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RESEARCH

Administrator Perspectives of Patient-Centered and Culturally Appropriate Reproductive Health Care for Women From Somalia

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ABSTRACT

Objective: To explore health care administrators' perspectives on (a) institutional values, practices, and policies on the provision of patient- and family-centered and culturally appropriate reproductive health care for women from Somalia; (b) limitations imposed by these institutional values, practices, and policies; and (c) strategies to address these limitations.

Design: An exploratory single case study with in-person interviews and institutional document analysis guided by critical theory.

Setting: A Level 4 academic medical center on the West Coast of the United States.

Participants: Eleven health care administrators employed at the study site.

Methods: Administrators participated in semistructured interviews after reading a prototypical vignette to contextualize the clinical encounter of a Somali woman with health care providers. Data from interviews were analyzed using a deductive structural coding process. Institutional documents were analyzed to identify values, policies, and practices regarding patient- and family-centered and culturally appropriate care for women from Somalia.

Results: The overarching theme was *Our institution respects diversity and patient- and family-centered care.* The subthemes that emerged were *Current practices are important but difficult to institute*, *Current institutional policies are good but too nonspecific to follow*, and *Engagement between the provider and woman is of value but difficult to enact.* Recommendations to address these contrasts fell into two categories: pragmatic planning and changing the paradigm of care.

Conclusion: Cultural barriers, limitations caused by structural factors, and competing provider–patient paradigms contribute to challenges for many providers when caring for Somali women in some U.S. health care systems. Specific policies and training to provide culturally appropriate reproductive care for Somali women are imperative.

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Estimates suggest that between 140,000 and 150,000 Somali immigrants relocated to the United States by 2015 (Connor & Krogstad, 2015). Many Somalis who reside in the United States are women of childbearing age who seek reproductive care in what could be considered unfamiliar health care settings (Ameresekere et al., 2011). Researchers have described the experiences of Somali women who give birth in the United States (Ameresekere et al., 2011; Cook, 2008; Hill, Hunt, & Hyrkäs, 2012; Missal, Clark, & Kovaleva, 2016), but less is known about the values, policies, and practices that guide the providers who care for Somali women. Even less is known about how to provide patient-centered and culturally appropriate care within the Somali cultural framework.

Misunderstanding in the health care setting occurs when divergent expectations exist between providers and Somali women (Pavlish, Noor, & Brandt, 2010). Many providers and nurses find it difficult to navigate clinical encounters with women from outside of the United States, especially if the women decline suggested interventions (Degni, Suominen,

Respect and person-centered care are valued by this institution, but engagement with women from Somalia is perceived to be difficult.

Essén, El Ansari, & Vehviläinen-Julkunen, 2012). Because the nurse is often positioned between the maternity care provider and the woman, specific skills and knowledge are critical to successfully navigate scenarios that involve individuals from two different cultures (Heitzler, 2017). Nurse leaders in the United States have endorsed patient- and family-centered care (PFCC) and shared decision making based on a woman's values and preferences after informed consent has taken place (Association of Women's Health, Obstetric and Neonatal Nurses, 2012; Cook & Loomis, 2012). The American College of Obstetricians and Gynecologists (ACOG, 2016) indicated that the wishes of women who decline reproductive interventions should be respected. Understanding the perspectives of hospital administrators is necessary to address and reconcile the current challenge of honoring patient-centered care while navigating divergent provider–patient values and beliefs.

When a population experiences health inequities, it is necessary to mobilize policies and practices to overcome these inequities. The steps of policy development are identification of the problem, formulation of policy strategies to address the problem, and implementation and evaluation of the policy (Jansen, van Oers, Kok, & de Vries, 2010). Because of the influence of cultural factors and the prevalence of reproductive disparities in Somali women in the United States, a critical theory approach was used as a framework to guide the current study. Use of critical theory facilitates understanding of the sociocultural context to assist in the identification of social inequalities that influence health and promote health equity. Critical theory provides context and facilitates critical data analysis, identification of the problem, and action strategies (Mosqueda-Díaz, Vilchez-Barboza, Valenzuela-Suazo, & Sanhueza-Alvarado, 2014).

Literature Review

Divergent Beliefs of Health Care Providers and Somali Women

Health care providers in the United States and women from Somalia often have divergent beliefs about health, health care, and, in particular, reproductive health care (Hill et al., 2012; Pavlish et al. 2010; Wojnar, 2015). Ameresekere et al. (2011) noted that in the dominant culture in the United States, physical health tends to be privileged over social and mental health, which often directly conflicts with the beliefs of many Somali immigrants. These differences can result in misunderstandings and discrepant expectations between Somali women and providers during health care encounters. Pavlish et al. (2010) and Wojnar (2015) found that most Somali patients wanted to develop a trusting relationship with health care providers over time before they adhered to treatment regimens; providers wanted to deliver care safely and efficiently and placed less value on the long-term provider–patient relationship. Other authors suggested that Somali women lacked trust in the recommendations of health care providers because they often experienced discrimination within the health care system (Deyo, 2012; Wojnar, 2015).

Differences in perceptions of the quality of health care delivery and expectations about the provider–client relationship may have contributed to inequities in reproductive health between the Somali immigrant population and the population of White and Black women in Washington State (Johnson, Reed, Hitti, & Batra, 2005). Nulliparous Somali women were more likely to have cesarean births than Black or White women (odds ratio [OR] = 1.6, 95% confidence interval [CI] [1.1, 2.3] and OR = 2.0, 95% CI [1.4, 2.8], respectively) and were two times less likely to take their newborns home within 72 hours than Black women (OR = 1.7, 95% CI [1.2, 2.4]) and White women (OR = 2.3, 95% CI [1.6, 3.4]), even though Somali newborns did not have greater NICU admission rates (Johnson et al., 2005). Small et al. (2008) examined reproductive inequities in immigrant Somali women compared with native women in Australia, Belgium, Canada, Finland, Norway, and Sweden. Compared with native women, Somali women were less likely to give birth preterm (pooled OR = 0.72, 95% CI [0.64, 0.81]) or to have low-birth-weight infants (pooled OR = 0.89, 95% CI [0.82, 0.98]). However, Somali women had greater cesarean birth rates (pooled OR = 1.41, 95% CI [1.25, 1.59]) and more stillbirths (pooled OR = 1.86, 95% CI [1.38, 2.51]; Small et al., 2008).

Somali Women's Perspectives of Childbirth

A number of qualitative researchers have studied how women from Somalia experienced childbirth and reproductive care in the United States