

Closing the Referral Gap During Prolonged Labour in Somalia: From Traditional Birth Attendance to Emergency Obstetric Care

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Abstract: Prolonged labour in Somalia becomes dangerous not only because of the clinical risks of obstructed or non-progressive labour, but because the pathway from community-based labour care to facility-based emergency obstetric and newborn care is often slow, fragmented, and unreliable. Although maternal health literature has long described the “three delays”, the specific implementation gap between trusted community birth attendants and functionally ready emergency obstetric care remains insufficiently emphasized in discussions of prolonged labour in fragile settings. This commentary argues that delayed referral during prolonged labour in Somalia should be understood as a systems failure at the interface between community childbirth support and emergency obstetric care, rather than simply as a problem of home birth or poor knowledge. Studies describe low and unequal use of antenatal and facility-based delivery care, transport and referral barriers in displaced and urban populations, negative prior experiences of facility-based birth, and weaknesses in hospital collaboration and referral readiness. These findings support a more operational interpretation of maternal delay: one that links community recognition, transport feasibility, communication, and facility functionality into a single time-critical continuum. Drawing on Somalia-specific evidence, comparable referral literature, and WHO guidance on emergency obstetric care signal functions, intrapartum care, and the Labour Care Guide, this commentary proposes five operational commitments: standardized community referral triggers for prolonged labour; formalized traditional birth attendant (TBA)-to-facility communication and feedback; transport financed as part of clinical care; verification of referral destinations by actual emergency obstetric functionality; and respectful maternity care as a prerequisite for timely care-seeking. The commentary’s contribution is therefore not to restate known barriers, but to provide an implementation-oriented framework for closing the referral gap during prolonged labour in Somalia.

Keywords: prolonged labour, obstructed labour, referral, traditional birth attendants, emergency obstetric care

Introduction

Prolonged labour is a time-sensitive obstetric problem. As labour remains non-progressive, the risks of maternal exhaustion, dehydration, infection, uterine rupture, postpartum haemorrhage, and fetal compromise increase, while definitive treatment becomes more complex and more costly.^{1–3} In Somalia, this clinical urgency often collides with a fragmented care pathway in which labour begins at home, progress is assessed informally, and transfer to a health facility occurs only after deterioration is evident.^{4–7}

This commentary addresses an important but insufficiently articulated policy problem: delayed referral during prolonged labour in Somalia is not only a matter of late care-seeking, but also a failure to connect community first contact with timely, effective emergency obstetric care. The commentary contributes in three ways. First, it reframes prolonged-labour referral as a coordination failure between informal community childbirth care and formal emergency obstetric services. Second, it synthesizes emerging evidence from Somalia and Somaliland on barriers affecting that transition. Third, it proposes five operational commitments aimed at improving implementation in a fragile health system context.



Delayed Referral in Prolonged Labour is a Systems Failure

The “three delays” framework remains highly relevant, but its application in prolonged labour in Somalia should move beyond general description toward operational analysis. Available evidence suggests that delay is often a rational response to structural uncertainty rather than a simple knowledge deficit. In Mogadishu IDP settings, women and providers described financial hardship, transport barriers, insecurity, long distances, limited service hours, poor referral pathways, lack of privacy, and negative previous experiences as barriers to maternity care.⁴ Participants also reported situations in which a woman needing urgent care at night could not access transport and had to wait until morning.⁴

Recent studies from Somalia similarly show that maternal service utilization remains low and unequal. Antenatal care attendance is strongly shaped by family attitudes and knowledge of available services, and women who attend more antenatal care are more likely to deliver in a health structure.⁷ In major towns in Somalia, home delivery remains common even where facilities are geographically closer, with women citing financial reasons, long distance, and the perceived ease of giving birth at home.⁵ In Somaliland, women with previous facility-based birth experience described disrespect, poor explanation, and lack of reproductive agency, while home birth with a traditional birth attendant was often viewed as more trusting and culturally acceptable.⁶

Taken together, these findings suggest that prolonged labour in Somalia becomes dangerous through the interaction of multiple failures: delayed recognition, delayed decision-making, delayed transport, weak communication, and uncertainty about what care will actually be available on arrival. This is why prolonged labour should be treated as a systems test. It exposes the point at which household decision-making, community trust, transport availability, referral processes, and hospital readiness either function together or fail together.

Emergency Obstetric Care Must Mean Functionality, Not Signage

Referral only saves lives when the receiving facility can actually provide emergency obstetric and newborn care. The World Health Organization defines this capability through a set of emergency obstetric care signal functions and emphasizes recent performance rather than nominal designation.¹ This distinction is especially important in fragile settings, where a building labelled as a maternity facility may not have consistent blood availability, operative capacity, skilled staff, neonatal resuscitation readiness, or coordinated emergency response.¹

Evidence from Somaliland reinforces this concern. A mixed-method study from the national referral hospital found that severe obstetric haemorrhage, hypertensive disorders, and sepsis were major causes of maternal death, while missed opportunities included poor risk awareness in the community and inadequate interprofessional collaboration at the hospital.⁸ Most women who died had referred themselves, suggesting that the referral chain was weak before arrival, and the study identified poor communication and poor follow-up from diagnosis to treatment within the hospital itself.⁸ In policy terms, this means that arrival cannot be accepted as a proxy for access. A referral destination that is not functionally ready produces a false sense of safety and may create an additional delay rather than resolving the original one.

Traditional Birth Attendants Should Be Viewed as Referral Partners, Not Substitutes

A large proportion of births in Somalia and Somaliland still occur outside facilities or with strong community influence over place-of-birth decisions.⁴⁻⁷ In such contexts, traditional birth attendants remain trusted first contacts even where policy prioritizes skilled attendance and facility delivery. This reality should not be romanticized, but neither should it be ignored.

The relevant policy question is not whether traditional birth attendants should replace skilled birth attendants; they should not. The question is whether health systems can use their community legitimacy to improve early recognition and timely referral. Earlier work in Somaliland found that changing the role of traditional birth attendants from independent birth attendants toward birth companions and promoters of skilled attendance was feasible.⁹ More recent qualitative research from Somaliland shows that traditional birth attendants are increasingly acting as links between communities and the formal health system, with strong social trust that can be used to promote professional maternal care and referral.¹⁰ These findings support a pragmatic position: traditional birth attendants should be integrated as early-warning and referral partners within a clearly defined system that preserves the clinical authority of skilled personnel and the necessity of emergency obstetric and newborn care.

Five Operational Commitments to Close the Referral Gap

Standardize Community Referral Triggers for Prolonged Labour

Referral is delayed when recognition is inconsistent or subjective. World Health Organization intrapartum guidance emphasizes structured monitoring, timely escalation, and clear decision-making.^{2,3} In the Somali context, community-level referral triggers should therefore be simple, teachable, and auditable. They should not attempt to convert traditional birth attendants into clinical decision-makers, but should help households and first-contact attendants recognize when labour is no longer progressing safely and when transfer should not be postponed.

Such triggers could include labour not progressing as expected, severe maternal exhaustion, vaginal bleeding, fever, convulsions, suspected malpresentation, foul-smelling liquor, or signs of fetal compromise. The operational goal is early transfer before severe obstruction, sepsis, or fetal distress develops. Standardized triggers would also strengthen accountability by creating common expectations across households, community workers, traditional birth attendants, and facilities.

Formalize Traditional Birth Attendant-to-Facility Communication and Feedback

A referral pathway without communication is incomplete. Evidence from sub-Saharan Africa shows that referral decision-making, communication, and feedback remain major weak points, even where referral structures formally exist.^{11,12} Interventions using referral notes, mobile phones, triage tools, and improved communication between referring and receiving facilities have shown promise in improving coordination, though the evidence base remains limited.¹¹

For Somalia, a practical starting point would be to assign a maternity focal person at each referral facility, establish a basic call or messaging pathway for pre-arrival notification, and treat traditional birth attendant referrals as clinical handovers rather than informal transfers. Facilities should also provide simple feedback after referral completion. This is important not only for documentation, but also for trust. Where communities never hear what happened after referral, the relationship between community actors and facilities remains weak. A feedback loop can convert repeated informal acts of referral into a functional safety network.

Treat Transport as a Funded Clinical Intervention

Transport should not be framed as an external logistical issue. In prolonged labour, it is part of the clinical response. Systematic reviews of emergency obstetric referral and transport interventions show that transport, communication, financing mechanisms, and organizational redesign can reduce second-delay barriers and improve use of skilled care, although evidence quality varies and context matters.^{13–15} Low-cost transport support, ambulance access, transport vouchers, and community transport systems have all been used to reduce delays in reaching emergency obstetric care.^{12–15}

In Somalia, transport barriers are repeatedly documented alongside financial constraints and insecurity.^{4,5} The implication is clear: a written referral without a practical means of movement is not a real referral. District-level planning should therefore include emergency transport rosters, pooled referral funds, voucher models, or agreements with private drivers and facilities. These mechanisms must be linked to communication with the receiving facility; otherwise they only move the delay from the household to the hospital gate.

Verify Referral Destinations Using Actual Signal-Function Performance

Facilities receiving emergency referrals should be mapped according to what they actually do, not what they are called. The World Health Organization signal-function framework provides a practical basis for this.¹ Facilities expected to manage prolonged labour complications should demonstrate recent capacity to provide the relevant interventions, including assisted delivery where appropriate, neonatal resuscitation, caesarean section, and blood transfusion.¹

This matters because poor-quality referral is not only delayed referral; it is also referral to the wrong place. Systematic reviews on maternal referral quality have highlighted delays, lack of documentation, poor accompaniment, transport problems, and weak coordination as common problems in low-resource settings.¹² In Somalia, the added risk is that women may reach a facility that cannot provide definitive treatment and are then subjected to another transfer. Policy should therefore move toward district-level mapping of functionally capable sites and redesign referral pathways accordingly.

Make Respectful Maternity Care Non-Negotiable

Respectful maternity care is not an optional ethical addition to clinical care; it is a utilization intervention. When women expect verbal abuse, poor explanation, lack of privacy, or loss of agency, delays in seeking facility care become more likely.^{4,6,12} In Somaliland, women explicitly linked their choice of home birth to prior experiences of disrespect and lack of control in facilities.⁶ World Health Organization intrapartum care guidance recognizes respectful, person-centred care as a core component of quality, not an auxiliary one.²

Operationally, respectful care should be embedded in quality improvement, supervision, and measurement. Districts should monitor whether women receive privacy, clear communication, consent-based care, and dignified treatment. Without this, efforts to improve referral may fail because women and families do not trust what happens after arrival.

Discussion

The central argument of this commentary is that delayed referral during prolonged labour in Somalia should be understood as a coordination problem linking community childbirth care, transport, and emergency obstetric functionality. This interpretation is consistent with broader maternal referral research, which emphasizes that timely referral depends not only on the decision to seek care, but also on transport, communication, referral documentation, staff coordination, and readiness at the receiving facility.^{11–15}

The Somali case adds two points of practical importance. First, community trust is not distributed evenly across the system. In several studies from Somalia and Somaliland, traditional birth attendants or home-based support remain more trusted than facility care, particularly when women fear disrespect or poor explanation.^{4,6,10} Second, the weakness of the formal system means that even facility arrival may not guarantee effective treatment.^{1,8} These two realities create a dangerous gap during prolonged labour: women may delay leaving home because the facility is costly, distant, or mistrusted, and then still face additional delay after arrival because the receiving facility is not fully functional.

This commentary also has limitations. The Somalia-specific literature remains limited, and some of the most informative qualitative studies come from Somaliland and Mogadishu internally displaced person settings rather than nationally representative samples.^{4,6,8,10} However, the convergence of these findings with recent Somali studies on antenatal care and institutional delivery strengthens their policy relevance.^{5,7} The purpose of this commentary is therefore not to claim national uniformity, but to identify a recurring implementation gap that merits policy action.

Conclusion

Delayed referral during prolonged labour in Somalia should not be interpreted solely as an individual failure to seek care. It is more accurately understood as a systems failure connecting community first contact to emergency obstetric care. The problem is not simply that labour begins at home, but that the pathway from home or TBA-supported care to functionally ready emergency obstetric and newborn care is often slow, fragmented, and uncertain. Strengthening that pathway requires more than expanding facilities. It requires standardized referral triggers, formalized communication, funded transport, verification of facility functionality, and respectful maternity care as an operational priority. In fragile settings such as Somalia, reducing preventable maternal and perinatal harm during prolonged labour will depend on whether that bridge is built and maintained.

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