Sexual & Reproductive Healthcare 4 (2013) 99–106

Contents lists available at SciVerse ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.srhcjournal.org

Somali women's use of maternity health services and the outcome of their pregnancies: A descriptive study comparing Somali immigrants with native-born Swedish women

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ARTICLE INFO

Article history:
Received 26 October 2012
Revised 14 May 2013
Accepted 18 June 2013

Keywords:
Maternal morbidity
Perinatal outcome
Somali women
Health care utilisation
Case control study

ABSTRACT

Objectives: To describe how Somali immigrant women in a Swedish county use the antenatal care and health services, their reported and observed health problems and the outcome of their pregnancies.
Study design: Retrospective, case-control study, comparing data obtained from the records of antenatal and obstetric care for Somali born women with the same data for parity matched women born in Sweden giving birth between 2001 and 2009. *Main outcome measures*: Utilisation of antenatal health care (timing and number of visits), pregnancy complications (severe hyperemesis, anaemia, preeclampsia), mode of birth (normal vaginal, operative vaginal, caesarean), and infant outcomes (preterm birth, birth weight, and perinatal mortality).
Results: Compared to the 523 Swedish-born women the 262 Somali women booked later and made less visits for antenatal care. They were more likely to have anaemia, severe hyperemesis and a few patients were found to have very serious health conditions. Emergency caesarean section (OR 1.90, CI 1.16–3.10), especially before start of labour (OR 4.96, CI 1.73–14.22), high perinatal mortality with seven versus one perinatal deaths and small for date infants (OR 2.95, CI 1.49–5.82) was also more prevalent.
Conclusion: Pregnant Somali immigrant women still constitute a vulnerable group, which implicates that there is a missing link in the surveillance system that needs attention. There is an increased risk for intrauterine foetal death, small for date and low birth weight infants as well as serious maternal morbidity.

Introduction

Multi-ethnic populations are a challenge for public health care systems due to the diversity of cultural backgrounds and previous life experiences that impact health status and thus create specific health care needs. Policymakers and health care providers need to be aware of different health care needs within diverse populations, in order to design adequate and cost effective health care provisions [1]. Previous experiences of sexual and reproductive events and prior encounter with the health care system are all factors that may influence the health care seeking behaviour [2,3].

Moving to a different culture might threaten identity, because childbearing, family size and contraceptive use is influenced by deeply rooted cultural values and norms [2]. Universal access to health care within the population is of high priority in Sweden [4]. A cornerstone in public health work in Sweden is to promote universal access to safe and secure sexuality and good reproductive health and thus include also more vulnerable individuals or groups [4]. Despite this, in a recent published report on social differences in Swedish health care, it is stated that immigrated people initially refrain from health care services twice as often as Swedish born people [5]. National and international research indicate sub-optimal reproductive health care [6,7] and adverse sexual and reproductive health outcomes, such as bleeding, caesarean section and delivering babies small for gestational age and with low birth weight, among immigrant groups living in western settings [1,7–10]. Barriers to access reproductive health facilities have been reported and thus limit women's ability to exercise their rights in relation to sexual and reproductive issues [11].

The health care in Sweden provided during pregnancy and delivery is well established and is readily accessible to the popula-

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http://dx.doi.org/10.1016/j.srhc.2013.06.001

tion [12]. In the latest national guidelines for ANC in Sweden, it is emphasised that people with a different social background needs special attention and an interpreter should be used whenever needed [12]. There is however no detailed instructions about what this extra attention should contain.

One of the largest asylum-seeking groups in Sweden is of Somali origin [13].The present study was performed in a county in Sweden that caters for one of the largest Somali immigrant groups in Sweden, and the number of birth-giving Somali immigrants in the region has increased steadily over the last few years.

A Swedish national register study recently showed an excess mortality in women from low income countries, especially in relation to pregnancy complications [14]. Essen et al. (2000) showed, that especially women from sub-Saharan Africa have a higher risk of adverse outcome, including small-for-gestational age, neonatal distress and perinatal mortality [7], which is in line with the studies from other western settings (1, 8–10). However, most of the scientific studies conducted are based on data collected more than 10 years ago. From a public health perspective it is important to investigate if this pattern still exists in Swedish settings. Therefore, the present study intends to further explore possible differences between Somali immigrant and Swedish native women in relation to the use of antenatal care (ANC) and health services, reported health problems, and the outcomes of their pregnancies.

Materials and methods

Design and setting

A retrospective case control design was applied. Data obtained from the records of antenatal and obstetric care for Somali-born women and native Swedish women were collected. The present study was conducted in a Swedish county with a population of 250,000 and approximately 2800 deliveries per year. Most pregnant women in Sweden attend ANC units and are seen by a midwife on a regular basis. General practitioners are involved if a woman presents with general medical problems or an obstetrician if pregnancy or labour related problems occur. The Swedish national guidelines for ANC recommends approximately 10 visits for a normal pregnancy and that they start before 12 gestational weeks [12].

Study population

Records for 262 Somali women's deliveries were identified through a manual search of the labour ward logbooks for the years 2001 to 2009. The records of women with a possibly Arabic or Somali name were checked for information about nationality, which is indicated in the antenatal record. For each Somali woman thus identified, two control cases with the same parity (para 1, para 2–3, or para 4 and above) were chosen from the logbook. For each case and control, medical records from antenatal, obstetric, and gynaecological care were identified and reviewed. From 2001–2005 these data were available from paper records and from 2006 onwards these data were available from a computerised database. After excluding twin-pregnancies (n = 15), data from 180 Somali women and their 258 pregnancies and from 507 Swedish women and their 513 pregnancies remained for analysis. Some records were incomplete because the woman attended ANC late or not at all or was referred from another county for delivery. Some variables were not consistently noted in the records and thus these data were missing.

Definition of variables

Socio-demographic information included maternal age, parity, marital status, occupation – where no work outside home also included studies, body mass index (BMI), and smoking habits as reported by the women at the first ANC visit. BMI was categorised as underweight (below 20), normal (20–24.9), overweight (25–29.9), and obese (30 or higher).

Information in relation to health care utilisation during pregnancy included the number of visits to the ANC midwife, gestational age at the first ANC visit, admissions to the hospital in early (before 22 weeks) or late pregnancy (after 22 weeks), and booked and un-booked visits to an obstetrician. Information about visits to a general practitioner was not always available in the ANC records and could not be evaluated.

Women's health status during pregnancy included haemoglobin (HB) level at first visit and in late (after 32 weeks) pregnancy. Anaemia was defined as severe (below 90 g/L HB) or moderate (90–110 g/L HB). Weight gain was reported as 6 kg or less or more than 6 kg before 32 gestational weeks. Recorded complications during pregnancy included being admitted to a hospital due to hyperemesis, vaginal bleeding in early or late pregnancy, threatening premature labour, preeclampsia/hypertensive disorder, gestational diabetes, and urinary tract infection (UTI). Onset of labour, delivery mode, and indication for instrumental delivery was described according to the International Classification of Diseases (ICD), 10th revision [15]. Gestational age was based on ultrasound findings before 20 gestational weeks or was calculated from the date of first day of the last menstrual period, and was categorised very pre-term (less than 31 weeks and 6 days), pre-term (32 weeks to 36 weeks and 6 days), term (37 weeks to 41 weeks and 6 days), and post-term (42 weeks or more). Low birth weight was defined as a birth weight of less than 2500 grams. Small for gestational age (SGA) was defined as weight below two standard deviations of the mean birth weight for the actual birth age [16]. Pain relief during delivery was categorised into epidural anaesthesia, nitrous oxide, and non-pharmacological (acupuncture, transcutaneous electrical nerve stimulation, and sterile water injection).

Statistical analyses

All data were entered into SPSS for Windows. Swedish women were used as the reference. The non-numerical variables were grouped and coded, and descriptive statistics and cross tables were used for univariate analysis with odds ratios (OR) and 95% confidence intervals (CI).

Ethical approval

The study was approved by the Regional Ethical Review Board of Uppsala (2008/226).

Results

Maternal characteristics at the first ANC visit

More of the Somali women were less than 20 years old while fewer of the Somali women were more than 39 years old compared to the Swedish sample. Twenty-four per cent of all the women were primiparae, 37% were para 2–3, and 39% of the women had more than 3 deliveries. Among the Somali women, there were 18 (7.0%) who gave birth to their eighth child or more as compared to 9 (1.8%) of the control women. Being married or cohabiting with their partner was less common among the Somali women with more than one-fourth of the Somali women reporting that they did not live with their partner. This was even more common among the women pregnant for the first time where only 58.3% were married or cohabiting. Most Somali women were either housewives or reported that they were studying Swedish.