Somalia. They would like to understand the U.S. healthcare system better, but their limited English makes it difficult, and they need more time to gain an understanding than those who speak English. Glenda explained:

We [Somalis] used to have a country; most of us fled our native land because of the Civil War. Not only the healthcare system, overall, U.S culture is new to me and I cannot understand any system because of language and culture barriers.

Oriel explained: I speak English, yet I do not have access to quality prenatal healthcare. The U.S. healthcare system is very complicated and American culture needs time to understand.

Nancy shared:

The American health care system is very complicated and we [Somalis] did not have a healthcare system back home, but compared to Somalia, I would rather use the healthcare system in America because it is a hundred percent better than Somalia.

Unfamiliarity with the Process and Procedures of the U.S. Healthcare System. Dana observed that the U.S. healthcare system is different from state to state, with some states providing more support to EASSWs than others. Dana described it like this:

The U.S. healthcare system differs from state to state, I used to live in another state and the healthcare facilities used to provide an interpreter via video chat, and I used to feel that the interpreters used to facilitate the dialogue between the doctors and me.

Unfortunately, this service is not available in this state. In addition, the healthcare facilities used to send reminders to me before my appointments. So far in this state, I have not received any reminders.

Healthcare Providers' Skills

U.S. healthcare providers' skills- both in professional skills and in cultural competence- emerged as the second sub-theme under the major theme of lack of knowledge. The components of this sub-theme are the relationship between patients and doctors and a lack of cultural competence.

Relationship between Healthcare Providers and Patients. Three participants expressed that the lack of relationship between healthcare providers and patients resulted in poor quality care. One of the participants said doctors did not read or follow her case, and did not know that she had a miscarriage or had a stillbirth. Others shared that their limited ability to speak English and establish a relationship with a care provider often contributed to poor- and sometimes horrific- treatment. Lana said: "During my first delivery in the U.S., the doctor did not know how to aim the epidural needle, so he poked me in many places. However, my second baby's doctor was good". Melinda explained:

I lost my fetus and had a miscarriage because I was Rh negative; none of them [the doctors] read my file to know. Before my last pregnancy, I was in another state, a newly graduated doctor discovered it by just reading my file. He gave me an injection while I was pregnant with my last baby. There is no point in drawing blood if the doctors are not reading the results and taking actions that are necessary indicated; like for the Rh negative.

Lana shared:

My third baby was born in America. I used to go to my appointments regularly, but the time I was delivering, the doctor was not good. The technician who was giving epidural did not know what he was doing, so he poked me a couple of times. The hospital, I was in for my third child was also not good.

Janelle said:

When I was having my first baby, I was in [name of hospital] hospital there they ruptured my membrane and then they induced me. I was in labor for 14 hours and they did not give me painkillers. Lastly, a student delivered me and they did not tell me ahead of time. They pulled the baby using forceps and my doctor apologized to me. She felt bad and mad.

Three participants expressed a failure of healthcare providers to give adequate explanations regarding procedures or pregnancy outcomes. Anne said: "I imagined that needle going into my baby's eye, or heart, or any other organ" Nancy stated: "When seeing the doctors, they gave vitamins and ask you questions that have nothing to do with pregnancy, like the health of the parents". Anne stated:

I believe the older you are the wiser the baby you will get. When the doctors tested the blood of my baby, they said the baby was retarded and then few years later my baby was actually smart. The second baby they said same thing, but she is also healthy and is a smart baby. They put this diagnosis on record in the computer, but I do not really care what they put in their computer.

Lack of Cultural Competence. Participants expressed that they felt neither welcome nor understood by health care providers.

Oriel shared:

I think doctors' faces are not welcoming; when they see us, they start to frown. One time a nurse told me, "Do you think you would deliver in a hospital like this in Africa?"

Before I answered, she said, "I hate [this city] it's overcrowded." I was disappointed. I asked if my cousin could sleep with me, because I was worried she [the nurse] would hurt my baby and me.

Cathy expressed:

I believe, our [EASSWs] needs should be the number one priority. There should be interpreters that know enough English and Somali who keep confidentiality. Somali people need to learn more about depression and other diseases that are unfamiliar to them so that they [healthcare providers] will not label the mental illness clients as crazy. In the Somali language, this is stated in the following phrase, "*naag waalan*" (*Crazy Woman*).

Participants shared that some healthcare providers had pre-existing inaccurate assumptions about Somali people. Anne explained: "The doctors should not underestimate a Somali person's capability to understand, because some of us do. In addition, some Somali women are even doctors, engineers, teachers etc".

Beda summarized the need for healthcare providers to possess both good communication skills and cultural competence. She said: "I think, doctors should build a good relationship with their patients regardless of their background to earn trust and confidence. That helps gather information about the patient to administer accurate and proper treatment".

Interpreters' Training

The training of interpreters emerged as the third sub-theme under the major theme of lack of knowledge. The composed of this sub-theme were the need for interpreters to be prepared as cultural brokers and navigators of the system for patients.

Cultural Brokers-Navigators. Participants shared that there is a great need for interpreters to be trained and able to do more than just be called in crises to attempt to provide exact renditions of biotechnical English.

Dana explained:

We [EASSWs] need people [cultural brokers] who would be a bridge between the U.S. healthcare system and Somalis. I still have not gotten the hang of the American culture. There should be a learning program to teach us the culture, because we are Americans now, we need to adapt to this culture.

Glenda explained: "Some of the doctors use medical terminology that makes everything complicated including understanding the patient's problem, diagnosing the disease, and making the best decision to treat the patient".

When participants were asked, "At what point in your pregnancy did you seek prenatal care?" many gave unconfirmed treatment initiation periods. However, seven participants stated that they received treatment in their first trimester; three stated that treatment was received in their second trimester; four stated that treatment was received in their second or third trimester, three to four months; and the one participant stated that she saw her first doctor five months into her pregnancy (See Appendix C). Some of the participants revealed that they had become aware of what they needed to do to get proper prenatal healthcare in a timely manner, but others revealed that their only experience regarding childbirth included them being an interpreter for

another women in delivery. The erratic healthcare provider scheduling of prenatal appointment was an expressed concern of the research participants. A missed prenatal appointment subsequently would cause delay in future prenatal appointments, usually longer than a month in rescheduling.

Cultural barriers, unfavorable experiences (with some favorable ones,) systemic obstacles, and lack of knowledge form the basis of the overall description of these participants' experiences of the U.S. healthcare system during the prenatal period. The following chapter discusses the implications of these findings for future research, practice, and policy formation.

CHAPTER V

Analysis of the Inquiry

The 2000 Census showed that communities of color represent 53 percent of the state's population, and almost 40 percent of Californians speak a language other than English at home. The author's office notes that it is crucial to the health of California's diverse communities that culturally and linguistically appropriate health care services be readily available. The author's office also notes that a survey of providers found that over 70 percent of providers reported that language barriers compromise patient's understanding of treatment advice and make it harder for patients to explain their symptoms (P.SB 853 Senate Bill).

This chapter discusses and analyzes the findings of this study and proposes pathways for future research. Phenomenological inquiry was used in this study to explore lived experiences; and enhance understanding of what it is like for refugee and immigrant populations to access healthcare services. The participants shared with the researcher that their main issue were cultural barriers, especially language interpretation challenges.

According to the California:

Senate Bill (P. SB 853), 70% of healthcare providers surveyed stated that language presents a barrier for patients to express symptoms that are health related and further inhibits them from understanding treatment regimens. Almost all study participants expressed narratives regarding cultural barriers, belief systems, systematic obstacles, and lack of knowledge that promoted unequal access to quality prenatal healthcare services. According to the selected participants, language barriers had even resulted in inaccurate diagnoses that led to negative outcomes for them and their children.

One of the goals of the Center for Disease Control (CDC) is to decrease risks that are indicative of an adverse pregnancy outcome; thus decreasing healthcare problems for women and their future children. The goal aims for every woman to be healthy before her conception and subsequently deliver a healthy baby. As an example of the implementation of this goal, one of the CDC recommendations is that every woman should take folic acid *before* pregnancy to reduce the risks of birth defects. In this study, it became clear that EASSWs had access to prenatal healthcare services only late in the first trimester. Some participants stated that they missed their period, and made an appointment to see a doctor that often occurred a month later, which means that they actually did not see a doctor for two and half months. Thus, this group did not have access to pre-conception or even first trimester prenatal care, thus being denied adequate nutritional supplementation to prevent neural tube defects occurring in the critical first two months of gestation. This one example alone demonstrates the radical need for enhancement of prenatal care in this population.

The results of this study indicate that the provision of early prenatal care for this population is a complex, multiple-layered phenomenon. The four major themes that emerged include cultural barriers, belief systems, systematic obstacles, and lack of knowledge on the part of both patients and providers. Upon further examination of these themes, three major categories of factors (internal, external and systematic) were identified as contributing to a lack of access of prenatal care in this population.

1. The internal contributing factors include the participants' background, culture, and traditional norms.
2. The external contributing factors include; a lack of knowledge about health in general and the U.S. healthcare system by EASSWS, a lack of resources to get to prenatal visits,

such as; transportation and childcare services, a lack of health care providers' relational skills/cultural competence, and a lack of cultural brokers or navigators to guide these women through the system. (i.e. service/ provider plans, poor care continuity, paperwork, and long waiting periods)

3. The systematic contributing factors include limitations built into both private healthcare insurance and government-administered healthcare.

The experience of these factors fell into two discursive groups: 1) women who had given birth in East Africa *and* the U.S. following immigration (Group I; N=3); and 2) women who had *only* given birth in the U.S. (Group II; N=12).

Two Discursive Groups

Group I

Members of this group who had given birth both in East Africa and the U.S. expressed more difficulty in accessing prenatal care. These participants experienced communication barriers, lacked trust in information from the Western healthcare system, and maintained traditional perceptions towards the Western healthcare system. Participants were non-receptive to non-traditional births. Most participants in this group had been exposed to civil wars, showed symptoms of Post-Traumatic Stress Disorder (PTSD,) and experienced Post-Partum Depression. In addition, most members of this group were unable to read or write.

Group II

Members of this group who had given birth only in the U.S. expressed less difficulty in accessing prenatal care. Most members of this group were educated and more receptive to the Western healthcare system. They also were capable of communicating with healthcare providers, but these participants continued to feel cultural biases from providers as a

contributing factor. Both of the discursive groups preferred the same gender healthcare providers and practiced pork-restricted diets.

The demographics showed that ten (10) participants did not have a formal education, a barrier that prevented them from understanding the basic need of signing a legal medical document. Cultural traditions often interfered with the younger Somali mothers, in the study, expressed as an emotional distress factors associated with war trauma, and their struggles to adjust to the challenges of immigrating to the U.S.

In addition, the interviewees shared that they were suffering from failure to obtain quality healthcare services. The significant themes that emerged from the data consist of cultural beliefs that are incompatible with the U.S. healthcare system; and unfamiliarity with the U.S. healthcare services, language barriers, the lack of time with providers for expression of feelings/concerns, the inadequate or limited health coverage, and the logistic needs (transportation and childcare).

According to interviewees' responses, language barrier plays a major role in contributing to barriers to prenatal healthcare services. Participants shared that they suffered lack of communication and lack of /or poor interpreters. In this study, the interviewees were concerned regarding family members/children interpreters, patient confidentiality, and the lack of timely interpreter services.

Internal Contributing Factors

The internal contributing factors include the participants' background, culture, and traditional norms. These participants demonstrated a strong cultural belief system that is incongruent with the western healthcare system's treatment approaches. Participants stated that their native homeland is a gender-oriented culture where the male doctors only see male

patients, and female physicians see only female patients, particularly in dealing with women's reproductive system issues and obstetrics.

Participants stated their background prevented their access to quality healthcare services. If a woman has lived in a large city and grown up in a country whose infrastructure included a Western educational background, she most likely can interact with her physician. However, the participants in this study came from backgrounds that rendered them unable to do so. Some participants shared that they did not use a doctor of a different culture and that they only go to see a doctor when they are very sick. According to the perception of people in East African culture, only Allah (God) can prevent people from diseases, thus abrogating the value of preventative medicine.

The participants provided valuable information about their life experiences between two continents, one being developed, and the underdeveloped countries where there is not a system for healthcare services. East African women expressed their own personal feelings about their immigration from the motherland (Africa) that led them to resettle in a country in which people spoke a foreign language that they could not speak nor interpret. In addition, some participants felt that they were intimidated by to unfamiliar cultural practices and norms.

In this study population, spiritual beliefs allow them to be treated by a healthcare provider of the opposite gender only when their treatment does not involve their reproductive system. Research data indicates, however, that same-gender reproductive healthcare is not always available for this population in the U.S. However, the Somali people have strict concepts towards non-Somali healthcare providers, which stems from their traditional culture values rather than their religious values. It is the belief of the Somali culture that if you breach a spiritual belief that is religiously rooted, then the issue is between you and God (Allah). However, if you breach a

spiritual value that is culturally rooted, you are thought to be cursed for your entire life by Allah. In the Somali language, this is stated in the following phrase, “*Caado laga tago cara Allaha ayay leedahay*” (*Leaving the culture angers God*).

External Contributing Factors

Group I

The external contributing factors for this group included a lack of East African healthcare providers and a lack of culturally sensitive U.S. healthcare providers. Another external factor was a lack of qualified/adequate interpreters. Additional factors were noted for this group was their experience of inadequate healthcare, transportation restrictions, and violation of their cultural norms by using under-age children as interpreters for adult issues.

Group II

Although most members of this group were able to speak English, U.S. healthcare providers still practiced stereotyping towards them, such as giving only very limited explanations to them. Both study groups had patient privacy issues, and felt that cultural influences hindered accessing healthcare services. The external contributing factors included a lack of knowledge about the U.S. healthcare system by participants, a lack of resources to attend prenatal visits, such as; transportation and childcare services, a lack of health care providers’ relational skills/cultural competence, and a lack of trained interpreters who also could serve as cultural brokers/navigators to guide these women through the system.

Participants’ narratives disclosed that their healthcare providers did not accommodate the EASSW’s access to quality prenatal healthcare services with cultural linguists that could better facilitate a provider’s health services. Participants’ observations revealed to researcher that the lack of providers’ relational skills and cultural competence affected their relationship with these

healthcare providers. Thus, when these healthcare providers would introduce or mandate additional unexpected procedures, such as a C-section, these women then perceived this approach as a tactic to earn more money. The danger of such miscommunication is that if an EASS woman were in actual need of a C-section to save herself or her baby, the provider's approach would not have been culturally accepted. Therefore, the need for the patient and the healthcare provider to be culturally educated is an important process that needs to occur. Research data indicates the need for patient education as a primary factor that all healthcare providers need to consider, especially when it concerns the life of the mother and her child. This is an important area, in which health care providers need to be culturally sensitive.

Systematic Contributing Factors

Group I

Systematic contributing factors included participants' long waiting periods for appointments and a lack of insurance coverage. This participant group was additionally overwhelmed by providers' required paper work. Both groups lacked clear payment guidelines for healthcare services, and found that U.S. healthcare processes to be very different from the processes they had experienced in remote parts of East Africa.

Group II

Systematic contributing factors for this participant group included both limited insurance coverage and the limited number of healthcare providers who would accept their insurance coverage. Another systematic contributing factor for this participant group was feeling overwhelmed by paper work and a lack of familiarity with the billing processes generated by healthcare agencies. In addition, this group experienced limitations of certain healthcare

services imposed by insurance companies. Lastly, a systematic contributing factor included the erratic nature of healthcare providers' appointment scheduling.

Systematic contributing factors for both groups include the limitation of Medi-Cal insurance coverage; physicians' time limitations with their patients; and long waiting periods to see a doctor. Some participants expressed their unfamiliarity with the U.S. healthcare system, and expressed that they needed more time to be educated about it. Two of the study's participants stated that even though they prepared, by writing questions down for their doctor's visit, they were not allowed the time to ask their questions. It is reported that that western healthcare physicians often spend less than 15 minutes with their patients. The Somali culture would perceive this practice of healthcare services as being rude, impersonal, non-caring and wanting to get rid of the patient, in order to see another patient who may have more money to offer them. The systematic practice of the western healthcare system would function better if culturally sensitive treatment were improved. It also needs to consider interpreters' training and roles, with consideration of patient/physician relationship building to initiate trust and/or restore it.

Discussion and Recommendations

Unfortunately, it is common for EASSWs not to seek early medical attention that includes prenatal healthcare services. In addition, the English language is a challenge, which makes gathering information more difficult. In addition, the presence of an interpreter jeopardizes the one-on-one relationship between the patient and the healthcare provider. The Somali population is an oral society. When they discuss issues with an interpreter, they fear that this information will be revealed to their greater Somali society. Data from this study demonstrate that it is difficult to diagnose Somali patients, especially women of childbearing age, who were

predominantly unwilling to acknowledge and/or discuss in detail their emotional traumas or lasting impressionable experiences of having witnessed war atrocities.

Future research needs to emphasize the need for healthcare providers to be more culturally competent and supportive of EASSWs, and to be aware of the Somali immigrants who have made adaptations and can better interpret and speak the English language. There is a need for healthcare providers to be educated about the specific needs of immigrant populations, if they are to provide quality healthcare services. The major obstacle that these providers will encounter is language; another obstacle would include the peoples' cultural beliefs and practices, and their perception of western medicine.

More sensitivity is needed in accommodating EASSW's religious restrictions regarding vaccines, prenatal vitamins, and foods. The diet of the Somali population typically has some food restrictions that include no eating of pork products because of cultural, religious, and traditional beliefs. The researcher suggests that the medical institutions provide literature about alternative food selections during this populations' hospital stay.

In addition, many participants expressed a need for a female doctor, especially during delivery. While it may not always be possible to provide a female physician during the entire pregnancy course, the need for a female physician and privacy in the delivery room is a strongly expressed need by these participants.

The study provided data on the lack of EASSWs healthcare providers; therefore, the development of institutional policies that encourages the hiring, and identifying of Somali healthcare providers could better service East African patient population. Suggested strategic approaches could occur in high schools that would implement a teaching intervention that

creates more Somali health care providers through an academic medical concentration module, and a curriculum that prepares these students for a health care career.

A major finding of this study is a lack of linguistic interpreters that are bilingually competent in English and the Somali language in the medical field. Currently, there is no standard method for testing these linguists or certifying them as an interpreter for Somali-speaking populations. Such certification and institutional policies that enforce Health Insurance Portability and Accountability Act (HIPAA) privacy rules should be mandated, given the expressed concerns by these study participants that their personal information might be publicized.

From these data, it can be posited that the use of family member and friends as interpreters should be avoided whenever possible in the healthcare setting. In California, this practice is currently prohibited for a minor child to interpret for a family member or friend because of the potential for trauma that can occur when minors interpret for friends or family members.

Counties are prohibited from using minor children (under the age of 18) as interpreters, except temporarily under extenuating circumstances. Extenuating circumstances may include using a minor child to determine the appropriate language needs of the adult so that an appropriate interpreter or bilingual staff person could be called or the county may ask the client to wait while the county obtains the interpreter service. Other than in extenuating circumstances, minors may not be used as interpreters even if the applicant/beneficiary requests to do so. [Although] at the applicant's/beneficiary's request the minor may be present in addition to the county provided interpreter"(State of California –Health and Human Services Agency, 2010).

In particular, this study provided data on an entirely inappropriate incident that occurred when a Somali woman's 13 year old son was used as interpreter for his mother's physician who directed him to ask his mother personal questions about her body that were culturally and traditionally unacceptable. This study documents multiple incidences of culturally incompetent healthcare, which are strong indicators of the need for cultural competence training in health care providers. An example is the narrative in which an EASSW's physician assumed that the patient only wanted additional children because the government would pay for these births. In actuality, the Somali woman's cultural tradition of having multiple children represents a woman's worthiness of having a spouse and a long-term, intact marriage. Training for healthcare providers that inculcates a positive regard for patients and good communication skills might have prevented such an incident.

The other narrative, in which a hospital administrator labeled a hypertensive patient who refused to have a C-section "a killer", is another example of cultural incompetence (and possible malpractice). In this situation, an alternative approach could have been used, such as informing the patient that her life was in danger because of her hypertension instead of presenting her with a threat. Cross-Cultural training for Western health care providers and the Somali population should be conducted on an ongoing basis.

Limited medical insurance coverage has caused a limit on health care services, including dental services. Currently, recipients of Medi-Cal no longer can receive dental health care, which can present a major health risk for its recipients. Oral infections are noted to cause health complications in pregnant women that may cause premature delivery and labor, an additional expense procedure for these recipients of Medi-Cal coverage. In some cases a medical doctor can present a health care program that includes dental coverage in cases when the mother's

health can be life threatening. However, in most cases, these physicians do not choose this option of health care; they usually hold to the standard procedural processes.

An additional concern is that many of the treating physicians limit their time per patient because of payment restrictions. This practice causes many Somali patients to feel that they are not important to the physician; whereas, some feel that their language barrier plays a role in the mode of treatment that is provided by the treating physician. In such cases, the education of Somali persons would be helpful in overcoming this belief. Specifically, it would be valuable to educate EASSW patients that when a physician asks them, “Why are you here?” it does not mean that the physician is less concerned about their illness. Somali people may benefit from being taught the usual process of a physician’s interactions, and that the question “what brings you here today?” is a culturally normal question that the physician needs answered in order to provide his/her treatment assessment approach. Next, the physician is at liberty to begin his/her assessment and treatment; and because an established understanding of this individual must be in place prior to any examination and treatment services.

Currently in the U.S. healthcare system, a great deal of paperwork is involved in most medical treatment interactions. However, for EASSWs the task of paperwork completion is especially difficult because of two noted reasons-language barriers, and literacy challenges. This study documented that of 15 Somali women interviewed; ten women did not have any formal education. Thus, these women are illiterate in English, as well as in their native language. The use of trained interpreters as cultural brokers/navigators would be especially helpful for such persons.

Data showed that the participants who had children born both in East Africa and the United States expressed more difficulties in accessing prenatal care. Because of their past experiences

and communication barriers, they lacked trust when encountering an unknown and complex healthcare system. They maintained their traditional perceptions regarding the western healthcare system. These women had no perception of what a non-traditional, high technology delivery entailed, and they mistrusted of a strange and invasive system.

However, the participants who had delivered children only within the U.S. healthcare system appeared to be more receptive and acculturated, perhaps because of their increased familiarity with the system. Those who were English speakers expressed irritation when a physician assumed that they were incapable of speaking and/or interpreting the English language. However, this study also revealed that many of these English-speaking EASSWs continued to be influenced by their mothers' cultural traditional beliefs and instructed their daughters to have no participation in the non-traditional birth practices, such as a C-section delivery.

The training of interpreters as “brokers”- that is, persons who are able to understand the full range of the patient's choices and communicate them in a nuanced fashion to the patient- would be a much-needed improvement over the current situation in which even interpreters lack a grasp of the medical technology they are required to describe. An interpreter is able to be a cultural broker and request that the health care professional use language in a facilitative, and not an obstructive, manner would greatly enhance the healthcare of EASSWs in the prenatal period. Interpreters with such training could also serve as system navigators in what is described as an “overwhelming” healthcare system by this study's participants.

The EASSW's expectations are to use medications only for relieving pain symptoms that are caused by diseases, and then discontinue taking the pain medication as soon as possible. In this author's anecdotal experience, some EASSW's use family and friends' medications if they

have similar symptoms caused by diseases, especially if they have no access to healthcare.

The EASSW's health behaviors are a combination of medical and traditional healing practices that are learned from the elderly members of the community. Varieties of treatment such as fire burning, herbal remedies, casting out of bad conditions, and prayers are traditionally used for healing purposes of the Somali-speaking populations.

This study also demonstrated that EASSWs could, and did, demonstrate patterns of resistance when confronted with mandates that violated their cultural norms. For example, participants reported avoiding the possibility of C-sections by going to the hospital very late in the labor process, or discarding vitamins so that their baby “wouldn’t grow so big and may need a C-section.” These patterns of resistance to non-traditional deliveries are important narratives discovered in this research. Future research may focus on how these patterns of resistance to western medical practice may change or remain the same as the EASSWs population becomes acculturated across subsequent generations.

An additional area of needed research suggested by this study is the examination of EASSWs who were exposed to civil war and its accompanying violence. Such women are at high risk for developing Post-traumatic Stress Disorder (PTSD) and/or Post-Partum Depression. The identification of at risk women and the implementation of an intervention designed to promote their post-partum access to mental health professionals would be of particular value for future study.

The provision of resources, such as transportation and childcare, which would allow EASSWs seeking prenatal care to attend their clinic appointments that is an important consideration, given the statements of the study participants. The transition from a village environment that provided a helping hand at all times to an American urban setting was a

particularly challenging one for the new East African immigrant women in need of prenatal care. A lack of understanding of the public transportation system and decreased level of social support often encountered by the immigrant were particular barriers identified by these women in keeping their medical appointments.

Strengths and Limitations of the Study

According to Holloway and Wheeler (2010), interviews are the most frequently used and robust way of collecting data to understand personal views of a phenomenon. Moreover, observations without interviews lead to assumptions, and do not give in-depth perceptions of the problem. Therefore, this proposed study utilized both interview and observation methods to increase credibility of findings. This method's rationale was to discover similar and different statements, themes, and patterns to describe the target populations in terms of life experiences and feelings toward phenomena. The fact that researcher was an East African-American Somali speaking person increased level of the trust, comforted interviewees, and encouraged them to express more. No prior published studies could be located concerning the experiences and perceptions of prenatal healthcare services in this target population. Thus, a major strength of this study is its initial documentation of a phenomenon that is relatively unexplored. Data from this study can provide a basis for future research aimed at planning culturally competent interventions for this population and reducing health disparities. A limitation of the study is that it represents the experiences of a self-selected group of East African women in one particular geographic location of the U.S. However, the goal of phenomenological inquiry is not to generalize, but to enter the world of the speaker, and expand the horizons of understanding of the listener. Another limitation of the study is that the technique of acquiring subjects (snowball recruitment) resulted in a predominance of uneducated women.

Summary

In conclusion, data from this study indicate a need for research on the East African Somali Speaking populations to address healthcare disparities. Data from this study can provide a basis for future research that aimed at planning culturally competent interventions for this population and their healthcare providers to increase access to quality prenatal healthcare services. The study's significance was that no prior published studies could be located concerning the experiences and perceptions of prenatal healthcare services for the target population. The study's documentation of the critical need for healthcare providers to be more aware of their personal perceptions and assumptions towards EASSWs is particularly salient, and suggests further interventional studies designed to enhance provider cultural sensitivity. This study revealed the meaning of the lived experience of EASSWs accessing prenatal care across three major areas of contributing factors: internal, external, and systemic. It thus represents a starting point for future research designed to develop and test interventions designed to ameliorate these factors for the EASSP, with the goal of improving their access and use of prenatal care.

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Appendix A

Table 3: Demographic Data

Region	Number		Year in the U.S.	Number		Education	Number			Children	Number
Somali Italy	6		1-3	0		No Formal Education	10			1-3	1
Somali British	3		4-6	3		Some College	2			4-6	5
Somali French	1		7-10	3		H- School Diploma	1			7-10	1
Somali Ethiopian	4		11-13	5		Under Graduate	1			11-15	9
Somali Kenya	1		14-17	4		Graduate	0			USA	5
Total	15		Total	15		Total	15			East Africa	10

Age	Number			
26-29	2		Gov. Assist	Number
30-33	3		Employee	5
34-37	2		Unemployed	10
38-41	3		Total	15
42-45	5			
Total	15			

Exposed Civil War	Number
Yes	12
No	3
Total	15

Appendix B

Interview Guide

The interview began with the following introductory question:

- 1) What has been your experience about getting prenatal healthcare services if they are available to you?
- 2) This general, introductory question was followed by four prompt questions to expand participants' statements. These questions were:
 - a) How do you view prenatal healthcare services as provided by healthcare providers in the US?
 - b) Describe any problems that you have found within your experience with the prenatal healthcare system in the U.S. At what point in your pregnancy did you seek prenatal care? (If applicable)
 - c) Describe your reasons for not seeking care early in pregnancy.
 - d) Are there any other comments you would make about the prenatal healthcare care system in the U.S.A?

Appendix C

Table 2. Trimester in Pregnancy in Which Participants Had Initial Prenatal Visit

Name	First Trimester	Second Trimester	Third Trimester
Anne		✓	
Beda	✓		
Cathy	✓		
Dana		✓	
Ella		✓	
Florence	✓		
Glenda	✓		
Honey	✓	✓	
Ivy		✓	
Janelle	✓		
Kelly	✓		
Lana	✓		
Melinda	✓	✓	
Nancy	✓	✓	
Oriel	✓	✓	

Appendix D

Glossary of Terms Used in This Study

Allah: The Islamic name for God.

Black Magic: The practices and/or rituals that are considered as a tool for creating harm and/or negative outcomes for a specific person, place, or situation.

Caado Laga Tago Cara Allah Ayay Leedahay: A breach of spiritual value that is culturally rooted; “You will be cursed for the rest of your life.”

CDC Prevention: Centers for Disease Control prevention, which compiles data on diseases and health disparities in the United States.

Childbearing age: For the purposes of this study, a woman aged 18-45 years.

Civil War: Fighting within one’s co that is stimulated by religious practices/beliefs, political control, and/or tribal conflicts.

Cold War: A conflict over ideological (e.g., communism) differences carried on by methods short of sustained, overt military action.

Cultural Broker: A person that has culturally specific navigation skills.

Culture: An ingrained component of one’s personal identity that is usually taught within family and/or village settings at an early age.

Descriptive Phenomenology: A research method that helps one to understand the human needs from a philosophical approach that includes the elements of intentionality, essences, and bracketing.

Doctors Without Borders: A non-governmental organization that provides healthcare to underdeveloped countries.

East African: A Continental African region that is located in the Horn of Africa, and is located in the east end of Africa.

Experienced Elder Women: Women who serve as midwives, performing deliveries and administering other health remedies in the East African communities.

External Factors: Factors outside of a person, including environmental factors.

Halal: A method of preparing food according to Islamic laws. It includes non-pork meats that are slaughtered according to certain other religious laws, including Islamic and Jewish practices. For example, foods those are free of Pork.

Immigrant; Individuals that come from another country; legally or illegally for reasons of safety, economics, and often settle as residents.

Internal Factors: Factors within a person, which regulate a person's life.

Jin: the Somali word for Satan or the devil

Kosher: Jewish method of preparing foods according to religious laws.

Mogadishu: The capital of the Somali Central government.

Morbidity: A medical terminology used for indicating a disability and/or an illness.

Mortality: A medical term used for indication of a death.

Naag: Somali word for female

Nomadic: Transitional movements of population groups that are frequently guided by the environmental seasonal conditions.

Prenatal Care– East African vs. Western Healthcare: In Somali culture, pregnancy is traditionally regarded as being a natural occurrence, and therefore not requiring prenatal care. In the Western model of healthcare, pregnancy is viewed as a medical condition requiring both surveillance and intervention

Qualitative: A research approach that includes a narrative description of collected data.

Refugee: One that is moved by their country's government to resettle in another country for political and/or safety issues/concerns.

Religion: A method or practice that is rooted to one's life.

Semi-Nomadic: Movements of population groups in rural areas which are slower than Nomadic movement cycles, having less influence from seasonal environments.

Somali British: One of the British colonized country lands of Somali also known as Northern Somali.

Somali Ethiopia: One of the Somali country lands that is ruled by the Ethiopian government, also known as Ogaden.

Somali French: One of the French colonized country lands of Somali also known as D Joubiti Somali.

Somali Italy: One of the Italian colonized country lands of Somali that is also known as Southern Somali.

Somali Kenya: One of the Somali country lands that is ruled by the Kenyan government.

Somali: A language that is spoken by East Africans rooted from Somali descendants.

Systemic Factors: Factors resulting from social, political, or economic contexts.

Tradition: Somali practices that have a cultural basis.

Views on Cesarean Section- Western vs. Somali: In Western medicine, a Caesarian section is viewed as ensuring the health of the mother and baby in at-risk pregnancies. In Somali culture, the use of a Cesarean section is viewed as being intentionally hurt by another and felt to be a harmful procedure.

Waaalan: The Somali word for madness, considered as being crazy.

WHO: World Health Organization, a non-governmental organization that addresses worldwide health conditions and diseases.