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SLNMA

Somaliland Nursing & Midwifery Association



Voices of Nurses & Midwives

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KHADRA (JAMA) ALI EGAL



BIO

Khadra (Jama) Ali Egal is the Current Executive Director of SLNMA, She is a PhD candidate and UK trained Nurse & Midwife. She has worked as lead of Midwifery department at the University of Hargeisa for the last eight years. Khadra returned to her home country in 2013 aiming to improve maternity services focusing on midwifery education. As a member of the Somaliland Nursing and Midwifery Association since her return Khadra has been at the centre of shaping Somaliland's efforts towards maternity services quality improvement. Her PhD studies are dedicated to International Women's Health. Her thesis studies are focused on maternal near miss and deaths incidences, Respectful maternity care and current Midwifery practice all aimed at improving the quality of Midwifery care in Somaliland. With over ten international publications Khadra aims to increase the research culture in Somaliland and increase research that is conducted by nurses and Midwives for Nurses and Midwives in Somaliland and the East African region.

A LACK OF REPRODUCTIVE AGENCY IN FACILITY-BASED BIRTHS MAKES HOME BIRTH AS FIRST CHOICE REGARDLESS OF POTENTIAL RISKS AND MEDICAL NEEDS A QUALITATIVE STUDY AMONG MULTIPAROUS WOMEN IN SOMALILAND

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ABSTRACT

Background: Around 20 percent of births in Somaliland take place at health facilities staffed by trained healthcare professionals; 80 percent take place at home assisted by Traditional Birth Attendants (TBAs) with no formal training. There has been no research into women's choice of place of birth.

Objective: In this study, we explore multipara women's needs and preferences when choosing the place of birth.

Method: An explorative qualitative study using individual in-depth interviews analysed inductively using content analysis. The interviews were conducted in Somaliland with 25 multiparous women who had experience of giving birth both at home and at a health facility within the past three years.

Results: The results provide a description of how, for women in Somaliland, a lack of reproductive agency in facility-based births makes home births a first choice regardless of potential risks and medical need. The women in this study desired intentionality in their role as mothers and sought some measure of control over the environment where they planned to give birth, depending on the circumstances of that particular birth. The results describe what quality care means for multipara women in Somaliland and how women choose birthplace based on previous experiences of care. The expectation of respectful care was a vital part for women when choosing a place of birth.

Conclusion: To meet women's needs and preferences in Somaliland, further investments are needed to strengthen the midwifery profession and to define and test a context specific midwife-led continuity of care model to be scaled up. A dialogue to create new roles and responsibilities for the TBAs who attend most home births is further needed to link them to the formal healthcare system and assure timely healthcare seeking during pregnancy and birth.

Methodology

Design

This study is an exploratory qualitative study using individual in-depth interviews of multipara women (n=25) that were then analysed inductively using qualitative content analysis according to Elo et al. [25]. Ethical approval was obtained from the Somaliland MOHD and the research ethics committee at the University of Hargeisa. Dr: CS/41105/18.

Participants

In the *preparation phase* [25], eligible multipara women from Ahmed Dhagah community with experience of giving birth were identified as meeting the inclusion criteria for participation in this study. The criteria for inclusion was a multiparous woman who had experienced giving

birth at home and at a health facility within the last three years. Twenty-six women voluntarily agreed to take part in the study. One woman with experience of homebirth was excluded when she refused to be audio recorded. The interviews were conducted with 25 women between January 2015 and September 2019. For the socio-demographic details of the participants, see Table 1.

At the time, the participants lived in the Ahmed Dhagah district of Hargeisa, the capital city of Somaliland. The district contains eight small villages with an estimated population of 23,000 inhabitants. Healthcare is managed from one large hospital and four health facilities where, at the latter, the care is free of charge. Many of the women in this district were originally Internally Displaced People who had moved to the area as a result of the civil war in the 1990s. Many of them have a low socio-economic status and are considered vulnerable [19].

Data collection

Using a purposeful sampling approach [26], women who had experienced both types of birth setting and were able to reflect on their previous experiences, were approached by midwives employed at Ahmed Dhagah Mother and Child Health Clinic (MCH) and Hargeisa Group Hospital. The healthcare professionals asked the women to participate in the study when leaving the health facility after birth. In addition, local TBAs working in the area identified and approached women who they felt met the study criteria. These women were invited to take part in the study and were provided with verbal and written information about it. Participation was voluntary and the women were informed they could withdraw from the study without explanation. After giving their informed consent, participants signed a consent form with a thumbprint signature. An appointment for an interview to be held in the woman's home was then arranged.

The interviews were conducted by the first three authors using a semi-structured interview guide. The questions focused on the aim of the study, which was to collect data on women's choice of place of birth and to explore their experiences of these places. The questions were developed in English and then translated into Somali. They were then pilot tested on two of the participants which resulted in some minor clarifications to the guide before being used for the rest of the study. The questions included: Please tell me about your pregnancy and birth experiences.

Please tell me why you decided on a homebirth. How was your experience of antenatal care? Why did you decide on a facility birth? How was your experience of your homebirth/facility-based birth? Who delivered your baby? The questions enabled the interviewees to speak freely about their experiences and the prompt to "please tell me more" was used to encourage the informant to continue to tell their stories. The interviews were held in Somali, took about 45-60 minutes, were audiorecorded and transcribed verbatim into Somali and then translated into English by the first two authors and double-checked by local University of Hargeisa staff.

Analysis

The transcribed interviews (n=25) were analysed inductively using qualitative content analysis [25]. In the organization phase, the transcripts were read and re-read to get a sense of the data as a whole. At this stage, two content areas were identified: Care experiences in facility-based birth and TBA supported home birth. Through a series of collaborative discussions within the team, the authors analyzed the original 123 pages of data. Text parts, sentences, or small paragraphs with the same meaning were labelled with a code and grouped together, based on similarities and differences in the texts, initially, at the hierarchical level closest to the original content, into sub-categories. These sub-categories were then grouped into more generic categories at a higher level of abstraction. What emerged from this process, the overarching main category, has been described in one sentence as: A lack of reproductive agency in facility-based births makes home births a first choice regardless of potential risks and medical needs. Examples of this analytical process are provided in Table 2. The outcome of the analysis was based on the contrast between women's experience of facility-based births facilitated by healthcare professionals and homebirths facilitated by TBAs [25].

Results.

The Main Category

The main category that emerged from the findings was that a lack of reproductive agency in facility-based births makes home births a first choice regardless of potential risks and medical needs. Women wish to exercise intentionality in their roles as wife and mother by choosing the environment when giving birth which best suits their needs and preferences as illustrated below. The organization of the results is presented in Table 3. A detailed description of the results is given under the headings and subheadings of the content areas and the generic categories.

Facility-Based Birth and Care

Searching for safety

- needing specific medical competence

The women who had had a facility-based birth had chosen this process because they knew that healthcare professionals were competent and skilled at obstetric emergencies. The women in this study were aware of the local maternity services available to them and appreciated the difference in function, competency, and

capability between a healthcare professional at a health facility and a TBA. A facility-based birth, however, was only ever a second choice, selected when a TBA was not easily accessible, busy, or away when the woman went into labor:

"I delivered in the health facility. I started labor pains one day when I was alone, so I tried to seek a TBA as the first choice for a homebirth, but she was not present at that time, so as a second choice I saw a taxi driver that I knew, and I went to the health facility to give birth and, soon after I arrived at the health facility, I gave birth. All my family came to the health facility later." (Case 5)

Several women described how their experiences of care at a health facility had led them to decide to have their subsequent birth at home rather than at a facility. Choosing a facility-based birth was based on the desire to have an experienced midwife present while giving birth. Experiences of care at a health facility, however, prompted women decision to intentionally choose a home birth as their subsequent place of birth.

- using health education and examination results for guidance

Most of the women in this study had some form of antenatal care at a health facility, as part of the general measures in place in Somaliland designed to protect women's health during pregnancy. The women described how most of the healthcare professionals working at the health facilities provided them with general health messages, explained some dietary requirements, and encouraged them to take medicine that would protect their health. The antenatal healthcare professionals provided them with assessments and a screening service. Based on the results of these tests, although it was not verbalized at the appointment with the health care professional, the women considered their specific circumstances and planned their place of birth:

"I attended antenatal care, and they told me that I am normal and that my blood is fine...So, I thought if the baby is in a normal position, I could have the baby at home. That was why I decided to give birth at home." (Case 18)

However, even women who had had previous high-risk pregnancies that suggested they should be returnees to facility-based care, were still intentionally planning for a home birth, despite the evidence from their assessments and advice from healthcare professionals. Their strategy was that if they experienced abnormalities or emergencies at a homebirth, they would then decide to utilize the maternity services at the health facility. One participant said: *"The health facility is better when you face complications. There are trained healthcare professionals who manage your condition. There is care available that you cannot get at home." (Case 5)*

Being Met with Disrespect

- experiencing verbal abuse

One woman who had experienced a complicated birth in a health facility said she felt medically safe although she was verbally abused.

The women expressed disappointment with the quality of the health education, information, and advice they received from the healthcare professionals at the health facility. For example, pre-eclampsia was a prominent condition which the women in this study knew was one of the leading causes of maternal deaths.

They found it careless of the healthcare professionals to simply diagnose high blood pressure and then fail to advise and explain the effects pre-eclampsia could have on labor if left untreated:

"The healthcare professionals did not give me any health education or advice on how to manage my high blood pressure, but they measured my blood pressure and prescribed medication, and I bought my medication and used it regularly." (Case 3)

TBA Supported Home-Delivery

Preferring a trusting environment

- being a constant presence

According to the interviewees, TBAs supported women emotionally throughout their labor. The women valued this support a great deal and it motivated them to choose a homebirth. One of the study participants recalled:

"My TBA was always my supporter and although I delivered at home, she has always been available to me every minute of the birth she was with me. She never left my side and always asked me what I needed. She read something and stayed by my bedside all night. I felt her efforts to care for me the best she could." (Case 10)

TBAs providing accessible, individualized and respectful care, often lived nearby, either on the same street or in the same village.

- sharing values and cultural understanding

The participants felt that their TBAs shared the same values as they did and thus recognized the importance of dignity and understanding during the birthing process. The TBAs understood that they were a guest in the woman's own home and that, above all else, their care needed to reflect the woman's needs. One participant said: *"Home and hospital birth are completely different. Women search for normality, someone that assists you, who is kind and keeps your dignity intact." (Case 4)*

TBAs also expected to be paid for their services although their fee was lower than that of a health facility, and they often took the woman's financial situation into account. One woman pointed out that: *"The TBA took a lower price for the birth than at the health facility. The hospitals have a fixed price." (Case 6)*

During the interviews, the women talked at length about the importance they placed on respect and privacy during labor.

Feeling Empowered and Valued

- being encouraged to take responsibility

The participants stated that during their homebirth the TBAs

encouraged them to listen and trust their bodies. This made the women feel empowered and in control of the events during their labor. They also appreciated the privacy of being in labor at home where they were able to take care of their other children. This expression of responsibility greatly reduced their anxiety and stress levels. One woman explain

- appreciating the TBAs "background" role

TBAs were able to practice 'expectant management'. They were present, but in the background, watching the labor process, but allowing it to proceed on its own terms. The woman felt their TBA made them feel relaxed and empowered and did not rush or force the birthing process. The women thought that the healthcare professionals and TBAs had complementary roles and expertise. They felt greater collaboration between healthcare providers and TBAs could possibly improve maternity services in Somaliland. According to the women in this study, facility-based births disrupt family life because it forces them to be away from their children and the supportive and familiar environment of their home. Homebirths make all these concerns easy to manage:

"It was my home and not a hospital. I slept in my warm bed at home but in the health facility, it is possible you feel cold and moist after childbirth. I slept with my baby, I got relaxed, and I had all the other children with me in my home." (Case 4)

Homebirths were described as a first choice because of the knowledge the women had from their previous experiences of care, and their ability to compare and rank those experiences according to their own values and intentions.

Discussion

The results show that women perceived a lack of reproductive agency in facility-based births makes home births a first choice regardless of potential risks and medical needs. The fact that women felt empowered and in control in a home birth setting needs to be acknowledged, and these factors are important moving forward to improve the quality of maternal and newborn care in health facilities in accordance with WHO standards [27] and the QMNC framework (16).

A heavy workload for trained healthcare professionals with only minimal pay and the obligation to introduce complex and unfamiliar professional standards has the potential to create a culture and environment which are not always able to support a positive attitude towards women and their babies [28, 29]. In this study, women simultaneously acknowledged the important work healthcare professionals did when treating maternal health emergencies at the health facility, yet consistently stated their preference for the caring values of a TBA for a normal labor and birth. As suggested by the QMNC framework, engaging with community, in this case through TBAs, in a midwife-led continuity of care model is an important element of an ideal care philosophy [16]. Altering maternal and child health clinics into midwife-led continuity of care models has been suggested as a component of

birth preparedness and complication readiness for women in hard-to-reach areas [30]. For this philosophy to be realized, the number of midwives educated to global standards with the ability to provide holistic care within their local communities needs to be increased [31]. Our findings from Somaliland are supported by a growing literature that describes TBAs as a vital link between women and the healthcare professionals in their local maternity services [32]. A recent WHO report has shown that using shared values about birth, such as those expressed by women and TBAs, has been identified as a way to improve maternal and newborn health [33]. The WHO has also emphasized the importance of creating new roles and responsibilities for TBAs that link them to the formal healthcare system [34]. This is supported by a study that suggests TBAs could use their competence as a doula to provide cultural and psychosocial support during pregnancy and childbirth in Somaliland [35]. Another intervention, one supporting the results of this study, would be to provide healthcare professionals with training in respectful maternity care. This has been suggested in a review reporting that the maternity care healthcare professionals provide should be communicated to women and their families in a way that allows for planning, gives women the opportunity to choose, encourages them to ask questions, and is willing to disclose treatment results appropriately [36].

This study showed that healthcare professionals could have provided better health education and information to women at their antenatal check-ups, better informed them of the risks involved in pregnancy and birth, and offered them a better discussion of their birthing options. Such advice is especially important in fragile contexts like Somaliland. Women, like those in this study, are frequently obliged to carry out their own risk assessments and determine their own intentions during pregnancy. They are expected to interpret their own antenatal care assessments and, as a result, to determine for themselves their place of birth. Advice from trained health professionals communicated to them in a sensitive and collaborative way is crucial to achieve quality of care and to meet the need for a caring and convenient birth experience [27].

Midwives educated and trained according to ICM global standards, working in functional health systems and enabling environments can help reduce and prevent a majority of maternal and newborn deaths, and provide over 80 per cent of essential sexual, reproductive, maternal, and new-born health services [17]. However, there is a lack of midwives in many low-resource settings, and important investments are needed to educate midwives, build their capacity to do research within their field, and take on leadership roles. They are the group with whom TBAs should work most closely in order to close the gap between home and facility-based births and assure responsive, relational, cost-effective, and patient-centred care [16].

Midwives are the key to establish and assure that midwife-led continuity of care models are implemented and scaled up [18]. It would be beneficial to further understand the roles of midwives in the Somaliland health systems to identify the core contextual factors within political and health systems that act as barriers

or facilitators[37] in order to scale up access to high quality and acceptable maternal and new-born health care for women. Midwives competencies and capacity should be utilized at all levels in the health system using a multipronged approach improving leadership and management to develop and sustain midwife-led continuity of care models [38].

According to Yu et al. [31], the well-functioning midwife-led birthing centers studied in Australia result in significantly lower intervention rates, greater feelings of reproductive agency, and lower health system costs than carrying out normal births in hospitals, while avoiding some of the risks inherent in home births. Australia and Somaliland are obviously very different [39], but a similar study examining the specific circumstances of introducing midwife-led continuity of care in public health facilities in Somaliland would be informative, especially if carried out in combination with an investigation of the different functions and roles midwives and TBAs occupy, and how they could use their respective abilities to provide quality care for women and newborns. Addressing these challenges could encourage women to more willingly consider facility-based births, which would reduce adverse maternal and newborn health outcomes locally and globally.

Strengths and limitations

This study captures the preferences of women in Somaliland when choosing their place of birth and why they chose to give birth at a health facility assisted by a healthcare professional or at home assisted by a TBA. Our preconceptions as midwives may have shaped our understanding in the analysis. By using the content analysis method with all authors involved in the analysis process, we aimed to provide confidence to the reader of the reliability of the findings [25, 39]. The key strength of this study was therefore the research process and the personal interviews which gave voice to some of Somaliland's women. It is the first study of its kind in the Somaliland region and provides vital insights into women's choice of place of birth.

Despite the high credibility of its findings [25, 38], this study has a series of limitations that affect its transferability. Transferability refers to whether the findings have applicability in other contexts [25, 40]. The findings in this study have been confirmed in other studies in the field. This strengthens dependability [25, 40], showing that the findings are consistent. The main limitation of this study is that multipara women might, because of their age and experience, be more intentional than younger and less experienced primipara women when choosing their place of birth. This is evident in a previous health survey [41] that shows how agency with regards to women's sexual and reproductive health decisions seem to increase with age and childbirth. Women's choices of place of birth are influenced by many personal, social, and healthcare service factors. The findings of this study might thus be shaped by the participants' age, parity, knowledge, and experience. In addition, the financial status of the women might have influenced their choices [42]. Because women in our study were from a relatively poor socio-demographic background, they might have been more inclined to choose a home birth because of financial considerations.

The findings outlined here, therefore, should be transferred with caution to primipara women or women from secure economic backgrounds. Further research is needed to define and test a context specific midwife-led continuity of care model to be scaled up at public health facilities.

The function and role of TBAs and the possibility of linking TBAs more closely to the healthcare system, and possible barriers to such a development, are further suggested. Above all else, this research should be carried out within the framework of a long-term sustainable plan to assure quality and equal access to maternal healthcare in Somaliland based on the WHO standards for improving maternal and newborn quality of care in health facilities [27]. Even if there is existing literature examining women's choice of place for delivery [7, 10, 11, 14], this is one of the few studies coming from a fragile post-conflict setting.

Conclusion and implications

To meet women's needs and preferences in Somaliland, further investments are needed to strengthen the midwifery profession and to define and test a context specific midwife-led continuity of care model to be scaled up at public health facilities. A dialogue to create new roles and responsibilities for the TBAs who attend most home births is further needed to link them to the formal healthcare system and assure timely healthcare seeking during pregnancy and birth.

The implications of this study are to:

- increase the number of midwives, strengthen their role in midwife-led continuity of care models, and better organize and integrate them into the maternity care system at all levels
- provide healthcare professionals with a training package on respectful maternity care that would help to end the mistreatment of women in maternity services
- use context specific, scientific evidence as a foundation to develop a policy on quality maternity care for the Somaliland maternity services to be used in political decision making and investments.

End materials

Acknowledgements

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Ethics and consent

Ethics and consent procedure details are documented in the manuscript. Ethical clearance to conduct the study was obtained first from the Somaliland Ministry of Health and Development and second from the research ethics committee of the University of Hargeisa. Approval number Dr: CS/41105/18

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Table 1. Participants' sociodemographic information

| | |
|--------------------------|--------------|
| Female participants | N=25 |
| Age | 22-38 (M=31) |
| Marital status | |
| Married | 24 |
| Separated | 1 |
| Educational level | |
| Illiterate | 12 |
| Primary school | 2 |
| Intermediate | 4 |
| Lower secondary | 3 |
| Quran school | 4 |
| Occupation | |
| Housewife | 23 |
| Employed | 2 |

Table 2. Example of the analytical process

| Content areas | Text parts, sentences, or small paragraphs | Codes | Sub-categories | Generic categories | Main category |
|-------------------------------|---|---|---------------------------|-----------------------------------|---|
| Facility-based birth and care | <i>"The young healthcare professional spoke to me in bad words."</i> (Case 4) | Disrespectful care | Experiencing verbal abuse | Being met with disrespect | A lack of reproductive agency in facility-based births makes home births a first choice regardless of potential risks and medical needs |
| TBA supported home-delivery | <i>"Xalimo [her TBA] was very caring for me and my children. She checked on me regularly and encouraged me to listen to my body and to let her know how I feel whenever I needed something."</i> (Case 1) | TBAs referring complications to health facilities | Being a constant presence | Preferring a trusting environment | |

Table 3. Content areas, categories and sub-categories, and overarching main category of the results

| Content areas | Generic categories & sub-categories | Main category |
|-------------------------------|--|---|
| Facility-based birth and care | <p>Searching for safety</p> <ul style="list-style-type: none"> needing specific medical competence using health education and examination results for guidance <p>Being met with disrespect</p> <ul style="list-style-type: none"> experiencing verbal abuse having it told, not explained | A lack of reproductive agency in facility-based births makes home births a first choice regardless of potential risks and medical needs |
| TBA supported home birth | <p>Preferring a trusting environment</p> <ul style="list-style-type: none"> being a constant presence sharing values and cultural understanding relying on TBAs to make referrals if needed <p>Feeling empowered and valued</p> <ul style="list-style-type: none"> being encouraged to take responsibility appreciating the TBAs' "background" role | |

THE IMPORTANCE OF NURSES AND MIDWIVES PARTICIPATION IN HEALTH SERVICE MANAGEMENT AND POLICY MAKING.



INTRODUCTION.

Nurses and midwives make up the largest proportion of the health workforce, providing expert, skilled care to the population in Somaliland and play a key role in the successful delivery of health services.

Health Sector Reform is a sustained process of fundamental change in policies and institutional arrangements of the health sector, usually guided by the government. Any meaningful reform process ought to be based on evidence and information about the current state of affairs, and potential effect of alternative policy choices.

(<https://www.nhpcsomaliland.org/documents>)

Somaliland being a striving self-declared independent country which is trying to develop the health sector, it is timely to look at how nurses and midwives are developing their professional roles and determine their contribution and importance to health service development, delivery and policy making.

The Nurses and Midwives also take part in services delivery in different sectors like the Ministry of health and development, hospitals and MCH's. The Nurses and Midwives are encouraged to participate in National stakeholder's conferences and meetings

that enact policy for the health care development. Their also encouraged to participate in management and lead in the Ministry's, regional offices, hospital management, MCH's, NGO'S, INGO'S and educational institutions. This will make the health care service delivery better and this displays the roles of Nurses and Midwives in the health sector and it's a motivational factor for the upcoming Nurses and Midwives.

CONCLUSION.

Nurses and Midwives have broad influence in health care participation and policies. With a common understanding of nurses and Midwives policy influence as a concept, nurses will recognize the importance of participation on policy making in the health sector and their influence on this process and also on health care delivery outcomes.

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ANXIETY DURING PREGNANCY



Anxiety is feelings of worry, stress or fear, and is a normal part of life. However, if these feelings are persistent and strong enough to interfere with your daily life, this may be an anxiety disorder, a type of mood disorder.

Feeling anxious while pregnant is completely normal. It's natural to worry about whether your baby is healthy, have fears about being a good parent, or stress about how your relationship with your partner will change. The changes in your hormone levels that come with pregnancy can also affect your mood and emotions, making you more prone to worry and stress. However, there is a difference between normal worries and a more serious anxiety disorder during pregnancy, also called *antenatal anxiety*.

Prevalence of Anxiety during Pregnancy Happen

Antenatal anxiety is a very common experience. More than 1 in 10 women experience anxiety at some point during their pregnancy.

Signs and Symptoms of Anxiety during Pregnancy

The following are symptoms of more serious anxiety during pregnancy:

- Experiencing a frequent sense of panic, fear or restlessness
- An inability to concentrate on your day-to-day life
- Trouble functioning at work or home
- Having obsessive thoughts
- Not enjoying things that used to make you happy
- Heart palpitations
- Muscle tension
- Worrying excessively about things, especially your health or your baby
- Feeling afraid, or thinking that bad things will happen
- Difficulty sleeping
- Shortness of breath
- Excessive sweating

Risk factors of Anxiety during Pregnancy

- A previous diagnosis of an anxiety disorder, panic attacks, or depression
- A family history of mood disorders or panic attacks
- Anxiety during a past pregnancy
- Previous pregnancy loss or fertility struggles
- Complications during pregnancy
- Stress at home or work
- History of abuse or trauma
- Stressful life events, like the death or illness of a loved one
- Lack of a partner or social support during pregnancy
- Relationship problems, including domestic violence

Treatment of anxiety during pregnancy

Mild cases of anxiety during pregnancy typically don't require specific treatment. However, if symptoms become severe, treatments include

- **Psychoeducation** is important in the early stages and during diagnosis, to help reduce denial and stigma and lead to successful treatment.
- **Therapy** such as cognitive-behavioral therapy (CBT) is most often used on its own in mild cases or in combination with medication in more severe cases.
- **Medication** may be used in more severe cases. Typically a selective serotonin reuptake inhibitor (SSRI) (e.g., Prozac, Lexapro) would be prescribed. Benzodiazepines may be used for the short-term management of anxiety.
- **Support** is also an important component of coping. Seek out support from family, friends, and the community to help you cope.

Some other changes that may help manage anxiety symptoms include:

- **Exercise:** Exercise is a natural way to increase serotonin levels and decrease cortisol levels.
- **Eating a healthy diet:** Many foods have been shown to affect mood, the ability to handle stress, and focus. Avoid Caffeine, sugar, processed carbohydrates, artificial additives and lack of protein because they negatively affect your mental and physical health.
- **Get enough sleep:** A lack of sleep can greatly affect the body's and mind's ability to handle stress and cope with day-to-day challenges. Although anxiety can affect your ability to sleep, try to establish a sleep schedule routine so you go to sleep and get up at the same time each day.
- **Deep breathing exercise:** Deep breathing practices can help your body release endorphins without working up a sweat. It is recommended to do deep abdominal breathing for 20 to 30 minutes daily to help with anxiety. It will help provide more oxygen to your brain and stimulate your nervous system.

When to see Doctor

If your anxiety is affecting your daily life or if you're having frequent panic attacks, you should call your doctor right away. Only they can diagnose you with an anxiety disorder and recommend the best, most effective treatment options for you. Seeking help is the best step you can take to ensuring that you and your child stay safe and healthy.

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ANEMIA DURING PREGNANCY



Introduction.

When you're pregnant, you may develop anemia. When you have anemia, your blood doesn't have enough healthy red blood cells to carry oxygen to your tissues and to your baby.

During pregnancy, your body produces more blood to support the growth of your baby. If you're not getting enough iron or certain other nutrients, your body might not be able to produce the amount of red blood cells it needs to make this additional blood.

Anemia can leave you feeling tired and weak. If it is severe but goes untreated, it can increase your risk of serious complications like preterm delivery.

Anemia during pregnancy is one of the important factors associated with a number of maternal and foetal complications. It decreases the woman's reserve to tolerate bleeding either during or after child birth and makes prone to infections. Anemia during pregnancy also has been associated with increased risk of intra uterine growth restriction, premature delivery, low birth weight (LBW) and maternal and child mortality.

World Health Organization (WHO)/World Health Statistics data shows that 40.1% of pregnant women worldwide were anemic in 2016.

Types of Anemia During Pregnancy

Several types of anemia can develop during pregnancy. These include:

- Iron-deficiency anemia
- Folate-deficiency anemia
- Vitamin B12 deficiency
-

Here's why these types of anemia may develop:

Iron-deficiency anemia. This type of anemia occurs when the body doesn't have enough iron to produce adequate amounts of hemoglobin. That's a protein in red blood cells. It carries oxygen from the lungs to the rest of the body.

Iron deficiency Is the most common cause of anemia in pregnancy

Folate-deficiency anemia. Folate is the vitamin found naturally in certain foods like green leafy vegetables A type of B vitamin, the body needs folate to produce new cells, including healthy red blood cells. During pregnancy, women need extra folate. But sometimes they don't get enough from their diet. When that happens, the body can't make enough normal red blood cells to transport oxygen to tissues throughout the body. Man-made supplements of folate are called folic acid.

Folate deficiency can directly contribute to certain types of birth defects, such as neural tube abnormalities (spina bifida) and low birth weight.

Vitamin B12 deficiency. The body needs vitamin B12 to form healthy red blood cells. When a pregnant woman doesn't get enough vitamin B12 from their diet, their body can't produce enough healthy red blood cells. Women who don't eat meat, poultry, dairy products, and eggs have a greater risk of developing vitamin B12 deficiency, which may contribute to birth defects, such as neural tube abnormalities, and could lead to preterm labor.

The most common causes of anemia include

- nutritional deficiencies
- APH
- deficiencies in folate, vitamins B12
- haemoglobinopathies
- some infectious diseases, such as malaria, tuberculosis, HIV and parasitic infections.
- Blood loss during and after delivery can also cause anemia.

Risk Factors for Anemia in Pregnancy

All pregnant women are at risk for becoming anemic. That's because they need more iron and folic acid than usual. But the risk is higher if you:

- Are pregnant with multiples (more than one child)
- Have had two pregnancies close together
- Vomit a lot because of morning sickness
- Are a pregnant teenager

- Don't eat enough foods that are rich in iron
- Had anemia before you became pregnant

Symptoms of Anemia During Pregnancy

The most common symptoms of anemia during pregnancy are:

- Pale skin, lips, and nails
- Feeling tired or weak
- Dizziness
- Shortness of breath
- Rapid heartbeat
- Trouble concentrating

Risks of Anemia in Pregnancy

Severe or untreated iron-deficiency anemia during pregnancy can increase your risk of having:

- A preterm or low-birth-weight baby
- A blood transfusion (if you lose a significant amount of blood during delivery)
- Postpartum depression
- A baby with anemia
- A child with developmental delays

Untreated folate deficiency can increase your risk of having a:

- Preterm or low-birth-weight baby
- Baby with a serious birth defect of the spine or brain (neural tube defects)

Untreated vitamin B12 deficiency can also raise your risk of having a baby with neural tube defects.

Treatment for Anemia.

If you are anemic during your pregnancy, you may need to start taking an iron supplement and/or folic acid supplement in addition to your prenatal vitamins. Your doctor may also suggest that you add more foods that are high in iron and folic acid to your diet. Also recommend that you include more animal foods in your diet, such as:

- meat
- eggs
- dairy products
- blood transfusion if a complication



Preventing Anemia.

To prevent anemia during pregnancy, make sure you get enough iron. Eat well-balanced meals and add more foods that are high in iron to your diet.

Aim for at least three servings a day of iron-rich foods, such as:

- Lean red meat, poultry, and fish
- leafy, dark green vegetables (such as spinach, broccoli, and kale)
- iron-enriched cereals and grains
- beans, lentils, and tofu
- nuts and seeds
- eggs

Recommendation.

- Increasing iron intake
- Increasing folate intake
- Maximizing iron absorption
- Taking iron supplements
- Early hemoglobin checkup
- Increasing water drink

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CHILD MARRIAGE IN SOMALILAND: A Silent Health & Human Rights Issue

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Abstract

Marriages in which a child under the age of 18 years is involved occur worldwide, but are mainly seen in South Asia, Africa, and Latin America. A human rights violation, child marriage directly impacts girls' education, health, psychological well-being, and the health of their offspring. It increases the risk for depression, sexually transmitted infection, cervical cancer, malaria, obstetric fistulas, and maternal mortality. Their offspring are at an increased risk for premature birth and, subsequently, neonatal or infant death. The tradition, driven by poverty, is perpetuated to ensure girls' financial futures and to reinforce social ties. One of the most effective methods of reducing child marriage and its health consequences is mandating that girls stay in school.

Key words: *Child marriage, early marriage, maternal mortality*

1. Background and introduction:

1.1. Background

Child marriage, defined as marriage of a child under 18 years of age, is a silent and yet widespread practice. Today, over 60 million marriages include girls under the age of 18 years: approximately 31 million in South Asia, 14 million in sub-Saharan Africa, and 6.6 million in Latin America and the Caribbean. Each day, 25,000 girls are married and an anticipated 100 million girls will be married in 2012. Over 60% of girls are married under the age of 18 in some sub-Saharan countries and Bangladesh, and 40% to 60% of girls undergo child marriage in India.

The United Nations and other international agencies have declared that child marriage violates human rights and children's rights. The Universal Declaration of Human Rights states that individuals must enter marriage freely with full consent and must be at full age. In 1979, the Convention on the Elimination of All Forms of Discrimination Against Women stated that child marriage is illegal. In 1989, the Convention on the Rights of the Child defined children as

persons under the age of 18 years. Many countries passed laws changing the legal age of marriage to 18 years, but enforcement of these laws, and of laws requiring marriages to be registered, is weak.⁵ For example, although the legal age of marriage is 18 years, in Mali 65% of girls are married at a younger age; in Mozambique, it is 57%; and in India, it is 50%. In some parts of Ethiopia, although the legal age of marriage is 15 years, 50% of younger girls are married, and in Mali, 39% of younger girls are married. Furthermore, in some regions, an arranged marriage occurs at birth.⁶

1.2. Introduction:

1.2.1 Factors Driving Child Marriage

Three main forces drive child marriages:

A Poverty : the need to reinforce social ties, and the belief that it offers protection. Child marriage is predominantly seen in areas of poverty. Parents are faced with 2 economic incentives: to ensure their daughter's financial security and to reduce the economic burden daughters place on the family.

Child marriage is first and foremost a product of sheer economic need. Girls are costly to feed, clothe, and educate, and they eventually leave the household. Marriage brings a dowry to the bride's family. The younger the girl, the higher the dowry, and the sooner the economic burden of raising the girl is lifted.

By marrying their daughter to a "good" family, parents also establish social ties between tribes or clans and improve their social status. Parents also believe that marrying their daughters young protects them from rape, premarital sexual activity, unintended pregnancies, and sexually transmitted infections, especially human immunodeficiency virus (HIV) and AIDS.⁵

2. Results:

2.1. Health Consequences of Child Marriage

2.2.1 Isolation and Depression

Once married, girls are taken to their husband's household, where they assume the role of wife, domestic worker, and, eventually, mother. These new homes can be in a different village or town. Because of the high dowry paid, husbands are usually much older than the girls (and thus have little in common with them) and their new brides are expected to reproduce. Polygamy may also be acceptable in some of these regions. As a result, the girls feel rejected, isolated, and depressed. Some girls realize that survival requires embracing their new environment and proving their fertility. They lose their childhood and miss the opportunity to play, develop friendships, and be educated.

2.2.2 Risk of Sexually Transmitted Infection and Cervical Cancer

Parents believe that marrying their daughters early protects them from HIV/AIDS. Research has shown the opposite: marriage by the age of 20 years is a risk factor for HIV infection in girls.⁷ In Kenya, married girls are 50% more likely than unmarried girls to become infected with HIV. In Zambia, the risk is even higher (59%). And in Uganda, the HIV prevalence rate of married girls and single girls between the ages of 15 and 19 years is 89% and 66%, respectively. Their husbands infected these girls. Because the girls try to prove their fertility, they had high-frequency, unprotected intercourse with their husbands. Their older husbands had prior sexual partners or were polygamous. In addition, the girls' virginal status and physical immaturity increase the risk of HIV transmission secondary to hymenal, vaginal, or cervical lacerations. Other sexually transmitted infections, such as herpes simplex virus type 2, gonorrhea, and chlamydia, are also more frequently transmitted and enhance the girls' vulnerability to HIV. Research demonstrates that child marriage also increases the risk of human papillomavirus transmission and cervical cancer.

2.2.3 Risks During Pregnancy

Pregnant girls in malaria regions were found to be at higher risk for infection. Of the 10.5 million girls and women who become infected with malaria, 50% die. Their highest risk is during their first pregnancy. Pregnancy not only increases the risk of acquiring malaria, but pregnant girls under the age of 19 have a significantly higher malaria density than pregnant women over the age of 19.⁹ They are also at significant risk of malaria-related complications such as severe anemia, pulmonary edema, and hypoglycemia.

Rates of HIV and malaria coinfection are highest in Central African Republic, Malawi, Mozambique, Zambia, and Zimbabwe, where more than 90% of the population is exposed to malaria and more than 10% are HIV positive. Having both diseases complicates the management and treatment of each. HIV-infected patients have a higher likelihood of getting a more severe form of the malaria parasite, *Plasmodium falciparum*. They are less likely to respond as well to antimalarial medication. Malaria increases HIV viral load and increases the mother-to-child HIV transmission rate. Data demonstrate that the combination of these diseases proves deadly to the young pregnant mother.

2.2.4 Risks During Labor and Delivery

Deliveries from child marriages are "too soon, too close, too many, or too late."¹¹ Forty-five percent of girls in Mali, 42% in Uganda, and 25% in Ethiopia have given birth by the age of 18. In Western nations, the rates are 1% in Germany, 2% in France, and 10% in the United States. Girls between the ages of 10 and 14 years are 5 to 7 times more likely to die in childbirth; girls between the ages of 15 and 19 years are twice as likely. High death rates are secondary to eclampsia, postpartum hemorrhage, sepsis, HIV infection, malaria, and obstructed labor. Girls aged 10 to 15 years have small pelvises and are not ready for childbearing. Their risk for obstetric fistula is 88%.

2.2.5 Risks for Infants

Mothers under the age of 18 have a 35% to 55% higher risk of delivering a preterm or low-birthweight infant than mothers older than 19 years. The infant mortality rate is 60% higher when the mother is under the age of 18 years. Data demonstrate that even after surviving the first year, children younger than 5 years had a 28% higher mortality rate in the young mothers cohort. This morbidity and mortality is due to the young mothers' poor nutrition, physical and emotional immaturity, lack of access to social and reproductive services, and higher risk for infectious diseases.

3. Conclusions:

- Over 60 million marriages include a girl under the age of 18 years.
- The main forces that drive child marriage are poverty, the need to reinforce social ties, and the belief that marriage at an early age protects girls from rape, unintended pregnancy, and sexually transmitted infection.
- Marriage before the age of 18 increases the rate of human immunodeficiency virus (HIV) infection in girls.
- High death rates during pregnancy are secondary to eclampsia, postpartum hemorrhage, sepsis, HIV infections, and obstructed labor. The infant mortality rate is 60% higher when the mother is under the age of 18 years.
- Education not only delays marriage, pregnancy, and childbearing, but school-based sex education can be effective in changing the awareness, attitudes, and practices leading to risky sexual behavior in marriage.

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HEALTH JOURNEY OF CURABLE POSTPARTUM HEMORRHAGE

IN 25 YEARS OLD LEADS TO IRREVERSIBLE KIDNEY FAILURE FROM RELATIVE WITH HEALTHCARE BACKGROUND



Past Medical History

The unfortunate situations here in Somaliland are the lack of accurate health and medical history due to either lack of healthcare facilities in rural areas, or the lack of finances to fund a trip to the city to seek medical support. Hoodo Osman is a 25 years old young mother of 4 with 2 stillbirths, she lived in a rural place as a wife of a shepherd with low income. She was married at the age of 17, had her first child at 18 years old with no health complication during her pregnancy and delivery. Things changed with her second pregnancy where she had a kidney infection which she had got treatment for but still had massive swellings and generalized edema that continued till her delivery time of her 1st still birth. For the next 3 deliveries she had a child every year, keep in mind she had no medical attention at all, as the nearest MCH is hours away.

In the mid of January 2019 Hoodo gave birth to her 2nd still birth, but had massive bleeding that continued for hours alongside generalized edema. Her husband decided to not seek medical attention and to wait for 48hrs, after her conditions had not improved she was admitted to Burco General Hospital.

Upon admission her swellings and low hemoglobin was addressed first with blood transfusions, IV fluid resuscitation and antibiotics. Unfortunately her oliguria state was not noticed till day 2 where diuretics were given without any result. At that time her constant nausea, vomiting, and anuric state got us in Hargeisa worried so we asked for an electrolyte panel, which showed hyperkalemia at 7.5 mEq/L and elevated urea and creatinine. Despite Burco hospital having a dialysis unit they were uninterested to treat her and asked the family to take her to Hargeisa.

In Hargeisa General Hospital she was treated with IV medication in a gynecology ward by the nephrologist who was consulted after the family demanded admission and urgent treatment. The dialysis was commenced the next day (12 hrs from admission) for 3 days consecutively, unfortunately ascites with generalized edema was present due to hypoalbuminemia was an initial issue that was taking weeks to treat, but the one persistent issue was uncontrolled hypertension which for the next 3 months led to a left ventricular failure.

Hemodialysis 3 times per week was the norm schedule for Hoodo, as her kidney function showed chronic renal failure the other option

was kidney transplant from an immediate sibling or partner or life time of dialysis. So as there were no volunteers for the transplant despite funds being prepared by the extended family, the decision was to have a AV fistula put in as a dialysis access point.

The sepsis journey started from the first month being on dialysis and the patient was put on multiple antibiotics regimen without good outcome, this led to a septic shock that led to multi organ failure and for the first time severe hypotension. The low BP prevented good dialysis for a week which unfortunately was followed by cardiac arrest.

Reasons for how a manageable reversible disease lead to the mortality of a young mom

| | | |
|--|---|---|
| 1. Lack of prenatal care in rural area | 2. Lack of finance support to seek medical help for the poor class of the community | 3. Lack of community health education and health promotion |
| 4. Cultural belief in how invasive procedures are fatal and not necessary | 5. The poor referral systems from one health center or a city to specialist centers | 6. The appalling laboratory result system being collected and retained by family members instead of having it sent to the health professional who can read and analyze it |
| 7. The clash between family planning and contraceptive methods which are frowned at and considered as challenging to God's plan. | 8. The cultural outlook at seeking medical help once symptoms emerges till people lose their conscious or got worse | 9. Religious belief that being ill washes sins off which is good in community belief |
| 10. Communication failure between healthcare professional and poor uneducated people which leads to conflicts and sometimes physical/verbal aggression | 11. Poor staffing of critical care areas with trained staff | 12. Constant transporting patient for radiology or referral privately by the patient family who aren't trained to do so |

For me as an experienced nurse and carer for the patient who was there everyday in Hargeisa part:

1. I was shocked by the health system in general being money driven (if you can not pay you can not be treated, except in rare cases where an NGO/Government pays for it).

2. Also I had seen acute renal failure that was prevented from progressing to a chronic renal failure. I had known patients who lived for years on dialysis, so when a young 25 years old dies within 3 months of diagnosis it was a shock.

3. The fact that the dialysis unit machines are old and the solutions that they use are not doing the job as it did accelerate the disease's progress.

4. I noticed the lack of handwashing between patients in general wards which leads to susceptibility to hospital acquired infections like MRSA which is fatal at times.

5. Lack of a unified treatment for hypertension from 3 cardiologists and different ECHO results which were contradicting, which confuses families on whom to believe

6. The presence of only 2 dialysis centers in Somaliland, and one AV fistula surgery center in Borama.

7. Healthcare professional attitudes when questioned about their treatment plan by family can lead to conflicts and sometimes patient care being sidelined due to pride.

8. Lack of potent medications in hospital pharmacy which leads to worsening of disease symptoms

9. Absence of nutritionist role in hospital staff to aide patient adjust their diet and get access to nutritional supplements as alternative if needed

10. Poor quality of invasive lines which are bought from black market by the hospital

11. Absence of regular physician-patient meetings to review the case unless the morbidity is expected

12. Blood transfusion system here relies on family and friends blood donation (only male can donate), which is fine unless there is an emergency this would be catastrophic if there are no donors or the blood type is rare.

In conclusion I believe if it wasn't for me and my sister's profession and experience my cousin would have had a shorter life span but if I knew what I know now I would have transferred the patient to be with her kids around the 2 months mark in her dialysis journey to die peacefully with them.

Hope this was insightful and useful it was hard revisiting it though.

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INTIMATE PARTNER VIOLENCE

Intimate partner violence (IPV) is a significant yet preventable public health problem that affects millions of women regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background. Individuals who are subjected to IPV may have lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death. Although women of all ages may experience IPV, it is most prevalent among women of reproductive age and contributes to gynecologic disorders, pregnancy complications, and sexually transmitted infections, including human immunodeficiency virus (HIV). Obstetrician-gynecologists are in a unique position to assess and provide support for women who experience IPV because of the nature of the patient-physician relationship and the many opportunities for intervention that occur during the course of pregnancy, annual examinations, and other women's health visits.

Intimate partner violence encompasses subjection of a partner to physical abuse, psychological abuse, sexual violence, and reproductive coercion. Physical abuse can include throwing objects, pushing, kicking, biting, slapping, strangling, hitting, beating, threatening with any form of weapon, or using a weapon. Psychological abuse erodes a woman's sense of self-worth and can include harassment; verbal abuse such as name calling, degradation, and blaming; threats; stalking; and isolation.

Often, the abuser progressively isolates the woman from family and friends and may deprive her of food, money, transportation, and access to health care. Sexual violence includes a continuum of sexual activity that covers unwanted kissing, touching, or fondling; sexual coercion; and rape. Reproductive coercion involves behavior in a relationship related to reproductive health and can occur in the absence of physical or sexual violence. A partner may sabotage efforts at contraception, refuse to practice safe sex, intentionally expose a partner to a sexually transmitted infection (STI) or human immunodeficiency virus (HIV), control the outcome of a pregnancy (by forcing the woman to continue the pregnancy or to have an abortion or to injure her in a way to cause a miscarriage), forbid sterilization, or control access to other reproductive health services.

Consequences of Intimate Partner Violence

Some women subjected to IPV present with acute injuries to the head, face, breasts, abdomen, genitalia, or reproductive system, whereas others have non-acute presentations of abuse such as reports of chronic headaches, sleep and appetite disturbances, palpitations, chronic pelvic pain, urinary frequency or urgency, irritable bowel syndrome, sexual dysfunction, abdominal symptoms, and recurrent vaginal infections. These non-acute symptoms often represent clinical manifestations of internalized stress (ie, somatization). This stress can lead to posttraumatic

stress disorder, which is often associated with depression, anxiety disorders, substance abuse, and suicide.

Although more research is needed, IPV has been associated with poor pregnancy weight gain, infection, anemia, tobacco use, stillbirth, pelvic fracture, placental abruption, fetal injury, preterm delivery, and low birth weight. In addition, the severity of violence may sometimes escalate during pregnancy or the postpartum period.

Destruction of the family unit often results in loss of financial stability or lack of economic resources for independent living, leading to increased populations of homeless women and children. Efforts to control health care costs should focus on early detection and prevention of IPV.

Role of Health Care Providers

The medical community can play a vital role in identifying women who are experiencing IPV and halting the cycle of abuse through screening, offering ongoing support, and reviewing available prevention and referral options. Health care providers are often the first professionals to offer care to women who are abused. Adequate training and education among health care providers will provide the skills and confidence they need to work with patients, colleagues, and health care systems to combat violence and abuse. Obstetrician-gynecologists are in the unique position to provide assistance for women who experience IPV because of the nature of the patient-physician relationship and the many opportunities for intervention that occur during the course of annual examinations, pregnancy, and follow-up visits for ongoing care. Screening all patients at various times is also important because some women do not disclose abuse the first time they are asked.

Health care providers should screen all women for IPV at periodic intervals, such as annual examinations and new patient visits. Signs of depression, substance abuse, mental health problems, requests for repeat pregnancy tests when the patient does not wish to be pregnant, new or recurrent STIs, asking to be tested for an STI, or expressing fear when negotiating condom use with a partner should prompt an assessment for IPV. Screening for IPV during obstetric care should occur at the first prenatal visit, at least once per trimester, and at the postpartum checkup. Studies have shown that patient self-administered or computerized screenings are as effective as clinician interviewing in terms of disclosure, comfort, and time spent screening. Screening for IPV should be done privately. Health care providers should avoid questions that use stigmatizing terms such as "abuse," "rape," "battered," or "violence".

They should use a strategy that does not convey judgment and one with which they are comfortable. Written protocols will facilitate the routine assessment process:

- Screen for IPV in a private and safe setting with the woman alone and not with her partner, friends, family, or caregiver.
- Use professional language interpreters and not someone associated with the patient.
- At the beginning of the assessment, offer a framing statement to show that screening is done universally and not because IPV is suspected. Also, inform patients of the confidentiality of the discussion and exactly what state law mandates that a physician must disclose.

- Incorporate screening for IPV into the routine medical history by integrating questions into intake forms so that all patients are screened whether or not abuse is suspected.
- Establish and maintain relationships with community resources for women affected by IPV.
- Keep printed take-home resource materials such as safety procedures, hotline numbers, and referral information in privately accessible areas such as restrooms and examination rooms. Posters and other educational materials displayed in the office also can be helpful.
- Ensure that staff receives training about IPV and that training is regularly offered.

Even if abuse is not acknowledged, simply discussing IPV in a caring manner and having educational materials readily accessible may be of tremendous help. Providing all patients with educational materials is a useful strategy that normalizes the conversation, making it acceptable for them to take the information without disclosure.

Reference:

- <http://www.cdc.gov/ViolencePrevention>
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