SOMALILAND NURSING & MIDWIFERY ASSOCIATION

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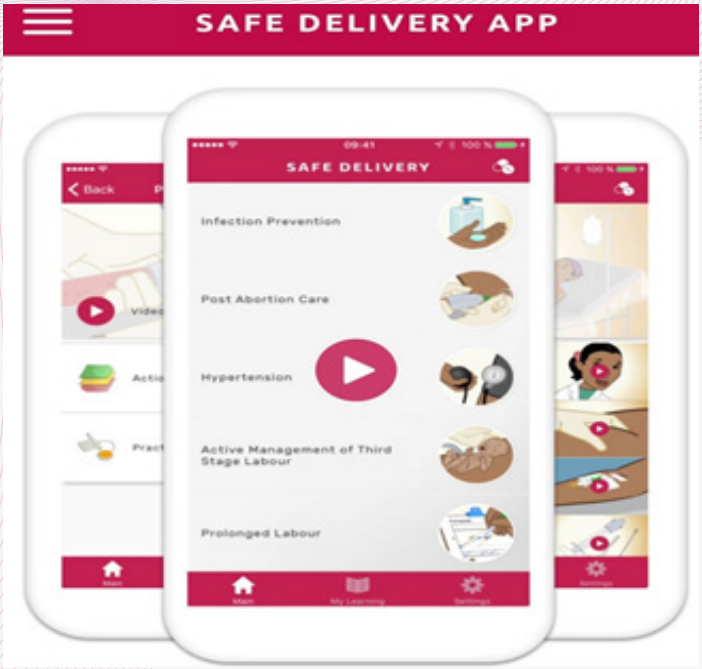
SAFE DELIVERY APP

About the Safe Delivery App

The Safe Delivery App, a free evidence-based mobile application, guides health workers in how to handle the most common childbirth emergencies – straight from their phones or tablets.



Every day, more than 800 women and 7,000 babies lose their lives during pregnancy and childbirth- and 99% are in low- and middle-income countries.

Most of these deaths can be prevented if the mother has access to skilled care during pregnancy and childbirth.

The Safe Delivery App provides skilled birth attendants instant, evidence-based clinical guidelines and uses simple, animated instruction videos, procedures, drug lists and e-learning tools to guide skilled birth attendants in basic emergency obstetric and new-born care.

It was developed in collaboration with the Universities of Copenhagen and Southern Denmark.

The App is available for free for download on Google Play or iTunes in key global language versions, as well as several country-specific versions.

How is it used?

The Safe Delivery App supports skilled birth attendants to provide a safer pregnancy and childbirth for women and newborns – straight from their smartphone or tablet.

The App can be used to improve skills, knowledge, and confidence for skilled birth attendants, whether as part of pre-service education, on-the-job training, professional development courses and much more, depending on need and context.

You can find the information on the following links:

https://www.maternity.dk/safe-delivery-app/about-the-app/background/

https://www.maternity.dk/how-is-it-used/

https://www.maternity.dk/partner-with-us/

https://www.maternity.dk/safe-delivery-app/training-exercises/

https://www.maternity.dk/safe-delivery-app/about-the-app/videos/

IMPROVING THE QUALITY OF MIDWIFERY CARE IN SOMALILAND

Midwifery has a strong public health function, for example through ensuring access to clean water and sanitation during childbirth, supporting breastfeeding mothers, malaria, TB, HIV, obesity in pregnancy, early childhood development and postpartum depression. It also includes delivering family planning services and tobacco cessation in pregnancy. It is beyond preventing maternal and newborn deaths; quality midwifery care improves over 50 other health-related outcomes.

Midwives are uniquely able to provide essential services to women and newborns in even the most difficult humanitarian, fragile and conflict-affected settings. This means that midwives will make a significant contribution to delivering on the commitments made in the Primary Health Care and the Global Action Plan on Healthy Lives and Well-Being.

More than 50 short-term, medium-term, and long-term outcomes that could be

Improved by care within the scope of midwifery are identified (Lancet. 2014):

Reduced maternal and neonatal mortality and morbidity, reduced stillbirth and preterm birth, decreased number of unnecessary interventions, and improved psychosocial and public health outcomes. Midwifery was associated with more efficient use of resources and improved outcomes when provided by midwives, who were educated, trained, licensed, and regulated.

Those Lance findings can be supported by a system-level shift from maternal and newborn care focused on identification and treatment of pathology for the minority to skilled care for all.

This change includes preventive and supportive care that works to strengthen women's capabilities in the context of respectful relationships is tailored to their needs, focuses on promotion of normal reproductive processes, and in which first-line management of complications, and accessible emergency treatment are provided when needed.

Midwifery is pivotal to this approach, which requires effective interdisciplinary teamwork and integration across facility and community settings. Future planning for maternal and newborn care systems can benefit t from using the quality framework in planning workforce development and resource allocation

Educating midwives to international standards is a cost-effective investment as it saves resources by reducing costly and unnecessary interventions. Yet there is a startling lack of investment in quality midwifery education, despite the evidence of the impact. Now is the time to take collective action to strengthen midwifery education.

How can we strengthen Midwifery education, and midwifery practice in Somaliland,

We need a collaborative action between SLNMA, SLMA, MOHD, NHPC, Health training institutions including Universities, and the international organizations working in Maternal, child and adolescent health in Somaliland. We need to review the midwifery curriculums keeping in mind the

Somaliland context while considering the international standards, ICM competencies and the WHO guidelines.

To make sure that the population receives the quality care services they deserve MoHD, NHPC and SLNMA to conduct clinical audits, supervision, appropriate distribution of midwives in the urban and rural places, as well as support to midwives.

Support can be In:

1. Technical support
2. Availing equipment and supplies to enable them provided the quality care
3. Mentoring and clinical instructions
4. Safe working environment
5. Reasonable and equitable wages and incentives

PATIENCE AND CARE

Rebuilding nursing and midwifery, in Somaliland

By Fouzia Mohamed Ismail

LACK OF AUTONOMY IN FACILITY-BASED BIRTHS MAKES WOMEN BECOME ABSENTEES OF MATERNITY SERVICES IN SOMALILAND FRAGILE CONTEXTS A QUALITATIVE STUDY

ABSTRACT

Background: Somaliland has high levels of both maternal and infant mortality. This has been attributed, in part, to the fact that nearly 80% of births in the country take place at home, with women assisted by Traditional Birth Attendants (TBA) who have limited medical knowledge when it comes to obstetric complications.

The aim: In this study we aim to capture multipara women's decision-making when choosing the place of birth, illuminated by their experiences of maternity services in Somaliland

Methods: An explorative qualitative approach using individual interviews conducted in Somaliland with 25 multiparous women who had experience of botha home and facility-based birth within the last three years.

Results:The main finding of this study was the description of how valuable autonomy and respectful care were for Somaliland women. Respectful care and the cost of maternity services were vital parts of women's autonomous decision-making when choosing a place of birth. Disrespectful care in maternity services made low-risk pregnancy women chose homebirth instead of a health facility birth. Women who had previous high-risk pregnancies that suggested they should be returnees to facility-based antenatal care, were still planning for a homebirth as their first choice.

Key conclusion:This qualitative study was conducted in the fragile context of Somaliland and suggests a need to transform maternal and child health clinics into midwifery-led birthing centers that promotenatural birth. It is further important to createnew roles and responsibilities for TBAs that link them to the formal health system assuring timely health care seeking during pregnancy and in relation to delivery. There is a need to conduct a country-wide study on the availability and distribution of healthcare providers and a long term sustainability plan to construct a long-term sustainable plan to assure quality and equal access to maternal health care in the country.

Introduction

It is well established that it can be difficult for women in fragile contexts to access adequate maternal healthcare. The idea that maternal mortality could be lowered if women had better access to maternal health services is one that has not been properly examined [1, 2]. The WHO has estimated that 830 women die every day because of preventable obstetric complications. Ninety-nine per cent of these deaths occur in low and middle-income countries of which more than half take place in sub-Saharan Africa [3].To achieve a reduction in maternal mortality, women need to be able to access healthcare facilities run by trained HealthCare professionals that deliver evidence-based practice and uphold quality and respect in every aspect of the care provision (WHO, 2018).

A healthcare professional in this article is defined as an accredited and skilled birth attendant with the potential to make a positive intervention of an emergency in the birth process. This includes midwives, nurses, or physicians who have been educated and trained in contrast to Traditional Birth Attendants (TBAs). Skilled Birth Attendants (SBAs) have proficiency in the skills needed to manage both normal and complicated pregnancies, births and follow-ups through the identification, management and timely referral of women and newborns for specialist treatment [4-7].

Methodology Design

This study employed an exploratory qualitative approach using individual interviews to illuminate women's decision-making when choosing a place of birth [25]. Ethical approval was obtained from the Somaliland MOHD and the research ethics committee at the University of Hargeisa.Dr: CS/41105/18.

Participants

Eligible multipara women from Ahmed Dhagahand the IDP camps with experience of delivery at both a health facility and at home were identified as meeting the inclusion criteria for participation in this study. Twenty-six women voluntarily agreed to take part in the study. One woman was excluded when she refused to be audio recorded. Individual in-depth interviews were conducted with 25 women between January 2015 and September 2019.

Results

The main category to emerge from this study is "Somaliland women value autonomous choices". Somaliland women make decisions about their place of birth based on what they perceive to be the best quality care given their circumstances and with some consideration of the financial implications of their decision. The interlinked generic categories are; "Clinical knowledge and cultural competence", "Strengthening women's capacities"and"Optimizing natural processes", "Providing respectful women-centered care and cultural understanding" and"Preventing complications through education and health promotion and maternal autonomy".

CThis study suggest a need to transform maternal and child health clinics into midwifery-led birthing centers.

To createnewroles and responsibilities for TBAs linking them to the formal health system assuring timely health care seeking during pregnancy and in relation to delivery.

To provide health care professionals with a training package on respectful maternity care that would help to end the mistreatment of women in maternity services.

To develop a policy on quality maternity care for the Somaliland maternity services. This would encourage respectful women-centered care at existing health facilities.

To conduct a country-wide study on the availability and distribution of healthcare providers.To construct a long-term sustainable plan to assure quality and equal access to maternal health care in the country.

Paper Context

Health authorities, in line with global guidance,advocate for availability of midwives to all women and newborns during birth. Also, research confirms that woman-centered, midwifery led, and respectful maternity care reduces maternal complications

and increases maternal satisfaction and return to the services provided. This includes-medications and equipment to deal with obstetric complications when it occurs.Still, women in low resource settings choose home births with untrained traditional birth attendance. This study provides a valuable description of why women in low resource settings, experienced in both health facility and home delivery, choose not to return to health facility birth even when this means they will risk severe complications. The findings of this study highlight the value of women-centered, midwifery led, respectful maternity care at health facility births. Addressing the above challenges can encourage women to accept facilities which would reduce maternal and newborn outcomes locally and globally.

References

[1]The world Bank: The world bank data. https://dataworldbankorg/indicator/SHDYNNMRT 2019. Accessed 1 November 2020.

[2]WHO U, UNFPA, World Bank Group and the United Nations Population Division. : Maternity mortality: Levels and trends 2000 to 2017. In Sexual and reproductive health, vol. https://www.who.int/reproductivehealth/publications/maternal-mortality-2000-2017/en/. Geneva; 2019. Accessed 1 November 2020.

[3]Black R, Laxminarayan R, Temmerman M, Walker N: Reproductive, Maternal, Newborn, and Child Health. Washington (DC): The World Bank; 2016.

[4]Organization WH: Definition of skilled health personnel providing care during childbirth: the 2018 joint statement by WHO, UNFPA, UNICEF, ICM, ICN, FIGO and IPA vol. https://apps.who.int/iris/bitstream/handle/10665/272818/WHORHR. Geneva; 2018. Accessed 1 November 2020.

[5]Zahn CM, Remick A, Catalano A, Goodman D, Kilpatrick SJ, Menard MK: Levels of Maternal Care Verification Pilot: Translating Guidance Into Practice. Obstet Gynecol 2018, 132:1401-1406.

[6]Doctor HV, Radovich E, Benova L: Time trends in facility-based and private-sector childbirth care: analysis of Demographic and Health Surveys from 25 sub-Saharan African countries from 2000 to 2016. J Glob Health 2019, 9:020406.

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POSTPARTUM DEPRESSION

Postpartum Depression is a serious mental health illness that can affect someone soon after having a baby. It affects around 1 in 500 mothers after giving birth.Many people who have given birth will experience mild mood changes after having a baby, known as the «baby blues». This is normal and usually only lasts for a few days.But postpartum psychosis is very different from the «baby blues». It›s a serious mental illness and should be treated as a medical emergency.It›s sometimes called puerperal psychosis or postnatal psychosis.

Symptoms of postpartum psychosis

Symptoms usually start suddenly within the first 2 weeks after giving birth - often within hours or days of giving birth. More rarely, they can develop several weeks after the baby is born.

- Hallucinations: hearing, seeing, smelling or feeling things that are not there
- Delusions – thoughts or beliefs that are unlikely to be true
- A manic mood – talking and thinking too much or too quickly, feeling «high» or «on top of the world»
- A low mood – showing signs of depression, being withdrawn or tearful, lacking energy, having a loss of appetite, anxiety, agitation or trouble sleeping
- Sometimes a mixture of both a manic mood and a low mood - or rapidly changing moods
- Loss of inhibitions
- Feeling suspicious or fearful
- Restlessness
- Feeling very confused
- Behaving in a way that›s out of character.

When to get medical help

- Postpartum psychosis is a serious mental illness that should be treated as a medical emergency. It can get worse rapidly and the illness can risk the safety of the mother and baby.
- See a GP immediately if you think you, or someone you know, may have developed symptoms of postpartum psychosis. You should request an urgent assessment on the same day.
- Treating postpartum Depression
- Treatment usually happens in hospital. Ideally, this would be with your baby in a specialist psychiatric unit called a mother and baby unit. But you may be admitted to a general psychiatric ward.
- Medicine: You may be prescribed 1 or more of the following:
- Antipsychotics – to help with manic and psychotic symptoms, such as delusions or hallucinations
- Mood stabilizers (for example, lithium) to stabilize your mood and prevent symptoms recurring
- Antidepressants-to help ease symptoms if you have significant symptoms of depression and may be used alongside a mood stabilizer.

Electroconvulsive therapy (ECT)

Electroconvulsive therapy (ECT) is sometimes recommended if all other treatment options have failed, or when the situation is thought to be life threatening.

Most people with postpartum psychosis make a full recovery as long as they receive the right treatment.

Psycho- therapy: -As you move forward with your recovery, you may benefit from seeing a therapist forcognitive behavioural therapy (CBT). CBT is talking therapies that can help you manage your problems by changing the way you think and behave.

Other forms of support

It can be hard to come to terms with the experience of postpartum psychosis as you recover. Talking to peers and others with lived experience of the illness may be helpful. Some inpatient units and communities have peer support workers who have experienced the illness, and you can also access support through charities.

Causes

We›re not sure what causes postpartum psychosis, but you›re more at risk if you:

- Already have a diagnosis of bipolar disorder or schizophrenia.
- Have a family history of mental health illness, particularly postpartum psychosis (even if you have no

history of mental illness)
- Developed postpartum psychosis after a previous pregnancy

Reducing the risk of postpartum psychosis

If you›re at high risk of developing postpartum psychosis, you should have specialist care during pregnancy and be seen by a prenatal psychiatrist.You should have a prebirth planning meeting at around 32 weeks of pregnancy with everyone involved in your care. This includes your partner, family or friends, mental health professionals, your midwife, obstetrician, health visitor and GP.

This is to make sure that everyone is aware of your risk of postpartum psychosis. You should all agree on a plan for your care during pregnancy and after you›ve given birth.You›ll get a written copy of your care plan explaining how you and your family can get help quickly if you become ill, as well as strategies you can use to reduce your risk of becoming ill.In the first few weeks after your baby is born, you should have regular home visits from a midwife, health visitor and mental health nurse.

Recovering from postpartum psychosis

The most severe symptoms tend to last 2 to 12 weeks, and it can take 6 to 12 months or more to recover completely from the condition. But with treatment and the right support, most people with postpartum psychosis do make a full recovery.An episode of postpartum psychosis is sometimes followed by a period of depression, anxiety and low confidence. It might take a while for you to come to terms with what happened.

Some mothers have difficulty bonding with their baby after an episode of postpartum psychosis, or feel some sadness at missing out on time with their baby. With support from your partner, family, friends and your mental health team, or talking to others with lived experience, you can overcome these feelings.Many people who›ve had postpartum psychosis go on to have more children. Although there is about a 1 in 2 chance you will have another episode after a future pregnancy, you should be able to get help quickly with the right care and the risks can be reduced with appropriate interventions.

Supporting people with their recovery

People with postpartum psychosis will need support to help them with their recovery.

You can help your partner, relative or friend by:

- Being calm and supportive
- Taking time to listen
- Helping with housework and cooking
- Helping with childcare and nighttime feeds
- Letting them get as much sleep as possible
- Helping with shopping and household chores
- Keeping the home as calm and quiet as possible
- Not having too many visitors

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SLNMA

BIRTH SPACING

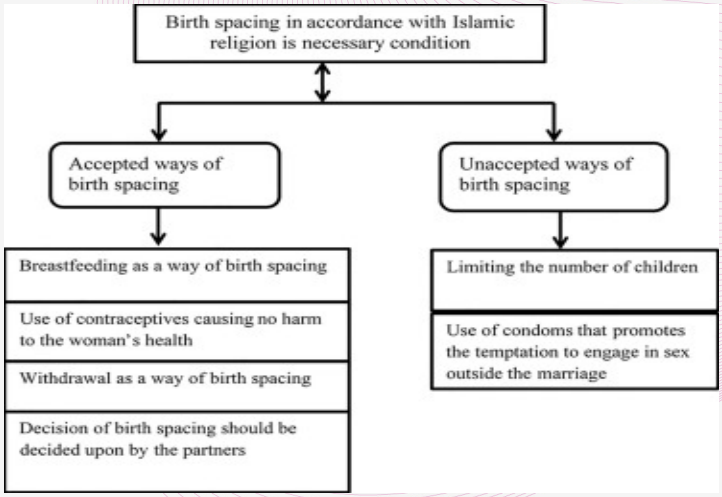
Birth Spacing is the practice of waiting between pregnancies. A woman's body needs to rest following pregnancy it can help a mother to obtain a good physical and mental. After having a baby, it is a good idea to wait at least 18 months before getting pregnant again to maintain the best health for her body and her children. The 18-month rest period is called "birth spacing." When the time between pregnancies is less than 18 months, her body may not be ready to have a healthy baby.

When a woman does not wait at least 18 months between pregnancies, there is an increased risk of having a poor birth outcome (such as a premature birth or a low birth weight baby). These conditions can threaten the health of the child and the mother. These conditions are associated with infant mortality and other short-term and long-term health complications.

Somali region has one of the highest ratios of maternal mortality (732 deaths per 100,000 live births). The infant mortality rate is 72 deaths per 1000 live births. The desired number of children for Somali families has been estimated as high as six per family. In a recent Near Miss study conducted in the Somali region in 2015 the mortality rate at a local tertiary hospital was 1328 deaths per 100,000 live births, with the major causes of death being pre-eclampsia, hypertensive disorder, and obstetric hemorrhage. About 22% of these deaths were stillbirths.

There are a number of methods women and men may choose to avoid an unplanned pregnancy during healthy birth spacing. They may choose to avoid having sex during the fertile days of a woman's cycle (such as a Calendar or Rhythm Method). They may choose a barrier method of birth control to keep the male's sperm from the woman's egg (such as a male condom). A woman may choose a medication or hormonal method (such as the pill, injectables, patch or implants). Each method varies in degree of effectiveness. All of these methods are reversible and allow the woman to resume trying to get pregnant after the healthy 18- month birth spacing period.

According to the Islamic religion there are two perspectives of views of birth spacing were identified: accepted ways and unaccepted ways. The accepted ways include breastfeeding, use of contraceptives causing no harm to the women's health. The preferred method should be determined by a joint agreement between the husband and wife, and that Muslim doctors should play a key role while the couples investigate their preferred method. Using contraceptives with the intention to limit the number of children was against Islamic values and practice. In addition, it was believed that using condoms promoted the temptation to engage in sex outside the marriage and was therefore prohibited.



According to the religious Islamic leaders selected practice recommendations for contraceptive use is permitted in relation to birth spacing to promote the health of the mother and child. When providing professional contraceptive counseling to Muslim women, the word "birth spacing" is recommended to be used instead of "family planning".

Islamic medical professionals should be trained to assist in assessing families which contraceptive methods may be medically advisable. A woman's health status (including high blood pressure, cholesterol, diabetes, anemia, or other conditions), body mass index and other considerations are all important factors in choosing a contraceptive method. These same factors are also important to address when choosing to get pregnant.

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DIABETES

Diabetes is a chronic (long-lasting) health condition that affects how your body turns food into energy. With diabetes, your body either doesn't make enough insulin or can't use it as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease.

There are a few different types of diabetes:

- Type 1 diabetes is an autoimmune disease. The immune system attacks and destroys cells in the pancreas, where insulin is made. It's unclear what causes this attack. About 10 percent of people with diabetes have this type.
- Type 2 diabetes occurs when your body becomes resistant to insulin, and sugar builds up in your blood.
- Pre-diabetes occurs when your blood sugar is higher than normal, but it's not high enough for a diagnosis of type 2 diabetes.
- Gestational diabetes is high blood sugar during pregnancy. Insulin-blocking hormones produced by the placenta cause this type of diabetes.

Type 1 Diabetes

Type 1 diabetes is thought to be caused by an autoimmune reaction (the body attacks itself by mistake) that stops your body from making insulin. Approximately 5-10% of the people who have diabetes have type 1. Symptoms of type 1 diabetes often develop quickly. It's usually diagnosed in children, teens, and young adults. If you have type 1diabetes you'll need to take insulin every day to survive.

Type 2 Diabetes

With type 2 diabetes, your body doesn't use insulin well and can't keep blood sugar at normal levels. About 90-95% of people with diabetes have type 2. It develops over many years and is usually diagnosed in adults (but more and more in children, teens, and young adults)

Gestational Diabetes

Gestational diabetes develops in pregnant women who have never had diabetes. If you have gestational diabetes, your baby could be at higher risk for health problems. Gestational diabetes usually goes away after your baby is born but increases your risk for type 2 diabetes later in life

Prediabetes

With prediabetes, blood sugar levels are higher than normal, but not high enough yet to be diagnosed as type 2 diabetes. Prediabetes raises your risk for type 2 diabetes, heart disease, and stroke.

General Symptom's

- Increased hunger
- Increased thirst
- Weight loss
- Frequent urination
- Blurry vision
- Extreme fatigue
- Sores that don't heal

Diabetes diagnosis

Anyone who has symptoms of diabetes or is at risk for the disease should be tested. Women are routinely tested for gestational diabetes during their second or third trimes-

ters of pregnancy.

Doctors use these blood tests to diagnose prediabetes and diabetes:

- The fasting plasma glucose (FPG) test measures your blood sugar after you've fasted for 8 hours.
- The A1C test provides a snapshot of your blood sugar levels over the previous 3 months.
- To diagnose gestational diabetes, your doctor will test your blood sugar levels between the 24th and 28th weeks of your pregnancy.
- During the glucose challenge test, your blood sugar is checked an hour after you drink a sugary liquid.
- During the 3 hour glucose tolerance test, your blood sugar is checked after you fast overnight and then drinks a sugary liquid.

The earlier you get diagnosed with diabetes, the sooner you can start treatment.

Diabetes prevention

Type 1 diabetes isn't preventable because it's caused by a problem with the immune system. Some causes of type 2 diabetes, such as your genes or age, aren't under your control either.

Yet many other diabetes risk factors are controllable. Most diabetes prevention strategies involve making simple adjustments to your diet and fitness routine.

If you've been diagnosed with prediabetes, here are a few things you can do to delay or prevent type 2 diabetes:

- Get at least 150 minutes per week of aerobic exercise, such as walking or cycling.
- Cut saturated and transfats, along with refined carbohydrates, out of your diet.
- Eat more fruits, vegetables, and whole grains.
- Eat smaller portions.
- Try to lose 7 percentTrusted Source of your body weight if you're overweight or obese.

These aren't the only ways to prevent diabetes. Discover more strategies that may help you avoid this chronic disease.

The bottom line

Both genes and environmental factors play a role in triggering diabetes. There isn't a cure yet for diabetes, but losing weight, eating healthy food, and being active can really help. Taking medicine as needed, getting diabetes self-management education and support, and keeping health care appointments can also reduce the impact of diabetes on your life.

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Reference

June 11, 2020 Centers for Disease Control and Prevention

What is diabetes? (n.d.).

idf.org/aboutdiabetes/what-is-diabetes.html

American Heart Association Editorial Staff. (2018). https://www.heart.org/en/healthy-living/healthy-eating/eat-smart/sugar/added-sugars

DIETARY RECOMMENDATIONS THROUGHOUT COVID 19 PANDEMIC

Introduction

In December 2019, an epidemic of pneumonia cases of unidentified origin was reported in Wuhan, Hubei Province, China 1. This was then recognized as Corona Virus disease 2019 (COVID 19) and has occurred as a global health risk due to its enlarged geographic spread over the last two years2. The disease can be asymptomatic or present mild symptoms of the upper respiratory tract3. The most severe cases are characterized by acute respiratory distress syndrome and multi organ failure4. Additionally, as the disease develops, multi-organ failure has also been informed caused by acute inflammation. Globally, the morbidity rate of covid 19 has been estimated more than 130 million cases and caused more than 2 million deaths and ongoing5. The Covid 19 has modelled recurrent trials throughout its sequence fluctuating from virus isolation, detection, prevention to vaccine development. Although covid 19 can similarly affect all age groups, individuals with other chronic diseases may aggravate the inflammatory response resulting from the covid 19, which can cause an elevated risk for adverse effects and death6. The systematic inflammation in individuals with non-communicable diseases (NCDs) such as diabetics can cause severe respiratory symptoms of the infection7. Though COVID-19 is a new pandemic, and information on nutritional status throughout infection and in recovery are only launch to progress, it is apparent from the knowledge developed to date, and equivalents with conditions that have similar symptoms and disease paths, that patients who have moderate-to-severe infections of COVID-19 are at risk of malnutrition 8. Those at risk of a severe COVID-19 infection, specifically older adults and those with chronic diseases, are similarly those who are an at-risk group of malnutrition9. Furthermore, as malnutrition is left unobserved and untreated, it can increase the period of hospital stay10.

Importance of nutrient intake towards covid 19

The nutritional status of the individual might be affected by several factors, including health status. Thus it›s important to provide appropriate nutrients and a healthy diet. Through the COVID-19 pandemic, while no foods or dietary supplements can prevent or cure COVID-19, healthy diets are essential for improving the immune system11. It is also capable of easing the risk and morbidity associated with COVID-19. Moreover, improved nutrition and dietary nutrient intake affect the immune system through cell activation and signaling molecule modification12. Besides, numerous dietary ingredients are determinants of gut microbial composition and subsequently shape the body›s immune responses13. Hence, the current studies recommend that the only bearable way to endure the recent situation is to strengthen the immune system13,14. Even though Dietary supplementation has not been linked to COVID-19 prevention, however, supplementation with vitamins C and D, as well as with zinc and selenium, was highlighted as hypothetically advantageous for individuals with, or at risk of, respiratory viral infections or for those in whom nutrient deficiency is perceived 15. A sufficient intake of zinc, iron, and vitamins A, B 12, B6, C, and E is vital for well-functioning of immune system and supports in COVID-19 prevention16.

Dietary recommendations for COVID 19

Although there is currently no evidence that any supplement can ‹boost› our immune system and treat or prevent any viral infections, a balanced diet assures a strong immune system that can support any attack by the virus. Moreover, Vitamin C is one of the key elements of water-soluble vitamins, which lean towards a strong immune system. The daily recommended dietary allowance (RDA) for Vitamin C is 90mg/d for men and 75mg/d for women. In the existing situation, it is crucial to be mindful of the exact types of food that can advance our immune system to battle COVID-19 17 Here are some professional and reliable dietary guidelines to endure COVID-19 18:

- Drink 8–10 glasses of water every day. It helps transport nutrients in the blood, gets rid of waste, and regulates body temperature.
- food should be prepared and served at acceptable temperatures (≥72°C for 2 mins).
- consume fruits daily (guava, apple, banana, strawberry, grapefruit, pineapple, papaya, orange) with a serving size of two cups (4 servings).
- Consume unsaturated fats (found in avocado, fish, nuts, olive oil, and sunflower) rather than saturated fats (found in butter, fatty meat, coconut and palm oils, cheese, ghee, and cream).
- consume fresh vegetables (green bell peppers, garlic, ginger, kale, lime, coriander (dried), green chili pepper), 2.5 cups of vegetables (5 servings), legumes (beans and lentils). Maintain a healthy lifestyle of exercise, meditation, and regular sleep. Adequate sleep will help to support immune functioning.
- Do not overcook vegetables as it causes the loss of chief nutrients such as vitamins and minerals.
- Avoid all fizzy, carbonated, concentrated juices and all drinks which contain sugar.
- Limit the salt intake.
- consume whole grains and nuts, 180 g of grains (unprocessed maize, oats, wheat, millet, brown rice or
- For snacks, choose fresh fruits and raw vegetables rather than foods that are high in sugar, salt or fat. Avoid irregular snacking.
- roots such as yam, potato, taro or
- cassava). Use nuts like almonds
- Red meat can be eaten once or twice per week, and poultry 2−3 times per week. Use foods from animal sources (e.g., fish, fish, eggs, and milk) and 160 g of meat and beans.
- Eat at home to avoid contact with other people and try to reduce the chance of being exposed to COVID19.
- When using dried or canned fruits and vegetables, choose varieties without added sugar or salt.

Additional considerations related to diet

While a variety of approaches might be essential to promote an individual's nutritional status during COVID-19 illness to manage nutritional issues related to diet, however, essential points to consider are including19:

- Sustaining a balanced diet or missing out on some key food groups.
- Meeting essential vitamins and minerals required, including Vitamin D intakes which might be a certain concern. This includes spending slight time outdoors. a daily supplement containing 400 international units (IU) (10 µg) of vitamin D is recommended (National Institute for Health and Care Excellence (NICE)) 19
- Individuals recovering from illness with muscle wasting or feel weak need more attention with their protein intake20
- The need for food fortification advice.
- Dietary Management of COVID-19 symptoms that might affect food intakes, such as shortness of breath, dry mouth, and loss of taste and smell.

Conclusion

Though COVID-19 is a new pandemic, and information on nutritional status throughout infection and in recovery are only launch to progress, it is apparent from the knowledge developed to date, and equivalents with conditions that have similar symptoms and disease paths, that patients who have moderate-to-severe infections of COVID-19 are at risk of malnutrition. The nutritional status of the individual might be affected by several factors including health status, which also affects the immune system, thus it's important to provide appropriate nutrients and a healthy diet. while no foods or dietary supplements can prevent or cure COVID-19, healthy diets are essential for improving the immune system and assist healing process. Current studies recommend that the only bearable way to endure in the recent situation is to strengthen the immune system. Even though Dietary supplementation has not been linked to COVID-19 prevention, however, supplementation with vitamins C and D, as well as with zinc and selenium.

References

1.Hui, D. S., Azhar, E. I., Madani, T. A., Ntoumi, F., Kock, R., Dar, O., ... & Petersen, E. (2020). The continuing 2019-nCoV epidemic threat of novel coronaviruses to global health—The latest 2019 novel coronavirus outbreak in Wuhan, China. International journal of infectious diseases, 91, 264-266.

2.Meo, S. A., Al-Khlaiwi, T., Usmani, A. M., Meo, A. S., Klonoff, D. C., & Hoang, T. D. (2020). Biological and epidemiological trends in the prevalence and mortality due to outbreaks of novel coronavirus COVID-19. Journal of King Saud University-Science, 32(4), 2495-2499.

3.Huff, H. V., & Singh, A. (2020). Asymptomatic transmission during the coronavirus disease 2019 pandemic and implications for public health strategies. Clinical Infectious Diseases, 71(10), 2752-2756.

4.Keith, P., Day, M., Choe, C., Perkins, L., Moyer, L., Hays, E., ... & Scott, L. K. (2020). The successful use of therapeutic plasma exchange for severe COVID-19 acute respiratory distress syndrome with multiple organ failure. SAGE open medical case reports, 8, 2050313X20933473.

5.(CSSE), C.-1. D. (2021). https://github.com/CSSEGISandData. Retrieved from https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48 e9ecf6

6.Liu, H., Chen, S., Liu, M., Nie, H., & Lu, H. (2020). Comorbid chronic diseases are strongly correlated with disease severity among COVID-19 patients: a systematic review and metaanalysis. Aging and disease, 11(3), 668.

7.Pal, R., & Bhadada, S. K. (2020). COVID-19 and non-communicable diseases. Postgraduate Medical Journal, 96(1137), 429-430.

8.Liu, A., Cong, J., Wang, Q., Mei, Y., Peng, Y., Zhou, M., ... & He, P. (2021). Risk of Malnutrition Is Common in Patients with Coronavirus Disease 2019 (COVID-19) in Wuhan, China: A Cross-sectional Study. The Journal of Nutrition.

9.Li, T., Zhang, Y., Gong, C., Wang, J., Liu, B., Shi, L., & Duan, J. (2020). Prevalence of malnutrition and analysis of related factors in elderly patients with COVID-19 in Wuhan, China. European journal of clinical nutrition, 74(6), 871-875.

10.Yu, Y., Ye, J., Chen, M., Jiang, C., Lin, W., Lu, Y., ... & Li, D. (2021). Malnutrition prolongs the hospitalization of patients with COVID-19 infection: a clinical epidemiological analysis. The journal of nutrition, health & aging, 25(3), 369-373.

11.Iddir, M., Brito, A., Dingeo, G., Fernandez Del Campo, S. S., Samouda, H., La Frano, M. R., & Bohn, T. (2020). Strengthening the immune system and reducing inflammation and oxidative stress through diet and nutrition: considerations during the COVID-19 crisis. Nutrients, 12(6), 1562.

12.Kau, A. L., Ahern, P. P., Griffin, N. W., Goodman, A. L., & Gordon, J. I. (2011). Human nutrition, the gut microbiome and the immune system. Nature, 474(7351), 327-336.

13.Yang, F., Zhang, Y., Tariq, A., Jiang, X., Ahmed, Z., Zhihao, Z., ... & Bussmann, R. W. (2020). Food as medicine: A possible preventive measure against coronavirus disease (COVID-19). Phytotherapy Research, 34(12), 3124-3136.

14.Sharma, L. (2020). Dietary management to build adaptive immunity against COVID-

19. Journal of PeerScientist, 2(2), e1000016.

15.Ghosh, J. (2021). Potential role of Vitamin D as an antiviral agent. Medical Journal of Dr.

DY Patil Vidyapeeth, 14(1), 3.

16.BourBour, F., Mirzaei Dahka, S., Gholamalizadeh, M., Akbari, M. E., Shadnoush, M., Haghighi, M., ... & Doaei, S. (2020). Nutrients in prevention, treatment, and management of viral infections; special focus on Coronavirus. Archives of Physiology and Biochemistry, 1-10.

17.Aman, F., & Masood, S. (2020). How Nutrition can help to fight against COVID-19 Pandemic. Pakistan journal of medical sciences, 36(COVID19-S4), S121–S123.

https://doi.org/10.12669/pjms.36.COVID19-S4.2776

18.Aman, F., & Masood, S. (2020). How Nutrition can help to fight against COVID-19 Pandemic. Pakistan journal of medical sciences, 36(COVID19-S4), S121–S123.

https://doi.org/10.12669/pjms.36.COVID19-S4.2776

19.National Institute for Health and Care Excellence. Vitamin D deficiency in adults-treatment and prevention. 2018. https://tinyurl.com/y5gbtb44 (accessed 22 July 2020) Google Scholar

20.Deutz NEP, Bauer JM, Barazzoni R et al.. Protein intake and exercise for optimal muscle function with aging: recommendations from the ESPEN Expert Group. Clin Nutr. 2014; 33(6):929–936. https://doi.org/10.1016/j.clnu.2014.04.007 Crossref, Medline, Google Scholar

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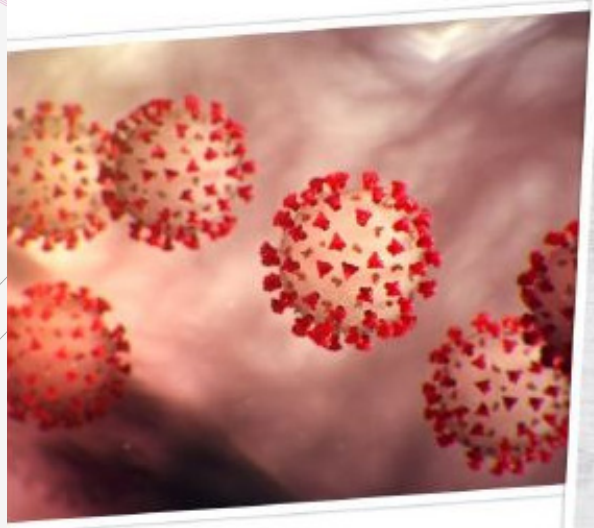


FACTORS AFFECTING UTILIZATIONOF ANTENATAL CARE (ANC) SERVICES AMONG WOMEN OF CHILDBEARING AGE IN, HARGEISA, SOMALILAND

INTRODUCTION

Background to the study

Antenatal care is the most important method for detecting pregnancy problems in the early period, because Antenatal care is the best mechanism to minimize maternal mortality, and give good information for pregnant women about their birth and how to prevent related problems. The best and most advantage of Antenatal Care is to protect the health of women's and their infants as well as indicating the danger signals that will be occurred and needs to be further treated by advanced health professionals.

In Somaliland access to health care services is improving, the country has faced challenges in increasing health care utilization and the proportion of women who give birth with the assistance of skilled attendants is the lowest in Sub-Saharan Africa. The health care system was seriously damaged during to the civil war and conflicts in the 1990s. This led to low socio-economic status especially among many women and girls and caused a lack of education and health care services. Currently, the government of Somaliland aims to rebuild, establish health institutions and improve the health care system for the entire population (UNHCR 2014). it is estimated that the country's maternal and child mortality rates are among the highest in the world.

It's perceived that one of the reasons behind these high rates include low utilization of antenatal care services in Somaliland. Empirical evidence has shown that antenatal care services play an important role in improving maternal and newborn health outcomes. The focus of antenatal care services includes ensuring availability, accessibility, affordability and acceptability of these services. As such provision of antenatal care services creates a platform for educating the mother on pregnancy danger signs, detecting any complications at an early stage and advising the pregnant women to seek appropriate treatment on time. Hargeisa, Somaliland has a well-defined antenatal care services program provided at the Maternal and child health centres (MCHs). However, the utilization of antenatal care services is low with country indicators stating only 20% of pregnant women utilize antenatal care services (MOH, 2013). The low rates are suggested to be due to low levels of trust and confidence with the healthcare providers in the MCHs, confidence with the care provided by traditional birth attendants at home.

Objectives

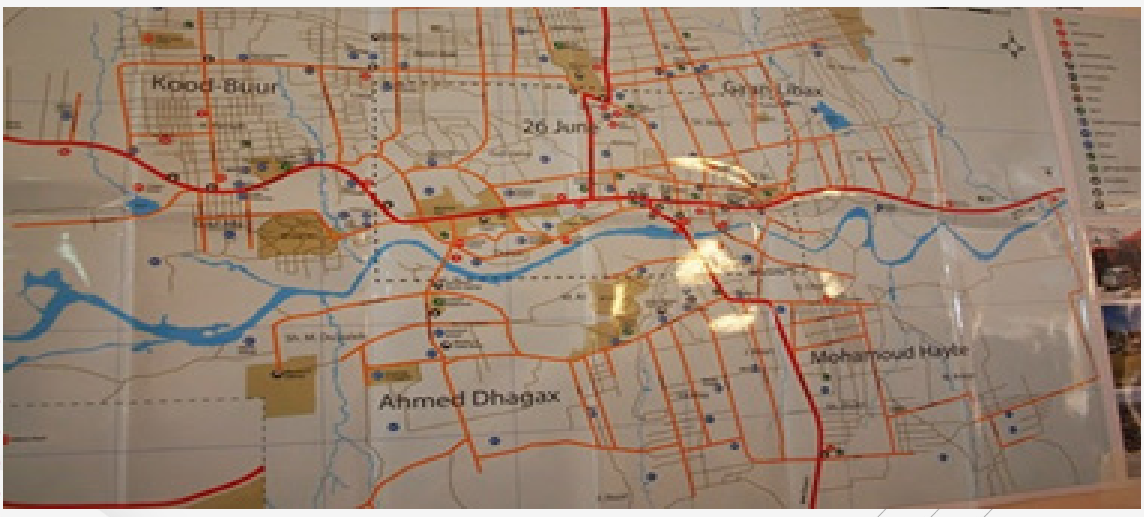
The general objective of this study is to assess factors affecting utilization of Antenatal care services among women of childbearing age in Hargeisa, Somaliland.

The study mainly focused on availability, accessibility, acceptability, and affordability of health care services.

- Availability was measured by asking study participants whether MCHs are available within their reach or not, if the MCHs have drugs, equipment and ambulance, if the MCHs have qualified staff, and it was also asked was whether the health care workers had good attitude or bad attitude which can influence uptake of ANC services
- Regarding accessibility of the antenatal care services, this was measured by asking study participants, if they are satisfied and if they prefer the antenatal care services provided and if they are any barriers and pregnancy related traditional beliefs that prevent pregnant women from starting antenatal care services in the first semester.
- Regarding acceptability was to determine the acceptability of antenatal care services by mothers in Hargeisa, Somaliland. The study wanted to establish whether the women get permission from someone when attending ANC, and that could have a role in determining women's health.
- Another scale was used to measure affordability of antenatal care services under variables such as the cost of visit card, drugs, transportation, immunization, delivery, and caesarean section. The scale had the options: free, cheap, medium and expensive.

METHODOLOGY

Quantitative data with descriptive cross sectional study was conducted to determine the availability, accessibility, acceptability, and affordability of antenatal care services among 258 women of childbearing age from Iftin MCH, Guryo-samo MCH, New Hargeisa MCH, Hawadle MCH, Sahardiid MCH. Each MCH selected represented each of the five main districts in Hargeisa, and these MCHs were selected because they serve the largest catchment populations, and the sample sizes in each of the MCHs and the catchment population were calculated proportionally.



The study conducted from March 2017 to May 2018. Questionnaires and structured interview schedules were used as tools for data collection. The questionnaires were personally administered by the researcher after getting consent from participants and those women who were unable to fill the questionnaires were interviewed.

RESULTS

Study Respondents' Sociodemographic Information

The sociodemographic factors of study participants are shown in Table 1. Regarding the place of residence, majority 94 (36%) of the study participants resided in Mohamud Haybe district. In terms of age, most of the study participants' ages ranged between 25 and 34 years (60.4%). Majority of participants were married 252 (97.7%), terms of family size half the participants has family between 4-6 including mother and father 114 (44%), in educational level 63(24%) were university graduates, majority of study participants 204 (79%) were unemployed mothers, according to father occupation 135 (52.3 %) were office work/ services work and more than half of the participants 162(62.8%) had family income between 100----499 USD per month.

Table 1 Sociodemographic Factors of Study Participants

Residence	n=258	%
Ahmed Dhagah	84	32.8
Mohamud Haybe	94	36
26 June	20	7.8
Ibrahim Kood-buur	28	10.9
Gacan-Libaah	32	12.5
Age	n=258	%
15-24 years	51	19.8
25-34 years	156	60.4
35-44 years	51	19.8
Marital_Status	n=258	%
Married	252	97.7
Divorced	6	2.3
Family_Size	n=258	%
1-3	57	22
4-6	114	44
7-10	59	23
Above 10	28	11
Educational_Level	n=258	%
Never gone to school	53	20.5
Quran/Madarasah School	24	9.4

Primary School	55	21.5
Intermediate School	27	10.5
Secondary School	36	14.1
University graduate	63	24
Mothers_Occupation	n=258	%
Unemployed	204	79
Office work, non-manual work or service work	42	16.3
Manual work (cleaners)	9	3.5
Student	3	1.2
Fathers_Occupation	n=258	%
Unemployed	24	9.3
Office work, non-manual work or service work	135	52.3
Manual work	99	38.4
Family_Income	n=258	%
Below 30 USD	6	2.3
30-59 USD	9	3.5
60-99 USD	21	8.1
100-499 USD	162	62.8
500-999 USD	42	16.3
1000 USD and above	18	7.0

Obstetric Characteristics of Study Participants

A data collected 258 study participants form five districts in Hargeisa showing that 135 (52.3%) give birth 1-3 children, at least half of the participants 93 (36%) had history of obstetric problem including abortion and still birth, while 197 (76.4%) exclusively breast-feeding for the first six month of child age, while majority of the participants 141 (54.7%) were received TT1/TT2 immunization, 56 (21.7%) mothers had history of food restrictions during pregnancy including major nutrient and majority of participants 174(67.4%) were not using different method of family planning.

Table 2 Obstetric Related Factors

Gravida	n=258	%
1 to 3	135	52.3
4 to 7	77	29.9
Above 8	46	17.8
History_of_Still birth	n=258	%
Yes	93	36
No	165	64

Did_You_Practice_Exclusive_Breastfeeding	n=258	%
Yes	197	76.4
No	61	23.6
Maternal_History_of_immunization	n=258	%
TT1/TT2	141	54.7
TT1	71	27.5
Not immunized	46	17.8
Are_there_any_food_restrictions_during_pregnancy	n=258	%
Yes	56	21.7
No	202	78.3
Do_You_Practice_Family_Planning	n=258	%
Yes	84	32.6
No	174	67.4
Did_you_have_any_obstetric_problems_with_previous_pregnancy	n=258	%
Yes	95	36.8
No	163	63.2

Availability of Antenatal Care services

According availability of MCH Facility as showing below table majority of participants 237 (91.9%) had MCH facility available, half of the participants 215(83.3%) have full equipped MCH facility including essential drugs, basic Equipment and Ambulance, more than half of total participants 220 (85.3%) had qualified staff in their nearest health facility, at least 50 (19.4) proclaiming health professional had bad attitude, in terms of short waiting hours 106(41.1%) had long waiting hours in their Respective health facility and 76(29.5) had experience non flexible clinical schedules

Table 3 Availability of Antenatal Care Services

Is_MCH_Available	n=258	%
Yes	237	91.9
No	21	8.1
Drugs_Equipment_Ambulance_available	n=258	%
Yes	215	83.3

No	43	16.7
Qualified_Staffs	n=258	%
Yes	220	85.3
No	38	14.7
Health_worker_attitude	n=258	%
Good	208	80.6
Bad	50	19.4
Short_waiting_hours	n=258	%
Yes	152	58.9
No	106	41.1
Flexibility_of_clinical_schedules	n=258	%
Yes	182	70.5
No	76	29.5

Accessibility of Antenatal Care Services

A total of 258 study participants 158 (61.2) prefer private facility while seeking medical advice, 218 (84.5.2%) had distance of 5K/M and Below, and more than half of the participants 175 (67.8) have transport available

Table 4 Accessibility of Antenatal Care Services

Which antenatal centre do you prefer	n=258	%
Public	100	38.8
Private	158	61.2
Distance_from_home_to_health_center	n=258	%
5 Km and below	218	84.5
6 km to 10 km	33	12.8
Above 10 km	7	2.7
Is_transport_to_ANC_available	n=258	%
Available	175	67.8
Not Available	83	32.2

Acceptability of Antenatal Care Services

Study participants of 258 mother 238 (92.2%) were preferring MCH facility, while 67(26%) had third visit in their last pregnancy, while 184 (71.3%) go MCH facility for checkups during pregnancy while 16 (6.2%) mother go for delivery, 128 (49.6%) get health promotion during ANC Visit, while 192 (74.4%) received good quality of care from MCH facility, 39 (15.1%) mother preferring to deliver home, while 142 (55%)

need permission to go ANC check UP, 177 (68.6%) got permission from their husband, 207 (80.2%) does not spouse accompanied during ANC visit, 219 (84.9%) mentioned that their husband is the decision maker, where 26(10.1%) receive their husband support, encouragement, and follow-up on women›s condition during ANC Visit, a total of 155 (60.1%) come ANC For normal ANC checkups while 157 (60.8%) visit ANC when they feel un well and 151 (58.5%) do not have any ANC traditional barriers, which is in hinted to not go ANC .

Table 5 Acceptability of Antenatal Care Services

Whats_your_preference_and_Satisfaction	n=258	%
MCH	238	92.2
TBA	20	7.8
Number of ANC Visits in your last pregnancy	n=258	%
0	15	5.8
1	21	8.1
2	58	22.5
3	67	26
4	50	19.4
More than 4 visits	47	18.2
Why do you go for ANC	n=258	%
Check Up	184	71.3
Immunization	13	5.1
Health Education	31	12
Delivery	16	6.2
None	14	5.4
What treatment or advise did you get	n=258	%
Nutrition Advice	84	32.6
Health Promotion	128	49.6
Family planing/IYCF Conselling	32	12.4
None	14	5.4
Whats your experience with the quality of care	n=258	%
Good	192	74.4
Not bad	46	17.8
Bad	9	3.5
None	11	4.3
Do_you_intend_to_give_birth_at_home_or_in_hospital	n=258	%
Hospital	219	84.9
Home	39	15.1

Did_you_need_permission_to_attend_ANC	n=258	%
Yes	142	55
No	116	45
if_yes_from_who	n=258	%
Father	10	3.9
Husband	177	68.6
Mother	47	18.2
Mother in Law	13	5
Other	11	4.3
Does_your_spouse_accompany_youto_ANC	n=258	%
Yes	51	19.8
No	207	80.2
Whats the benefit of the accompaniment to RH	n=258	%
Decision Maker	219	84.9
Drop Off to the health center	7	2.7
Support, encouragement, follow-up on women›s condition	26	10.1
Strengths Confidentiality between couple	6	2.3
Times a pregnant woman should Visit ANC When No Problem	n=258	%
0	2	0.8
1-3times	155	60.1
4 or More	88	34
Never	10	3.9
Don›t know	3	1.2
Times a pregnant woman_ should Visit ANC When Problem Exists	n=258	%
Dont know	2	0.8
0	3	1.2
1-3	96	37.2
4 or more	157	60.8
Barriers to ANC in First Trimester	n=258	%
Yes	151	58.5
Non	104	40.3
Sometimes	3	1.2

Affordability of Antenatal Care services

A total 258 study participants 130 (50.5%) were received free ANC Card. While 95 (36.8%) also receives free drugs during their ANC Checkups. 90 (34.9%) get cheap transportations to the maternal and health centres. 202 (78.3%) were received free immunization while 122 (47.3%) receives medium charge, at least 38 (14.7%) had expensive delivery service and 165 (63.9%) had expensive c/section services.

Table 6 Affordability of Antenatal Care Services

Cost_of_visit_card	n=258	%
Free	130	50.5
Cheap	80	31
Medium	39	15
Expensive	9	3.5
Cost_of_drugs	n=258	%
Free	95	36.8
Cheap	89	34.5
Medium	56	21.7
Expensive	18	7
Cost_of_transportation_to_ANC	n=258	%
Free	80	31
Cheap	90	34.9
Medium	71	27.5
Expensive	17	6.6
Cost_of_immunization	n=258	%
Free	202	78.3
Cheap	26	10
Medium	27	10.5
Expensive	3	1.2
Cost of delivery	n=258	%
Free	47	18.2
Cheap	51	19.8
Medium	122	47.3
Expensive	38	14.7
Cost of caeserean Section	n=258	%
Free	33	12.8
Cheap	25	9.7
Medium	35	13.6
Expensive	165	63.9

CONCLUSION

The study reflected that literacy has a part to play in determining whether a mother will utilise maternal and child health services or not, as well as bad attitude by health care workers and long waiting time towards clients will discourage them from coming for the services. Most of the respondents prefer private facility than the public hospitals; where most of the respondents get permission from husband (decision maker) when attending ANC, but unfortunately majority of husband doesn't accompany to ANC check-ups to their women. According to the affordability majority of the respondents rated some of the services including delivery and caesarean section an expensive, This is because the economic activity may determine whether a mother will get money during pregnancy to seek the services.

RECOMMENDATIONS

Based on the findings, This study recommends:

1.Development of policies and public health programs focusing on increased awareness and behavioral change among pregnant women attending health centers to receive antenatal care services as well as other high risk groups in the population

2.Health promotion of family planning/ birth spacing through mass media. Poster and health education in MCH facility to promote family /birth spacing uptake

3.IYCF counselling session during NAC visit and postnatal check

4.Health seeking behaviour activity to reduce still birth and abortion

5.Capacity building of health professional of behaviour change communication massages,

6.Expanding of primary health care services and health system strengthen though resource allocation and supportive supervision.

7.Improve public health services by improve quality of health care services in the public Maternal and child health services

8.Improving male involvement of reproductive health services through male to male Interpersonal communication agents,

9.Government engagement of free health services or cost sharing mechanism.

10.Ministry of health development should implement research library to keep written documents or researches done before in order to improve data about maternal and child health which help researchers to use as reference.

The delivery of antenatal care services in an appropriate way may enable the pregnant women utilize these services thereby reducing on the cases of maternal mortality and morbidity, still births and early neonatal deaths within the community. The findings of the study can be useful to the country's health care system in decision making on the provision of antenatal services in different health care facilities, and will also serve as a reference for giving intervention accordingly by the Ministry of Health Development and others who concerned; for conducting further researches, the findings of this study will have special importance for health care providers because it will serve as base line for filling gaps of the actual practices on antenatal care by improving uptake of these services.

REFERENCES

Carroli G, Villar J, Piaggio G, Khan-Neelofur D, Gulmezogiu M, et al. WHO systematic review

of randomized controlled trials of routine antenatal care.2001 may 19; 357(9268):1565-70.

Creswell JW. Research Design. Qualitative, Quantitative, and Mixed Methods Approaches,

Fourth Edition.Sage Publications, 2014.

Chiang C, Labeeb SA, Higuchi M, Mohamed AG, Aoyama A. Barriers to the use of basic health

services among women in rural southern Egypt (Upper Egypt).Nagoya J Med Sci.2013;75(3-4):225-31.

Kendall, T., Langer, A. (2015). Critical maternal health knowledge gaps in low- and middle-income countries for the post-2015 era. Reprod Health,5(12):55. Doi: doi:10.1186/s12978-015-0044-5

Lungu F, Malata A, Chirwa E, Mbendera I. Quality assessment of focused antenatal

care services in Malawi. African Journal of Midwifery and Women›s Health, 21 Oct

2011, pp 169 – 175.

Magadi MA, Madise NJ, Rodrigues RN. Variations in antenatal care between women of

different communities in Kenya. 1999. [Accessed on 26th June 2012] Available from:

http://www.aphrc.org/documents/Working%20Paper%2014.pdf.

Ganle, John & Otupiri, Easmon & R, Fitpatrick. (2015). Socio-cultural Barriers to Accessibility and Utilization of Maternal and Newborn Healthcare Services in Ghana after User-fee Aboli-tion. International Journal of Maternal and child health. 3. 1-14.

Lechthaler F, Abakar MF, Schelling E, Hattendorf J, Ouedraogo B, Moto DD, Zinsstag J. (2018).Bottlenecks in the provision of antenatal care: rural settled and mobile pastoralist communities in Chad.Trop Med Int Health. 23(9):1033-1044.

Fagbamigbe AF, Idemudia ES.Barriers to antenatal care use in Nigeria: evidences from non-users and implications for maternal health programming. (2015). BMC Pregnancy Childbirth.17;15:95.

Kanyangarara M, Munos MK, Walker N. (2017). Quality of antenatal care service provision in health facilities across sub-Saharan Africa: Evidence from nationally representative health facility assessments. Journal of Global Health.7 (2)

Mbuagbaw L, Medley N, Darzi AJ, Richardson M, Habiba Garga K, Ongolo-Zogo P. (2015). Health system and community level interventions for improving antenatal care coverage and health outcomes.Cochrane Database Syst Rev. 1;(12):CD010994.

He, J., Toloo, G.-S., Hou, X.-Y., and Fitz-Gerald, G. (2016) Qualitative study of patients› choice between public and private hospital emergency departments. Emergency Medicine Australasia, doi: 10.1111/1742-6723.12530.

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EFFECT OF SHOCK OF HUMAN

Shock is defined as inadequate organ perfusion and tissue oxygenation. Shock is a clinical diagnosis and it is most important to identify the cause in the trauma patient shock is most often due to hemorrhage and hypovolemia the diagnosis and treatment of shock should occur almost simultaneously

The diagnosis of shock is based on assessment of the clinical findings of

- Tachycardia
- Decreased capillary refill time
- Hypotension
- Tachypnea
- Decreased urine output
- Changes in mental state

General observations such as pallor, hypothermia and cool extremities help to make the diagnosis physiological compensation for blood loss may prevent a measurable fall in blood pressure until up to 30% of the circulating volume has been lost

Shock in a trauma patient is classified as hemorrhagic or non-hemorrhagic

Hemorrhagic shock is due to acute loss of blood and nearly all patients with multiple injuries have some hypovolemia due to hemorrhage

Non hemorrhagic shock includes cardiogenic shock (myocardial dysfunction, cardiac tamponade and tension pneumothorax) neurogenic shock, burns and septic shock.

Cardiogenic shock is due to inadequate heart function this may be from

- Myocardial contusion
- Cardiac tamponade from both blunt and penetrating injury
- Tension pneumothorax (preventing blood returning to heart
- Myocardial infraction

Clinical assessment of the jugular venous pressure is important in cardiogenic shock. It is often increased continuous ECG monitoring and central venous pressure (CVP) measurement can be useful as can the use of diagnostic ultrasound.

Neurogenic shock is due to the loss of sympathetic tone usually resulting from spinal cord injury. Isolated intracranial injuries do not cause shock the features of neurogenic shock are hypotension without compensatory tachycardia or skin vasoconstriction hypotension in patients with spinal cord injury can often also due to bleeding.

Septic shock is rare in the early phase of trauma but is a common cause of late death via multi organ failure in the weeks following injury. Septic shock may occur with penetrating abdominal injury and contamination of the peritoneal cavity by intestinal contents if the patient does not have a fever it my difficult to distinguish from hemorrhagic shock.

Management and conclusion of shock

- Insert at least two large bore iv cannulas 16 gauge or larger jugular femoral or subclavian venous access but down or intraosseous infusions may be necessary
- Take blood for type cross match and laboratory tests
- First line infusion fluids are crystalloids electrolyte solutions Eg: Ringers lactate (Hartmann's solution) or normal saline blood loss of more

than 10% of blood volume (7ml/kg in adults) or continuing expected blood loss will require blood transfusion

- All fluids must be warmed to body temperature if possible hypothermia prevents clotting
- Don't give IV solutions containing glucose.
- The routine use of vasoconstrictors is not recommended

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FACTORS AFFECTING FAMILY PLANNING UTILIZATION

According to the World Health Organization definition is this: "Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births.

Family planning plays a major role in reducing maternal and newborn mortality, remains unknown while others deny the facts that presented by health care workers and authorities.

Although the majority of the woman are aware of the importance of contraceptive methods and interested in child spacing, systemic and socio-cultural barriers were found to be hindering their access to contraception. Several barriers were identified including, lack of adequate information, religious beliefs, gender roles and social pressure.

Religious beliefs, cultural barriers, and misconceptions associated with contraceptive use are known to prevent both women and men from accessing reproductive health services and information.

Some women were using contraceptives with the intention to limit the number of children is considered to be against Islamic values and traditions, Nevertheless, cultural traditions, religious misperceptions and social norms are not static but, rather, a dynamic process that changes with the circumstances that surround it . Migration to a new country, exposure to different social context, and improved educational levels can influence traditions and cultural beliefs of individuals, which in turn play a key role in reshaping a community's norms, behaviors, and values.

In Islamic religion, contraception is mainly addressed in the context of marriage and family. As a social system culture, and civilization, Islam considers the family the basic unit of society. Thus, Islam would be sympathetic to family planning if spacing pregnancies and limiting their number made the mother more physically fit and the father more financially at ease, particularly since these actions do not violate any prohibition in the Quran or in the Prophet's tradition (Sunnah). If excessive fertility leads to proven health risks for mothers and children, or economic hardship and embarrassment for the father, or the inability of parents to raise their children properly, Muslims would be allowed to regulate their fertility in such a way as to reduce these hardships.

A small number of Islamic jurists and other

Islamic groups oppose family planning and contraceptive use generally on two grounds. First, they believe that withdrawal or any practice that prevents pregnancy is infanticide, which is repeatedly condemned and prohibited in the Quran. Second, the opponents of family planning, whether jurists or non- jurists, believe that the larger the number of Muslims and the higher their population growth rate, the greater their power. These advocates claim that a large population is ordained by the religion and that failure to achieve it deviates from the right path. They find support for their views not only in the holy book but also in the Prophet's tradition. Hence, they oppose family planning, especially if it becomes community or government policy. They also claim that family planning programs, having originated in the West countries, represent a conspiracy to reduce the number of Muslims and diminish their power.

According to socio cultural factors most women in the developed countries have a plan regarding their education, career, marriage, and when they hope to start a family. So they all want to be prepared to give their families the best they possibly can. In many countries, however, women do not have these choices, and conversely, having children may determine whether or not they can pursue an education or a career. In developing countries, women have increased risk of dying in childbirth, are controlled by their husbands, and their value can be determined by their fertility.

The following are some examples of socio-cultural barriers to family planning in the Democratic Republic of the Congo. Although each community has its own socio-cultural barriers to family planning, many of the same issues that exist in the DRC are similar in other francophone sub-Saharan African countries.

Traditionally, having many children symbolized high social status

Adolescents are not considered adults until they have a child

Women become a man's property after marriage, therefore having little say in family planningIn impoverished areas, women have few choices other than becoming a mother and wife

Other general cultural barriers to family planning include:

- Social stigma
- Rumors and myths about contraceptives i.e. that condoms are only used to prevent STI transmission
- Lack of male involvement in family planning
- Familial pressure
- Fear of side effects of services
- Early marriage
- Factors associated with poverty or trauma in the population
- Domestic violence

- Decision-making positions being fully or mainly controlled by men within the community
- Many interactive studies were made for the last 10 years most of them concluded their results that the husbands and religious leaders are a major entry point for birth spacing interventions along with Mothers and doctors both play an important role in recommending a method to women, so programs should target both all those groups.
- Cultural attitudes seem to be improving towards voluntary modern birth spacing, but continued education needs to be done to counteract beliefs that these methods are not acceptable in religion and may render women infertile.
- Work needs to continue in encouraging women to discuss birth spacing with their husbands. This can be promoted via the recently launched interpersonal communication campaign with men.

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INTRODUCTION OF BREASTFEEDING

Breastfeeding is the normal way of providing young infants with the nutrients they need for healthy growth and development. Colostrum, the yellowish, sticky breast milk produced at the end of pregnancy, is recommended by WHO as the perfect food for the newborn, and feeding should be initiated within the first hour after birth. Exclusive breastfeeding is recommended up to six months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond.

Breastfeeding has many health benefits for both mother and infant. Breast milk contains all the nutrients an infant need in the first 6 months of life. Exclusive breastfeeding is the most widely known and effective intervention for preventing early-childhood deaths. Optimum breastfeeding practices can prevent 1.4 million deaths worldwide among children under five every year. The aim of this study was to assess the prevalence of exclusive breastfeeding and associated factors among mothers who have an infant six months up to one year old in Hargeisa, Somaliland Breast milk is loaded with antibodies that help your baby fight off viruses and bacteria which is critical in those tender early months. This particularly applies to colostrum first milk provides high amount of immunoglobulin A (IGA) as well as several other antibodies. When mothers exposed to viruses or bacteria women started to producing antibodies that then go into the milk its immunity baby IGA protects the baby from getting sick by forming a protective layer in the baby's nose, throat and digestive system formula doesn't provide antibody protection for babies. That babies who are not breastfed are more vulnerable to the health issues like pneumonia, diarrhea, and infection. Middle ear infections, respiratory tract infection, colds and infections the breastfeeding, particularly exclusively and long as possible

may protect against all those infections Breastfeeding is linked with reduction in gut infection.

Mothers who breastfeed have a lower risk for depression oxytocin also increases during breastfeeding it encourage uterine contractions and reduces bleeding, helps the uterus return to its previous size.

Identified a relationship between birthing practices and breastfeeding initiation Continuous support during labor and delivery is a key component to increasing breastfeeding initiation. The results indicated that due to cultural influences, contradictory beliefs and practices, lack of critical thinking and lack of long term planning, traditional birthing support was not always indicative of immediate breastfeeding initiation. The presence of a labor companion is a low-cost, preventative intervention that is consistent with the cultural practices of Somaliland. Breastfeeding education and support should, therefore, include a tertiary approach which includes pregnant and birthing women, labor support persons or family members and health care providers. While breastfeeding rates have improved globally, disparities in breastfeeding practices persist particularly in rural and low resource settings

By Rahma Ahmed Awale

R.N

SOCIAL MEDIA: A TOOL FOR WOMEN'S ACTIVISM

Being outspoken women in the Somali context is difficult. Women in Somalia and Somaliland are dominated by a patriarchal culture, full of inequality, and with a constant threat of violence. Being an activist or trying to change these repressive social norms are a huge challenge – but the most effective way to reach people and raise awareness is through social media.

One of the issues that my work as an activist focuses on is FGM (female genital mutilation). Somaliland has the highest prevalence of FGM in the world, with an estimated 98% of women and girls aged from 15 to 49 having undergone the practice. It is internationally recognized as a human rights violation and a form of gender-based violence, and is a marker of deeply-rooted inequality between men and women. FGM harms the health of women and girls, as well as violating their physical integrity and right to be free of inhumane, cruel and degrading treatment. There are no health benefits to FGM, and in some cases it is the direct or indirect cause of death in young girls and women.

Many organizations are fighting to end this practice, but awareness-raising has typically focused on educating girls and elderly women. But men remain the driving force behind FGM, since it is mainly practiced to preserve girls' virginity. One of the central struggles in changing social attitudes is how to reach more people who continue to promote FGM in their communities, men and women alike – and social media is now playing an essential role.

Safe spaces for women's voices

Social media has changed the face of activism worldwide, but in societies like Somaliland it is particularly important. Despite its negative side – it is unquestionable that trolling and online harassment are serious issues – it is the best tool for an activ-

ist like me: a woman living in a conservative community, where there are few other platforms where we can where women can speak out and share ideas and opinions.

Sometimes it's our only option. In my country, women don't have access to journals, magazines, or other traditional forms of media. These platforms are all owned and managed by men. Social media, on the other hand, has none of these traditional gatekeepers and is open to everyone. Of course there are risks, and many women who raise their voices online are silenced as harshly as they are in the real world. One young female activist received so much online abuse as a result of her posts that her fiancé broke of their engagement. Nevertheless, it remains the only place where women's voices can be heard at all.

In a context where women's voices have long been silenced, social media has helped many women to speak out and find the courage to tackle oppressive social norms. I have seen this in action in my own campaigns, particularly using WhatsApp. I decided to start a Whatsapp group for sharing ideas and working with young girls who have progressive opinions but feel too afraid – with good reason - to express them in public. These girls felt safe to speak out in the group; we discussed their ideas and found ways of turning them into action, helping them take the next step with their families, friends, and other networks. With this kind of mentoring and support, many of the girls developed into activists and leaders. They were there to support each other, knowing they were not alone.

This is true not only for young women but for youth more generally, since the views of young people are not often taken seriously. Creating the space where they could listen to each other and collaborate helped them build confidence as well as learning from each other.

Fighting FGM on Facebook and Twitter

My Facebook page and Twitter profile, which I use to campaign against FGM, have large numbers of followers. It helps me project my own voice further than it could ever go in the offline world. Young people can read the information I post and share, learning about the issues. I focus on reaching these young people, the change-makers of the future, to help them think for themselves and question the beliefs that prevail within their communities.

My Facebook group is full of examples of how young people's minds have been opened, prompting some to change their lifestyle and in some cases to become social activists. One young woman who joined the group began with a very different attitude towards FGM, the values she had learned from her mother: "FGM is your pride, and you should never touch it until marriage". She herself was suffering from complications related to FGM but had not realized that it was the cause. When she learned that I was a doctor, she wanted to discuss her symptoms with me in private. She told me that she'd even dropped out of university because she gets ill so often and experiences so much pain. When I told her that the only cure was to open the FGM, at first she refused for fear of the shame if her family found out. Later, however, she engaged in conversation with other young women in the online group, listened to their views, and finally decided to do it. As a result, she could finish university and begin building a life for herself. It is these stories that motivate me to continue speaking out about this issue and creating space for discussion.

Translating online activism into real change

For many people, social media is where they begin to question their long-held beliefs on topics like FGM, and also where they can come together to build networks that become real-life campaigns. When we are organizing outreach work to go into communities and raise awareness, we post on the Facebook group to find volunteers. Most of the time, there's far more response than we expect. This shows how many youth have the courage to follow the example of others and stand up for social change, and gives us huge encouragement as activists. Within one generation, it will be possible to change outdated and harmful social norms.

Online campaigns have led to many new professional relationships for me, as a number of young men and women have asked me to act as their mentor. After engaging in online activism, they want to understand how best to use their talents and become effective activists. This has created a group of trained social media campaigners who also engage in offline work, as we work together to build campaigns and then visit villages and communities to raise awareness about FGM. We are currently working to engage with decision-makers to make FGM illegal, as Somaliland is currently one of the few countries where it is not yet criminalised. Social media has helped me build networks with youth and young women in the communities that we aim to reach.

Many social media users have sent me private messages in response to my posts, telling me how inspired and motivated my work has made them feel. In one case, a young woman who followed my campaign on Facebook approached me when I went to her village in the west of the country, on the Lughaya coast. She told me that I›d inspired her to start raising awareness among others in the village, and showed me the results of her work - how many women had listened to her and decided to stop cutting their daughters. Moments like this make me feel very proud.

The respect and positive feedback that I get online encourages other users to take the message seriously, and also helps me engage with decision-makers. Many of these figures follow me online, and put the information I share into practice when formulating new policies. And it enables others to reach out to me; the organisers of the Hargeisa International Bookfair recently invited me to facilitate a panel discussion about youth and social development, including the issue of FGM. This was a huge event to be part of, and helped spread the message that I continue to advocate online.

Social media: learning to swim

Both online and offline, an activist needs to be persistent and resilient. The world of Facebook and Twitter is like an ocean: with patience and vigilance, you can learn to swim. If you use social media wisely, with the emotional intelligence to stay calm in the face of whatever your opponents throw at you, you can help change a community.

There›s nothing bad about negative reactions to online posts. When I see a reaction, whether positive or negative, I know that the message has reached someone and that they›ve thought about it. The response is only the smoke, while the fire has been lit inside them. It shows that you are reaching people, and that even those who are against you today may understand what›s better for them and their community tomorrow. In conservative cultures women face red tape everywhere, and can do nothing without the approval of men - but social media gives

us, as women, the power to reach out to others and speak about the issues that matter with us without having to ask anyone›s permission.

Years ago, when I was campaigning against FGM offline, the subject was completely taboo. Today, with the help of social media, this is already changing. Learning to swim through the ocean of social media means knowing your allies, knowing your opponents, and staying resilient and committed to reaching your goals. My advice: to learn about the issue you want to change, every angle of it, both good and bad. Stay informed, and if you feel exhausted just take a break; it helps to rethink and reshape your strategy, and you›ll see how people on social media look forward to hearing more from you when you›re back online. And remember you›re never alone. You may be the first to break the ice, but others will join you. As the African proverb says, «If you want to go fast, go alone. If you want to go far, go together.»

By Dr Mariam Abdullahi Dahir

SOMALILAND NURSING & MIDWIFERY ASSOCIATION