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Giving Birth On Foreign Soil: A Phenomenological Study Of Somali Women Giving Birth In North Dakota And Minnesota

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GIVING BIRTH ON FOREIGN SOIL: A PHENOMENOLOGICAL STUDY OF SOMALI WOMEN GIVING BIRTH IN NORTH DAKOTA AND MINNESOTA

by

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This dissertation, submitted by Tracy Jo Enger in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

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Tracy Jo Enger
December 2, 2021

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This work is dedicated to my mom.

She taught me to always notice and include the people in the margins.

ABSTRACT

Health disparities continue to exist in minority populations in the United States. People of color have a higher incidence of negative birth outcomes; and view their experiences with less satisfaction.

The purpose of this study was to explore what Somali Muslim have women have experienced during their labor and delivery in Minnesota and North Dakota. This research was conducted to improve our understanding of the needs of Somali women during labor and delivery in order to provide nursing care that is culturally sensitive.

Phenomenological data was collected from personal interviews with Somali women who had given birth in North Dakota and Minnesota. Data was coded for themes and implications for improving nursing education and practice were identified.

Findings indicate that ineffective communication because of language barriers was a primary reason for dissatisfaction of the participants' labor experience. The need for nurses to provide culturally sensitive care is central to the profession and should be ingrained during nursing education and continue into practice.

CHAPTER I

INTRODUCTION

Giving birth is a profound and life-changing human experience. It is not just a physiological and biological facet of being female, but as a phenomenon "birth is socially marked and shaped" (Jordan, 1993, p. 3). While the powers of uterine contractions and pushing efforts of women in labor is certainly similar for most women, the meaning of the experience itself is quite variable. Giving birth allows "becoming", developing new roles in relation to self and others. As with all phenomena, women attribute meaning to this experience based on multiple facets of humanity, to include their expectations, background knowledge and culture.

The desired outcome of this work is to determine what is the lived experience of Somali Muslim women that have given birth in North Dakota and Minnesota. By determining the meaning of those experiences, and giving a voice to that population of women, it may be possible to identify how to educate our nurses and change our nursing practice to better meet the needs of this specific demographic of patients and reduce health disparities. Nurses that work to support pregnant women during labor and delivery are in the unique position to influence the experience that these women and their families have, thus influencing the outcomes of care. According to Peplau (1997), the relationship between a nurse and their patient is at the center of nursing. The quality of that interpersonal relationship can be a powerful factor for healthy birth outcomes.

Preparing Nursing Students to Provide Culturally Sensitive Care

Ricks, Abbyad and Polinard (2021), state that "implicit biases and racist attitudes of healthcare workers are fundamental contributing factors to race-based health inequities" (p. 1). In an attempt to combat this issue, and to meet the accreditation requirements as a school of nursing, an institution of nursing education must demonstrate the inclusion of content related to cultural competence and diversity. According to Giddens (2017, p. 32), "Cultural competence is an expected component of nursing education and professional nursing practice." The organization that is the watchdog for assessment of nursing curricula is the American Association of College of Nursing (AACN). The expected competencies of graduates from a baccalaureate, master's and Doctor of Nursing Practice are outlined in a document called "The Essentials: Core Competencies for Professional Nursing Programs". The latest edition was published in April of 2021. This statement supports the purpose of this research by outlining the requirements of nursing education, "Shifting U.S. population demographics, health workforce shortages, and persistent health inequities necessitate the preparation of nurses able to address systemic racism and pervasive inequities in health care" (AACN, 2021, p. 6). In addition, "Making nursing education equitable and inclusive requires actively combating structural racism, discrimination, systemic inequity, exclusion, and bias" (AACN, 2020).

Of the 10 new domains that are included in the "Essentials", the one that most closely supports the need to understand diverse cultures is Domain 2- Person Centered Care. This domain states that nursing care should focus on the individual person. By learning about the specific, individual needs of our patients, nurses can better provide the kind of care that demonstrates this domain. Ongoing evaluation of students in a clinical setting is vital to safe and competent practice. The National Council Licensure Examination for nurses, N-CLEX, is the final evaluation of the nursing student's ability to plan for and provide culturally sensitive care.

Measuring Clinical Outcomes for Patients

One of the ways that outcomes of care are measured is called an HCAPS (Hospital Consumer Assessment of Healthcare Providers and Systems) score (Mazurenko, Fairbanks, Collum, Ferdinand, Menachemi, 2017). Healthcare institutions are reimbursed for services in the United States partially based on this metric. This is not simply a measure of whether a patient was happy or not with their care but uses a survey tool that assesses ten different domains to include "quality communication with doctors and nurses, responsiveness of hospital staff, adequacy of pain management and education about medication and discharge information" (Mazurenko, Fairbanks, Collum, Ferdinand, Menachemi, 2017, p. 273). Minority groups consistently reported lower rates of satisfaction with their care according to the authors.

Two other systemic reviews of the literature conducted by Doyle, Lennox and Bell (2013) and Price, et al. (2014) conveyed that higher HCAPS scores correlated with higher performance of clinical outcomes, patient safety and healthcare utilization. What I am hoping to discover is how Somali Muslim women would "rate" their labor and delivery experiences in North Dakota and Minnesota through phenomenological research. How would this population ascribe meaning to this experience, and what effect did their nursing care have on the meaning of the experience?

The personal impetus for this research was based on a story that was shared with me by a close, friend and fellow obstetrics nurse. She described the scene of a busy delivery room just minutes prior to birth of the baby. It was noisy in the room as the health care providers were preparing for immediate assessments of newborn and mother. Assessment findings determine the need for intervention and are a critical role of the nurse. The baby's father was present in the room, and he asked that the room be silent once the baby was born. The providers shared late

that they thought the father was being "demanding" and should basically stay out of the way. The reality of the situation was that the family was Muslim. Their religious beliefs dictated that the "Adhan", or call to prayer, be whispered into the baby's right ear immediately after birth by the baby's father. His voice was to be the first one heard by his infant. The healthcare providers were not Muslim and did not have the knowledge that may have guided them to be compassionate and accommodating to a very personal and precious need of the family. Might this experience have influenced their satisfaction, and in turn birth outcomes? I have no knowledge of any adverse issues with this family; but do believe that to provide care that is patient centered and culturally sensitive, nurses must know their patient's preferences and beliefs.

The Institute of Medicine, (IOM) has described the delivery of healthcare in the United States as being "fragmented and impersonal" (Institute of Medicine, IOM, 2001). One of the primary measures the IOM suggested to combat this problem was to teach healthcare workers to provide care that is based on individual needs and preferences. Morgan & Yoder (2012), state that providing care that is patient-centered is an "essential component of quality health care delivery" (p. 6). For nurses to provide holistic and patient centered care during this time, they must be knowledgeable about how their patients perceive this experience and what they need from their care providers to have optimal outcomes. Although "person or patient-centered care" and "culturally sensitive care" are two separate concepts, I do believe they are dependent on one another. Training and education of health care providers must begin early so that the very fabric of the care provided is sensitive to the holistic needs of the individual. The population of interest for this study is women who have immigrated from Somalia, practice Islam, and that have given birth in Minnesota and North Dakota.

Somalia is a country located in Africa that has been resettling individuals to other countries because of many decades of political unrest. The primary religious influence in Somali is Islam. A more detailed history of Somali and its people is included in the literature review of this document.

Health Disparities Among People of Color

The issue of concern is that minority populations in the U.S. have poorer outcomes after labor and delivery as compared to majority populations (Johnson, Reed, Hitti and Batra (2005), Lightfoot, Blevins, Lum and Dube (2016), Shahawy, Deshpande & Nour (2015). Statistics from the Centers for Disease Control as reported by Ricks, Abbyad & Polinard (2021), convey that a black woman is "212 % more likely to die from pregnancy or childbirth-related causes than a White woman" (p. 1). This is unacceptable. Some examples of birth outcomes can be defined by physiological status of the mother or infant, psychological status of the mother, family functioning, birth interventions and complications, or patient satisfaction with care. It would be imperative to make determinations about which specific outcomes are being measured prior to making statements about the efficacy of interventions. The specific interventions must also be identified.

Johnson, Reed, Hitti and Batra (2005), write specifically about the Somali immigrants in Washington as a "high-risk population" related to their findings regarding increased adverse pregnancy outcomes. The outcomes they measured where Somali women had worse outcomes included: rates of cesarean section, post term delivery, and perineal lacerations. The outcomes measured for newborns of Somali women that had worse outcomes included: lower 5-minute Apgar scores, meconium aspiration and needing assisted ventilation. Lightfoot, Blevins, Lum and Dube (2016), also report African refugees experience increase disparities related to health

care, and “Somalis were among the groups in the state of Minnesota receiving the least health services” (p. 253). Shahawy, Deshpande & Nour (2015) report that the number of Muslim women is steadily increasing in the U.S., and health care providers can decrease disparities of care by being culturally aware and culturally sensitive in the care they provide. The state of Minnesota has become home to approximately one third of the Somali refugees that have resettled in the United States according to Lightfoot et al., (2016). The authors agree that disparity exists between health outcomes for people of color and Caucasian people.

Because high quality prenatal care improves pregnancy outcomes, lack of access to care or the presence of other barriers to care contributes to this issue (Lowdermilk, Perry, Cashion & Alden, 2016). Cultural insensitivity could be among those barriers if women feel unheard, or uncared for by their health care providers.

A systematic review of the literature conducted by Govere & Govere (2016) shows support for cultural competence training of healthcare providers to improve patient satisfaction of minority groups. Seven studies were compared, and five of the seven found a significant relationship between the two variables. A second systematic review by Chipps, Simpson and Brysiewicz (2008), also found that cultural competency training of healthcare providers improves patient satisfaction. Neither of these reviews was directed at physiological outcomes of care.

Immigration into the United States is increasing the diversity of people that require care, but there is a decided lack of knowledge about the needs of the people that are relocating in Minnesota and North Dakota. The information that currently exists in the literature about the experience of Somali Muslim women giving birth in Minnesota and North Dakota is quite limited. Lightfoot, Blevins, Lum & Dube (2016) agree that “the body of knowledge upon which

to build culturally relevant interventions for this population remains limited" (p. 253). Through this research study, I hope to gain knowledge regarding the lived experience of Somali women that have immigrated to the United States and have given birth in Minnesota or North Dakota. By interviewing this population about their experiences, I improved my own understanding about the specific cultural needs of this group during labor and delivery, and help educated other healthcare providers. The end results may contribute to improved birth outcomes and increased satisfaction with the birth experience of Somali Muslim women in Minnesota or North Dakota and decrease the health disparity that currently exists.

Theoretical Framework

Maxwell (2013) describes a theoretical framework as a sort of guide about the viability of the research that is being proposed. A strong framework helps to guide the process with previously accepted ideas. Ideally, the framework should identify why the work is important, and identify work that has already been done related to the topic. Gaps in the knowledge should also be identified.

As noted above, the phenomena that I am interested in understanding is the lived experience of Somali women that have given birth in Minnesota and North Dakota. Moreover, what does that experience mean to them, and how can health care providers utilize that information to meet the health care needs of this population? The theory that I have chosen to support this work is Madeline Leininger's "Theory of Cultural Care Diversity and Universality". The basic premise in her theory is that "if one can explain care meaning, patterns and processes, one can explain and predict health or well-being" (Leininger, 1988). With a focus on prevention of illness or complications during labor and delivery, culturally sensitive care can be developed based on those identified meanings, patterns, and processes. Dr. Leininger's focus was primarily

nurses; but I believe the constructs are applicable to any member of the care team. Leininger's goal was to assist nurses in providing "culturally congruent nursing care practices" (p. 152) that would improve health care outcomes. For this research that means identifying what Somali Muslim women need during labor in the attempt to increase the odds of having a positive birth experience and reduce the risk of poor outcomes.

Leininger's Theory of Cultural Care Diversity and Universality

Dr. Madeline Leininger (1925-2012) was an American nurse/anthropologist. She wrote her "Theory of Cultural Care Diversity and Universality" in the 1950's, long before cultural competence was a buzzword. She developed this theory based on clinical experiences that enlightened her to the fact that not all her patients had the same needs and expectations. The culture of the client influenced both the desire for care, and the reaction to it. The "Sunrise Model" is used to depict facets of this theory (Used with permission from nurselabs.com).

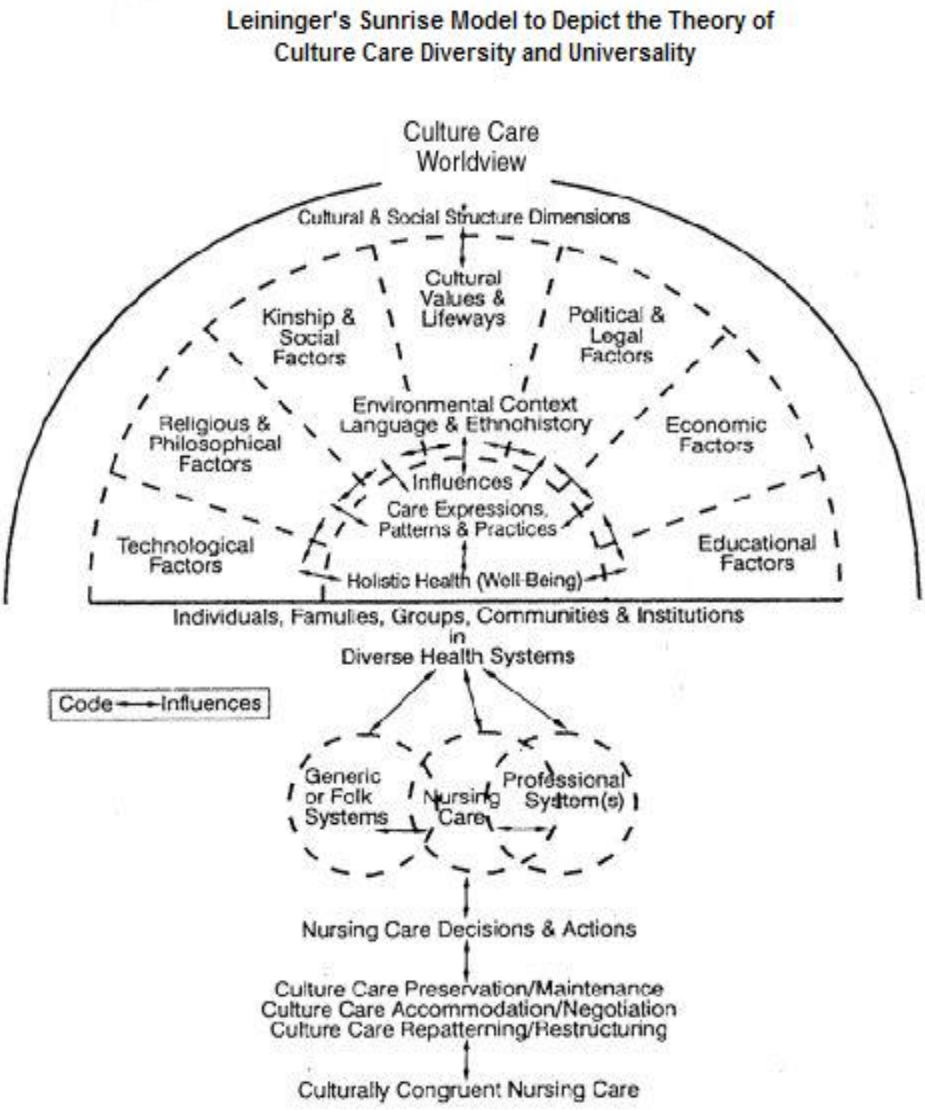

Figure 1. Leininger's Sunrise Model to Depict the Theory of Culture Care Diversity and Universality. Source: Finn, J, Lee, M. (1996).

As an anthropologist, Leininger adapted the term "culture" from that field of practice and married it with the concept of "care" from nursing. She theorized that to provide care that meets the needs of the patient, that care must take in to account the whole person to include physical aspects, social aspects, and culture. To do that we must understand culture as part of the whole.

"The language usages, symbols and meanings about care in diverse cultures had to be understood in order to derive the essences and patterns of cultural care" (Leininger, 1988, p. 155).

The primary components of this theory attempt to define the relationships between the constructs that Leininger felt composed the world view of a person, a group, and institutions. They included: technological factors, religion and philosophy, kinship and social factors, cultural values and lifeways, political and legal factors, economic and educational factors.

Dr. Leininger suggests that in using this theory, one may take one or more pieces of the whole to "start the discovery process according to personal interest regarding care" (Leininger, 1988, p. 157). I propose to examine the components of religious and philosophical factors, cultural values as they relate to individuals during the time of childbirth. I plan to devise my interview questions based on religious and philosophical factors and cultural values. The interviews will be only semi-structured to allow for any expression the participants wish to make.

The theorist also offers some definitions for terms such as "culture", "cultural care diversity", "cultural care universality", but cautions against using predefined concepts as opposed to discovering the meaning of those terms to those participating in the research. The term "emic" means the views of the population being studied and should take priority in how those concepts are defined.

There are eight assumptive premises of this theory, three of which directly relate to my proposed research. They are as follows:

1. Care is essential for human growth, well-being, and survival and to face death or disabilities.

2. There are diverse and universal forms, expressions, patterns, and processes of human care that exist transculturally.
3. Care is the essence of nursing and the distinct, dominant, and unifying feature of nursing.
4. Culture care is the broadest means to know, explain, account for and predict for nursing care phenomena and to guide nursing care practices.
5. Knowledge of meaning and practices derived from worldviews, social structure factors, cultural values, environmental context, and language uses are essential to guide nursing decisions and actions in providing culturally congruent care.
6. Cultures have folk and professional care values, beliefs, and practices that influence cultural care practices in Western and non-Western cultures.
7. Care is essential to curing; however, there can be no curing without caring, but there can be caring without curing.
8. Nursing is a transcultural phenomenon requiring knowledge of different cultures to provide care that is congruent with the client's lifeways, social structure, and environmental context.

As the researcher, I chose premise numbers 5, 6 and 8 to guide this work. Premise 5 helped me shape my interview questions to include content about cultural values related to childbirth and language usage. Premise 6 helped guide me to ask questions regarding specific birth rituals and care practices of non-Western cultures. Premise 8 outlines the need to provide care that makes sense to the patient within the context of their own culture.

A critical point in Leininger's research was the discovery that "people of different cultural backgrounds had *different* expectations for care and needed a different culturally based

framework to guide care" (Leininger, 1988, p. 153). The theorist stated that a knowledge generating open inquiry was possible a better way of gathering information as opposed to scientific methods that were rigid and controlled. She states that the "use of inductive strategies to get to people truths, realities and other life-death knowledge about human conditions is essential" (1988, p. 154). Using this theory supports both the method that I would like to utilize, namely phenomenological interviewing and analysis. It also supports phenomenology as a philosophy.

CHAPTER II

LITERATURE REVIEW

A literature review was conducted to determine what is known about the attitudes and customs of Somali women related to childbirth. Key search terms included: Somalia, Somali women AND childbirth, Muslim women AND childbirth, culture AND childbirth, nursing care and culture. To begin to understand the people of Somalia, one must have at least an elementary understanding of the history, religion, politics, and culture that is predominant in that region of the world. One must also be cognizant that considerable diversity exists among individuals, and generalizations must be discouraged. Friedlander & Staloch (2014) stress the avoidance of making assumptions or stereotypes about Muslim women as it "limits our abilities to be competent care providers" (p.51). General findings from the literature will be supported, or not supported by direct interviews with the participants of this study. Knowledge of the experience that Somali Muslim women have had giving birth in Minnesota and North Dakota will increase our understanding of this population and hopefully influence the level of culturally sensitive care provided.

Background on Somalia

Somalia is a nation located in the Horn of Africa, with a population of approximately 8 million (Lewis, 2008). The capital city is Mogadishu. Hundreds of years of political unrest and civil wars have contributed to the displacement of thousands of Somali people to locations across the globe including the United States. Lewis (2008), states "as many as two million people were believed to be residents outside their homeland as refugees" (p. 1). Lewis (2008) wrote at length

regarding the powers that have fought to dominate, or at least influence the political climate of that land. To give context to this research study, I will outline some of the major influences in Somalia in the last fifty years that may have an impact on the attitudes and perspectives of Somali women.

Religion and Politics

The primary religious influence in Somalia is Islam, thought to be a result of trading connections to the Arabian Peninsula (Lewis, 2008). Although some Christian settlements exist, primarily resulting from the attempts by Christian missionaries to convert the Somali people, this is not the dominant religion. The notion of "separation of church and state" is not generally accepted in Somali as the religious laws dictate much of the public laws. Sharia law (the religious law of Islam) is outlined in the Islam holy text, the Qur'an.

In the study conducted by Lightfoot et al. (2016), religion was identified as one of the most important health assets identified by the Somali population interviewed. In relation to health, their religion helped them to "know how to live" (p. 255), to include healthy eating, exercise, and relationships. As noted by Lowdermilk et al. (2016), lifestyle and behaviors can have great impact on healthy pregnancy and birth, so it is important to understand and incorporate these beliefs in healthcare interventions.

The practice of Islam forbids the use of tobacco, alcohol, and other illicit drugs. This is also important to healthy pregnancy and overall health. This view of health as a positive state, encouraged by the religion of Islam offers insight into the Somali worldview of health.

Family Structure

According to Lewis (2008), Somali people are "traditionally polygynous" (p. 11). This means that is acceptable to have multiple wives at any given time. This is not to say that it is

acceptable for a woman to have multiple husbands. In accordance with the Qur'an, a man may have up to four wives, but a woman may only have one husband. Historically, marriages were arranged among clans that had similar customs, or sometimes to join hostile clans (Lewis, 2008). As of this writing, arranged marriages are becoming less common. The primary purpose of marriage in the Muslim tradition is the creation of children. According to Salim (2009), the need and want to "have children and reproduce" is part of the desire put into a woman by Allah as an expression of worship and faith. This is of importance to note when caring for the pregnant or laboring Muslim woman.

Male children are preferred as they "add strength and honor to a father's lineage" (p. 12). Women have gained more rights in terms of inheritance, primarily due to the enactment of the "Family Law" in 1975. In theory, according to this law women have the same rights to inherit land or property as men, but Lewis questions the actual degree to which this is followed, especially in the nomadic clans.

Commerce and Lifework

Historically, the Somali people were nomadic. They traveled with their livestock to find pastureland where food was available. The majority of the people's livelihood consisted of herding of camels, cattle, sheep, and goats (Lewis, 2008). Farming was and is, also a common means of income and independence. More recently, many people have relocated to urban areas and work in various areas of commerce and fisheries.

Language

According to Lewis (2008), the primary languages of the Somali people include Somali language which is either Cushitic or Horner, English or Arabic. Multiple dialects also exist, depending on the region where the individual is from. Rose (2011) discusses the issue of

language as a barrier to proper healthcare. “Many individuals who do not speak English do not receive optimal care because of language barriers” (p. 13). An important aspect of this research will be to discover if information is given in the first language of patients, or how communication is affected if English is the only language that is spoken or written by healthcare providers. Communication that is not effective may contribute to errors in the delivery of healthcare and poorer outcomes.

Attitudes and Customs Related to Childbirth

The desire for this work is to not only discover important customs related to giving birth, but the meaning that is attributed to this phenomenon by the women interviewed. In the Muslim tradition, the purpose of marriage is to produce children. Pregnancy and motherhood are both a “revered status” (Shahawy, Deshpande & Nour ,2015), and children are considered a gift from Allah. Quintanilha, Mayan, Thompson & Bell (2016), also report that Somali women described being treated as “queens” when pregnant (p. 4). Support came from female relatives and friends. This social support was perceived to help create a healthy environment for the pregnant mother and allow her to rest and recuperate after the birth as well.

Participants in the study presented by Quintanilha et al. (2016), related that when “back home” in Somali, the culture felt more inclusive and shared. They compared that to Canada, where they felt the culture supported more of an “I culture” and where they were more individually responsible for their own health and well-being (p. 4). Social support was declared to be very important to the participants.

In accordance with Islamic beliefs, a baby is thought to have a soul, called “ensoulment”, prior to birth. Some scholars declare to this to occur at conception, some at forty days post

conception and some at 120 days post conception (Shahawy, Deshpande & Nour, 2015). This could contribute to certain attitudes regarding abortion or miscarriage.

Prayers are encouraged during pregnancy and delivery by the religion of Islam. Salim (2009) uses the term "du'a" to describe the prayers that are offered to Allah and encourages the Muslim woman to place reliance on Him to help her endure the pain of childbirth. Lewis (2008) does report that it is acceptable and widely practiced among Muslim people to accept modern medicinal practice as well as prayer and Islamic traditional remedies. Advocating for patient's desires for treatment, or lack of treatment or intervention must incorporate her wishes and may at times conflict with a prescribed practice guide.

Female Circumcision

Female circumcision has been practiced in many parts of Africa for centuries according to Althaus (1997). Many organizations that advocate for human rights consider this a violation of women's rights and consider it to be "a ritualized form of child abuse and violence against women" (Althaus, 1997, p.130). The World Health Organization has spoken out against this practice and identified it as having many negative health consequences.

Female circumcision is the removal of all or part of the female genitals. Johnsdotter (2003), states that there are variations in the degree of tissue removed during this procedure, and the motivation behind it. For Muslim women in Somali the two most common types are "pharaonic" and "Sunnah" circumcision. The first removes most of the external genitals and stitching together of the vaginal opening called infibulation. The latter is less extensive and may involve a "pricking" of the clitoris. Johnsdotter relays the primary reason for the procedure is a religious law that requires young women to be virgins at the time of their marriage and thus "remain pure" (p. 362) until that time. According to studies conducted and reported by

Johnsdotter, (2014) about “80% of Somali girls are infibulated” (p. 362). Another source states the number may be close to 98% of either type of circumcision (Johnson, Reed, Hitti & Batra, 2005).

There is much discussion and disagreement regarding the interpretation of the religious writings of the Qur’an. While there is no direct mention of female circumcision in the Qur’an according to Johnsdotter (2014), scholars of the writings have *interpreted* certain passages to support it. Others still, claim that the Prophet Mohammed would have condemned the infibulation procedure (p. 363). Religious texts such as the Qur’an are not available for or encouraged to be read by ordinary people. “This activity (the study of religious texts) is restricted to the educated and the religious elite, therefore many lay Muslims understand clitoridectomy and infibulation to be religious duties” (Johnsdotter, 2014, p. 364). The procedure may also be performed as a “marker for cultural identity” (Johnson, Reed, Hitti & Batra, 2005, p. 476). Local custom, tradition, and family support seem to determine who should undergo the circumcision.

Lowdermilk, (2016) outlines the obstetric complications that can arise during labor and childbirth following a female circumcision. They include prolonged labor, cesarean section, lacerations, hemorrhage, and febrile illness. Johnson, Reed, Hitti & Batra, (2005) also suggest increased intra-partum and post-partum risks associated with female circumcision.

In the post-partum period (after the baby has been born), the mother may request that the vagina be sutured once more. This practice increases risk of infection and other complications and will not generally be performed in the United States. This could leave the woman feeling unheard or disrespected if this is a culturally dictated norm that is of great value to her.

Desire for Modesty

While diversity exists among Somali women, one of the commonly cited notions was the importance of modesty (Friedlander & Staloch, (2014), Shahawy, Deshpande & Nour, (2015). Keeping the female body covered is emphasized in Islam and should be respected to the degree that safe practice can still be provided. For example, it is common during birth practices in the United States to perform assessments on a laboring mother and expose her body during the birth process. According to Hathout (1988) many Islamic scholars argue that the general guidelines of modest dress to not apply in the health care setting. But considering common practice to dress modestly, it may make the Muslim women very uncomfortable to be exposed. Covering of the body may include a headscarf called the "hijab" or a "burka" which covers the whole body. Some Muslim women will prefer to seek care from female providers, while others will be comfortable with a male provider. Every attempt should be made to ensure her privacy.

Diet

Nutrition plays an important role in a healthy pregnancy and childbirth. Considerations for Muslim women that are pregnant might include the ritual of fasting, especially during Ramadan. Although pregnant women are "exempt from fasting" during Ramadan, some may still choose to do so. "May Muslim women still choose to fast while pregnant or breastfeeding but avoid discussing it with their health care provider for fear of it being treated disrespectfully or being advised against it" (Kridli, 2011, p. 218). Fasting may affect laboratory tests, or possibly even the development and growth of the baby. It is therefore important for the Muslim women to feel comfortable having an open and honest conversation about her nutritional practices.

Trust of Western Medicine

Health and wellness are emphasized in the Qur'an, and in general terms Muslim people perceive the medical field in a positive light according to Shahawy, Deshpande & Nour, (2015).

However, due to racial discrimination in the United States, there may be distrust of the health care system (Padela, Gunter, Killawi, & Heisler, 2012). Taking the time to inquire about a patient's culture should be a routine part of the intake history and may help to support rapport and the building of a more trusting relationship.

Johnson et al. (2005) discuss a reluctance of some Somali women to be hesitant in accepting intervention during labor and delivery. This may include pain medication, epidurals, operative birth options such as forceps or cesarean section. The authors also reported less prenatal visits from Somali women when compared with white women who were control participants for their research. Prenatal visits have been related to improved outcomes for both mother and baby (Lowdermilk, 2016).

It is important to include background information about the people of Somalia to increase understanding of diverse worldviews. Each section above includes potential implications related to childbirth practices. Because the term "culture" as defined by Giddens, (2019), includes "patterns of shared beliefs, norms, roles and values" (p. 29) it is imperative to share this information. There must be an understanding that different worldviews, languages, and religions exist and may shape the needs of someone of a different cultural background from the caregiver.

CHAPTER III

METHODOLOGY

The method that was used for the completion of this study was descriptive phenomenology. Sloan & Bowe's (2014), definition of phenomenology as a theoretical viewpoint is that it "advocates the study of individuals' experiences because human behavior is determined by the phenomena of experience" (p. 2). As a research method, phenomenology attempts to give a voice to the experience of the participants in a reflective way. Creswell & Poth (2018) agree that a phenomenological study attempts to find the meaning of an experience by uncovering the essence of the experience as described by those that have had the experience.

Origins of Phenomenology

According to Groenwald (2004), the origins of phenomenology may be traced back to the philosophers Kant and Hegel, but Edmund Husserl developed this philosophy further in the twentieth century. Husserl (1859-1938) was a German mathematician. He took advantage of the chaos in the aftermath of the first world war to further his philosophical ideas. As disagreement between the ideals of positivism and relativism became more debated, phenomenology as a philosophy allowed reality to exist in how an individual, or group experiences it. "Realities are thus treated as pure phenomena and the only absolute data from where to begin" (Groenwald, 2004, p. 4). This notion differed vastly from a positivist point of view that held that reality and truth were absolute, existing, and able to be "proven". (Of course, scientists opt for the phrase "supported a hypothesis" instead of proven.) Instead of accepting the notion that absolute truths existed, Husserl's paradigm of thought allowed for multiple realities based on the experience of

the person or persons involved. In addition to living an experience, a participant must have a conscious awareness of said experience. Existential ideals regarding being conscious of an experience were also stressed by Franz Bertano, who was a teacher and mentor to Husserl (Holloway, 1997).

An important concept also developed by Husserl, called "epoche" means that a researcher suspends "judgements about what is real" until they have gathered enough data to support an idea (Creswell & Poth, 2018, p. 76.). This involves "bracketing" or separating the beliefs of the researcher as much as possible from the collected data. This allows for the generation of new and novel ideas that may be vastly different from the researcher's previously held beliefs. I recognize that as a woman, mother, and health care provider myself I will need to be able to suspend my own previously held truths in order to do due diligence for the truths that the participants of this study will hopefully share with me. One way to do this would be to personally reflect about the interview questions that I will be asking the participants.

A central goal of descriptive phenomenology is to describe "embodied, experiential meanings" (Finlay, 2009, p. 6). The basic purpose according to Creswell and Poth (2018), is to "reduce individual experiences with a phenomenon to a description of the universal essence (p. 75.) This type of research is most often used in the human sciences to allow participants to explain through their language (written or otherwise) the socially constructed meaning of an experience. The data collected is qualitative and in text form, as opposed to numerical forms found in quantitative data. It was obtained through dialogue and interviews. The researcher attempts to give a specific account of a situation by using everyday language to "reveal essential general meaning structures of a phenomenon" (Finlay, 2009, p. 10). As a part of the analysis process, I did use the language of the participants be examining in vivo statements and

identifying themes. After data was gathered, it was analyzed and synthesized to determine themes. The outcomes of this type of research study are "descriptions of meanings for individuals" (Sloan & Bowe, 2014, p. 4).

Analysis of this type of research involves moving from small pieces of data, such as a spoken word or phrase, to larger units such as themes. Creswell and Poth (2018) state that two themes must be summarized in phenomenological research—the "what" of the experience and the "how" of the experience.

The rationale for using the term "transcendental" is that the researcher must attempt to transcend above the data and present the findings as a "global view of the essences discovered" (Sloan & Bowe, 2014, p. 6). This is to say, as the researcher, I must remove myself from the data and not place interpretive meanings but present the experience purely as the participant describes it.

Epistemological Issues Related to Phenomenology

As researchers approach any given issue for study, they should be cognizant of the philosophical assumptions that they believe to be true. Those assumptions may affect the type of study that will be conducted, the methodology and the analysis of data. "Epistemology" just means *how* we know what we know (Creswell & Poth, 2018). For qualitative research such as phenomenology, the assumption is that we "know" information by gathering insight from the language of the participants. It is important to spend quality time with participants, and if possible, be near where they live and work.

Ontological Issues Related to Phenomenology

Ontology relates "to the nature of reality and its characteristics" (Creswell & Poth, 2018, p. 20.). With qualitative research, the reality may vary according to participants. As I do this type

of research, I must be open to multiple views of reality to do justice to the participant's explanations and beliefs. Gadamer, a follower of both Husserl and Heidegger felt that language was connected to the reality of being. He utilized the phenomenological approach of research to enhance the understanding of being, rather than just the epistemological stance of knowing (Sloan & Bowe, 2014).

Methodological Issues Related to Phenomenology

The method of a study describes the procedures used in collecting and analyzing data (Creswell & Poth, 2018). Because phenomenology is qualitative in nature, it would appropriate to utilize interviews, observation, focus groups to collect data. I decided to utilize semi-structured interviews with my aims and questions noted in the table below. I conducted a pilot interview with a Somali colleague to ensure the cultural appropriateness of my questions. I also made certain to inform participants that they could refrain from responding to any question/s that made them uncomfortable. They were also given the opportunity to share any information that I did not specifically ask about, but they thought was important for me to know.

Using the procedural steps outlined by Moustakas (1994), I will attempt to demonstrate why phenomenology as a research method is a viable choice for the issue described in the introduction. The type of "problem best suited for this type of research is one in which it is important to understand several individual's common or shared experience" (Creswell & Poth, 2018. P. 79). The question noted above fits perfectly with the intent to describe an experience of a person or a group of persons. Secondly, this could describe a phenomenon of interest in giving birth, and an opportunity to describe it. Additionally, I could describe the experience of giving birth in a foreign place, within a culture that is unlike the culture of the participants. As the

researcher, I could write about the lived experiences "as the combination of objective reality and individual consciousness" (p. 79).

This method allowed me as the researcher to gather data with interviews (language) regarding the attitudes and beliefs of this specific population of people related to the phenomena of childbirth in a foreign place, as a resettled refugee.

The primary goal of this study was to gain understanding of Somali Muslim women's experience of giving birth in North Dakota and Minnesota in the U.S. Additionally, I would like to determine if they are receiving culturally sensitive care by giving them a voice to describe their experience. People of all cultures make meaning of the birth process, and this study would help create knowledge of how this specific culture understands this experience. The goal would be to improve birth outcomes for this population by educating health care providers about the specific needs of Somali Muslim women. Max van Manen (2007) supports this goal that phenomenology formatively informs, reforms, the relationship between being and practice in the practice of nursing.

Understanding Myself -Bracketing

I am a White, middle-aged person that identifies as female. I have given birth to three children, two in the state of North Dakota. I speak the language of most of the population and the health care providers. I have background knowledge of labor and delivery nursing, and the physiology of labor. I also understand the nursing and medical interventions that are available in the event of a problem during labor.

I felt fully supported by the health care providers and could communicate with them with good understanding. I felt that my requests were listened to, and my needs as an individual were considered. I felt no fear asking for assistance or guidance when needed. I knew I could request

spiritual counsel at any time if desired. I had complete trust in my team of health care providers and understood what I was seeing on the equipment monitors that were used during my labor and delivery with my children. Because of these circumstances, I believe that giving birth is a safe and happy occurrence. I believe that I can trust the healthcare system to offer quality care and be compassionate about providing for my needs.

In relation to my own culture, the religious texts that I read reassure me that in the eyes of the God that I serve, I am a "pearl of great price", (RSV, 1952, Matthew 13:45-46), the "daughter of royalty", (RSV, 1952, Corinthians 6:18). Because of this, I believe that I have worth independent of others and expect to have my needs met. This is an example of the privilege that I have, and I am very aware of that privilege. My belief about the world is that is a beautiful place and has been given to us as a gift to enjoy. My worldview also includes the obligation to care for one another as a way of honoring my creator.

My labor and delivery experiences were satisfying with positive outcomes. I did still experience pain and fear, but I was reassured that I could request and receive assistance at any time. I felt in control of making decisions about my care. There were no cultural needs or customs that I felt were not met; or at the very least that I could not express a desire to occur.

A more insightful bias that I discovered about myself is my fear of Muslim people. I do not say this with pride or satisfaction, but with honesty and a desire to replace this bias with a legitimate evaluation based on personal exposure to actual Muslim people. I discovered this bias quite by accident when I entered a Halal market to inquire about displaying my research flyer. The overhead PA system was playing Arabic music that to me seemed like the music heard in movies about radical terrorists, especially after the events of September 11, 2001, with the destruction of the World Trade Center. I felt anxious and unsafe being alone in that space as a

female. There was certainly no actual reason for me to feel fear, and no event occurred that threatened me in any way. The gentleman behind the counter was kind and helpful. When I attempted to explain my purpose for being there, he offered information about how Muslim women like to drink his hot sweet tea to improve milk supply for their babies! I feel it is important to include this anecdote as an example of the reflexive process of recognizing my own bias. It is important to be aware of this bias and not allow it to influence the questions, or analysis of the responses that I receive during the interviews.

Mitigation of Bias

In the words of the late singer Michael Jackson (1988), "I'm starting with the man in the mirror." Mitigation of bias involves examining my own closely held truths and beliefs and asking myself if these truths are based on evidence or opinion. Informal methods of combatting bias, and on a bigger scale racism include learning about other cultures and embracing the idea of diversity as a positive circumstance. Exposure to ideologies that are different than my own have been examined. I have reviewed the literature regarding the Somali people and culture. I spent time with Somali women and got to know them personally. I have learned about white privilege and been open to worldviews other than my own. More formally, I have participated in curricular content about cultural diversity both as a student and as an instructor. I have engaged in campus wide anti-racism book readings and discussions.

Ricks, Abbyad and Polinard (2021), state that what is really needed is "cultural and structural shifts that embed anti-racism in everyday clinical practice and policy" (p. 8). This involves ongoing cultural training, and systems that recognize the need for organizational support for this training. This study is not directly related to racist behavior and attitudes that are

intentional; rather is the desire to increase the knowledge of a specific population so that bias can be replaced with accurate and specific needs.

Recruiting Participants

I planned to recruit participants at first by hanging flyers in local business that were owned by Somali people, and health care provider offices. The flyer described the study and the researcher's contact information was listed. (See appendices). The criteria for inclusion were women who have immigrated from Somalia, identify as Muslim, and have given birth in Minnesota or North Dakota, USA. Participants had to be least 18 years old. I also required either English speaking or being willing to participate with the assistance of an interpreter.

After several weeks of zero participant contact, I began speaking to colleagues that I knew had experience working with the Somali population. Personal communication prompted me to seek an "insider" to increase trust and the likelihood of participation. Those "insiders" turned out to be instructors of "Adult Basic Education" (ABE) courses at a local high school for new Americans. These courses teach English language and support integration into a new geographic location. This connection yielded 7 participants and 2 women who were willing to interpret for the others in the group. One concession that I made was to interview these women in groups of 3 and 4 instead of individually as they "felt more comfortable" and could bring their children with them. In lieu of a professional interpreter, I graciously accepted the offer of the 2 women willing to interpret for their friends as they have already established relationships and shared trust with one another.

Another group that aided in identifying participants is called "Global Friends Coalition". Their mission is to assist with resettling refugees through education, empowering and embracing. They also aim to alleviate poverty by supporting vulnerable New Americans, supporting those

immigrants that are resettling in the upper Midwestern United States. The Somali people are one of the largest groups that are given assistance by this organization. By contacting this organization and word-of-mouth I found 2 additional participants for a total of nine. I had hoped to recruit at least fifteen participants, but as I was seeing saturation of the themes the decision was made to stop at nine.

IRB Approval

Consent was obtained from Institutional Review Board of the University of North Dakota prior to beginning interviews. This research was not eligible for exemption because interviews were audio recorded. Informed consent was obtained prior to interview in writing. Participants were asked to consent to one to two interviews and be recorded. Participants were advised that they may stop the interview at any time without penalty of any kind. Data will be kept on audio tapes and computer files. A backup of files will be kept on a portable drive and kept in a locked office.

Interviews were recorded and demographic data was connected to recordings with numbers and codes names to ensure anonymity. Recordings of interviews were then transcribed verbatim into written documents to allow for reading and re-reading of the data.

Data Analysis

When gathering the data, I followed the analysis of data outlined by Moustakas, (1994). His work is a modification Stevik-Colaizzi-Keen method. As a novice researcher, I find it helpful to utilize methods that have been utilized previously with valid results. The first step was for me to describe my personal experience with labor as a nurse and a mother. It would be important to explore my own beliefs and experiences to set those aside or bracket them apart from the experiences of my participants. While it is not possible to separate my own thoughts from this

process, expressing them in an explicit way will make me aware of them, and keep them detached from the data given by participants.

Secondly, I developed a list of significant statements from the interview transcripts. This required reading and rereading. Because this type of research methodology reviews texts and/or transcripts I looked for "in vivo" statements and begin looking for themes from the significant statements. Creswell & Poth, (2018) calls these "clusters of meaning" (p. 79). This provides "the foundation for interpretation and removes repetition" (p. 201). The next procedural step I conducted was to describe both texturally, and structurally what the experience was like. The "what" and the "how" if you will.

The final step taken was to write and describe the "essence" of the experience as reported by the participants, which is the ultimate goal of this study, to understand and describe the "essence" of giving birth as an immigrant in a foreign country. My hope is that this leads to greater understanding of this population and translates into culturally sensitive nursing care and positive birth outcomes.

Establishing Trustworthiness and Authenticity

Qualitative research seeks to inform and understand a certain phenomenon. Unlike quantitative work which requires validation and reliability, I am striving to provide an authentic record of the experience that the study participants shared with me. To aid in the assurance of trustworthiness and authenticity I ensured the number of interviews was adequate. This was accomplished in part by adding participants until I began to see the same themes repeated among participants. As stated earlier, I did notice this happening after nine interviews.

I also conducted member checking; clarifying the responses to any questions to ensure the message sent was the message received. Lincoln & Guba (1985), state this method to be the

most critical part of establishing the credibility of a qualitative study. Because of the language barrier between myself and the participants, I note this as a limitation of the study as well. Using an unlicensed interpreter who was a friend of the participants, introduced the risk of error whether intentional or unintentional. I made the decision that this limitation was acceptable because the participants trusted the woman speaking for them and were comfortable in her presence.

Triangulation of data was accomplished through careful verbatim transcription of the interviews from audio recordings. Transcripts were read and re-reading when looking for clusters of meaning and themes. This data was compared to the data in the literature review.

I also attempted to clarify my own bias by reflecting on the interview questions as they related to my own culture and labor experiences. I identified my bias and the mitigation strategies used to mitigate those biases in an earlier section of this document.

Limitations of the Study

One notable limitation of this study was the use of a friend of the participants to interpret interview questions and responses. This could result in errors of the authenticity of responses. I, as the researcher that does not speak Somali, had to trust that the interpreter was accurate. For future research, a licensed interpreter could be utilized. Other limitations could be that participants were not all the same age and had not all been in the United States for the same number of years. These components could impact the fluency of language and trust of the healthcare system. Some participants had given birth in the state of Minnesota and some in the state of North Dakota. Future studies could focus on one specific region or state.

CHAPTER IV

FINDINGS

The purpose of this chapter is to present the data and discuss my analysis of the findings. This was accomplished by connecting significant statements made by the participants during the interview process, observations made by myself, and making associations to the themes from the literature. The most critical finding for me was that women of different cultures are more alike than different when considering their needs during labor and delivery.

Below is the demographic information regarding the study participants and includes age, total number of children, and the number of children born in ND and MN, and the length of time they lived in the United States. The names annotated are not the real names of the participants, but rather code names to protect anonymity.

Demographic Data of Participants

The code names of the female participants were as follows: Amburo, 33 years, Beydaan, 28 years, Fowsio, 39 years, Idil, 21 years, Jamilah, 23 years, Sahra, 20 years, Uba, 30 years, Waris, 20 years, and Yasmiin, 28 years. The average age of the study participants was 26.8 years. The average number of children they had given birth to in either Minnesota or North Dakota was 1 to 2 children. The average number of years they had lived in the United States was 6.1 years.

There were three significant themes that emerged from the data. The major themes included: the experience of motherhood and the birth, ineffective communication which may

have contributed to mistrust and fear, and Muslim specific needs. From these themes, I have formulated meanings and assertions which will guide the implications for practice and education.

Utilizing in vivo statements from the participants allowed me to give a voice to the experience these women had giving birth in either Minnesota or North Dakota. It was difficult to separate the nursing specific responses separately from the other healthcare providers and this distinction was not readily observed from participants.

Theme One—The Experience of Motherhood/Giving Birth

When asked what it meant to the participants to be a mother, the overwhelming response was that it was a positive experience and it meant that they were blessed by the God they serve in the Muslim religion. Some called this person "God", some "Allah". The belief that God determined the number of children a woman had demonstrates that Muslim women feel they do not have reproductive control but accept what occurs without question as an expression of their faith and devotion. This agrees with the literature stated by Salim (2009) that the primary purpose of marriage in the Muslim tradition is the creation of children. All nine of the women interviewed commented on the "gift" of motherhood.

Beydaan commented,

> "I am very lucky; it is a privilege to be a mother".

Amburo also stated,

> "It's amazing, the most precious thing in the world. Every pain that I had and everything I wanted to say left me when I saw my baby"

Fowsio stated,

> "Allah decides who will be a mom, you cannot choose."

Uba responded, "Being a mother is a gift from God, Allah".

Women who were not able to have children were considered "taboo". According to the participants, they have not been blessed by God, and in some circumstances will not be accepted into the circle of women in the community. Having multiple children is looked on as favorable, and it is considered rude if people outside the Somali community inquire about why a woman has a high number of children.

Waris said,

> "It is like taboo to not have children"

Yasmiin said,

> "When women do not have children; it is taboo. Right now, I have 2 children and people ask, 'Where are the rest'?"

Fowsio remarked on the "rude" comments she received when she was hospitalized to have her ninth baby,

> "The nurse asked me stupid questions about how I would care for all of the kids and pay for college. We don't care about college; we just want them have good manners and show respect."

Also, the use of birth control is forbidden in the Muslim religion.

Amburo stated,

> "Using birth control is fighting with God"

Beydaan also commented,

> "Birth control is against our religion"

The participants discussed the experience of pain and fear during childbirth, and their reluctance to ask for analgesic medications and/or epidurals. The pharmacological options were discussed with them, but often they felt the explanation went too quickly and they did not feel

they could ask additional questions. The informational video was played in English. This resulted in pain levels that were not acceptable to the participants, but they were unsure how to seek assistance. The experience of fear was reported by all nine of the women as well as some point during their labor.

Waris stated,

> "I pressed the pad and say, 'please help', that was the only words I knew. The pain went on for hours."

Jamilah agreed,

> "So much pain, too much pain. Almost 20 hours of pain. I didn't want epidural cuz I didn't want to be paralyzed."

Beydaan commented,

> "That time was painful. I was at the hospital all in pain."

Amburo stated that her baby was in the "head up" position and she had to lie on her chest upside down,

> "I am in pain, I have to lay upside down, I was scared. Immigrants must be quiet and shy and even when they are in pain. They will be like, 'I am ok'."

Waris also confirmed the presence of fear,

> "I was so scared and felt alone"

The need for the presence of another person may have played a role in the pain and fear that these women experienced. Somalian culture is a collectivist culture meaning they "foster development of an interdependent self-concept" (Giddens, 2017, p. 30). They view the self as it relates to being part of the group. In the literature review Shahawy, Deshpande & Nour, (2015) agreed that motherhood is "revered status" (p. 4) and that other women gather around her to

provide support. Community and gathering is highly valued, and if a laboring women felt isolated and alone it may have caused additional angst.

Beydaan mentioned how hard it was to be alone,

> "They really limited the how many people could be with you. I wanted my husband there for the birth, for bathing."

Waris remarked that other Somali women she knew said the same thing,

> "The nurse will check and then leave you alone. I want someone looking, watching me."

Fowsio expressed concern when her baby was born very quickly and she was in the room alone,

> "The baby comes very fast, the baby was just laying down on the bed and there was no one there, no one touched it."

Amburo was grateful to have her sisters close by, but would have preferred they be in the room along with her and her mother,

> "Thank God I had my sisters to support me. I wish they could have been in the room, but you know they can't just all be in there. Only one person was allowed in there."

In summary, the Somali Muslim women involved in this view motherhood as a gift from a benevolent higher power and the labor and delivery experience often included poorly managed pain, anxiety, and fear. They also greatly valued the concept of community and desired to have other women or their husbands present with them during labor and delivery.

Theme Two—Communication Challenges

During the interview process it was noted that the degrees of fluency of the English language varied a great deal among the participants. Those with less fluency requested meeting in groups as opposed to meeting with me one-on-one. In each group there was one woman willing to be an informal interpreter for the group. I felt that there would be more trust among the group members if the interpreter was a companion instead of hired professional interpreter. This may be a limitation of the study as I had to trust that the spokesperson was giving the best representation of the spoken words of the group.

Difficulty with verbal communication was voiced more than any other concern. As noted in Chapter II, Rose, (2011) agreed that many individuals who do not speak English do not receive optimal care because of language barriers. This challenge caused, or at least contributed to a decrease in trust between patient and provider. It also contributed to a feeling of exclusion when it came to decisions being made about the care of the woman and her baby. Some participants were afraid to voice their opinions as "New Americans".

Amburo shared,

> "Some women are alone in America; I didn't think the nurses would understand me as a New American."

Beydaan agreed,

> "It is really hard to get what you need if you cannot talk for yourself."

The educational literature was not always offered in the Somali language. This made it difficult to understand discharge instructions, and self-care information.

For Uba that was ok,

> "It was English, English is good to me. I can read it and write it, so I understand."

For others like Waris who knew no English at the time of her child's birth, the experience was very different.

"I knew no English and I would rather be quiet. Someone has to read all the papers to me, it is frustrating."

The participants that had given birth in Minnesota were fortunate to receive paperwork in Somali if they requested it, but the women who gave birth in North Dakota reported all the literature was written in English.

Yasmiin said she was told,

"Everything you need to know is in these papers. It was not nice."

This led to them not feeling safe or important. Some felt "pressured" to consent to caesarean section which they referred to as "c-section" or "operation". A desire for a slower presentation of information and options was desired. The participants with a greater degree of language fluency felt the most heard and were more comfortable asking questions.

Trust

Trust is vital to a healthy relationship of any kind. In healthcare, patients must be able to trust their providers at a time when they are vulnerable, frightened and may be in pain. LoCurto and Berg, (2016) state that "trust is associated with improved patient outcomes, there is more continuity of care, delivery of preventative care, adherence and satisfaction" (p. 1) The two participants that felt they could trust their providers were the two women who had a higher degree of English language fluency.

Beydaan stated,

"My experience was really good because I know that language. I could ask questions and understand the responses. Those that have a language barrier, it's hard to get what you want."

Uba spoke English fluently and had recently been certified as a nursing assistant,

"I trust because I graduate a nursing assistant program and I learned so many things."

Sahra also spoke fluent English and stated,

"I trusted my nurses. They were very kind."

On the opposite end of the continuum, several of the women stated the language barrier made trust much more difficult.

Beydaan related,

"I didn't know what was happening, I couldn't ask if it was all ok?"

Yasmiin did not feel like she could ask questions at all,

"No, I couldn't ask questions because of the language. That was a big problem."

Uba stated that without a translator,

"You don't speak English by yourself, you feel shy and afraid."

Waris remarked that she had only been in "America" for one year when she had her baby.

"I knew no English; I couldn't ask for help."

Amburo was concerned about how quickly things were explained,

"I had no trust. They didn't show me trust. I felt rushed to make decisions, I didn't feel safe to tell the truth."

In summary, the part of culture that created the biggest obstacle to optimal care was ineffective or impaired communication. In the following chapter, I will address possible interventions that could be employed to eliminate or decrease this obstacle.

Theme Three—Muslim Specific Needs

As the primary focus of this study, I was surprised to discover that having nurses that were well acquainted with Muslim birth practices was not a major concern for the participants. None of the participants felt that they were prevented from performing any rituals or customs that were important to them at the time of labor and delivery. One woman stated that she was afraid to ask if it was ok to say the "Adhan", but no one discouraged her from doing so. Honoring a patient's spiritual needs is part of providing holistic nursing care.

I believe it is important to share this information to honor the participants that were willing to share it with me. I have included five needs related to the practice of Islam to include: Halal food availability, the speaking of the Adhan, wearing of the hijab, modesty, and female circumcision. I had no intention of even inquiring about the practice of circumcision as I felt this may be an invasion of a deep privacy. I did not want to jeopardize the trust that I was building with these women. But as a final question, I asked if there was anything else that they felt was important for me to know and share. Three of the women stated that I needed to know "about being cut". As discussed in the literature, female circumcision is the practice of removing all or part of the female external genitalia (Johnsdotter, 2003).

Halal Food Availability

The discussion of Halal foods, which are the foods that are acceptable to consume for Muslim people was mentioned. Most of the women stated that family members were able to bring them food that was appropriate, or they could obtain something from the hospital cafeteria.

I was taught which foods were considered Halal, and which were Haram (forbidden). Alcohol and pork are strictly forbidden foods. (Kridli, 2011).

Beydaan taught me,

> "Beef is Halal and so is chicken. Pork and alcohol are Haram and forbidden. But it is not just the food. It also includes how the food is prepared and if the hands are clean."

Idil stated,

> "The animal must be cut fast so he doesn't suffer. Beef and chicken can be haram depending on how they kill."

Amburo had concerns about her nutrition while in the hospital,

> "I ate the same thing every day as Halal food choices were scarce."

Adhan

One of the birth related rituals that was important to the participants was the speaking of the "Adhan". This is considered a way to welcome the newborn to the world and the Islamic faith. A male relative, father, or uncle is first to hold the child and whisper into his ear the name of Allah. A portion of the Qur'an may also be ready at this time.

Sahra shared that she was afraid to ask the nurses if it would be alright to perform this ritual,

> "We were scared to ask, so we waited until we got the baby home."

Beydaan also stated that she insisted the baby be given to her uncle,

> "The nurses wanted to hand the baby to me, but I said, "no, give him to uncle to hold and say the Adhan'."

Uba added,

> "The Adhan must be done when a baby is born and again when he dies. He must hear the name of Allah and the first thing he need to hear when he arrives in the world from the stomach."

Wearing the Hijab and Modesty

When asked about the wearing of the hijab and desire for modesty, all the participants except for one stated that when managing health care issues, it was acceptable to remove the head covering and long garments. They also agreed that if it was possible, they would prefer to have a female provider. A male provider was accepted if that was the closest available option. At hospitals in the United States, a woman may receive care from the physician or midwife "on call" although they might not know the woman. The provider that supported the woman's prenatal care might not be the same provider that delivers her baby.

Yasmiin shared,

> "My doctor was a woman; I would prefer that. Health is number one, it is ok to take off Hijab in the hospital."

Beydaan also stated,

> "I had a woman doctor, so I was lucky."

Uba,

> "It is an obligation to wear Hijab, but at that time it is ok to take it off."

Amburo was the only woman in the interviews that felt strongly that the headscarf could not be removed,

> "No, it is not ok. I am having a male doctor, nurse and it has to do with my hair. If I am having the surgery, I want to make sure my hair is covered. When you are giving birth, it is ok for them to see your body naked, but not your hair."

She shared with me that the nurse was very accommodating and helped her roll and cover her hair with a surgical cap.

Amburo,

> "They did, they did. I rolled it really nicely, really tight and she grabbed the head thing and put it on."

Female Circumcision

As stated previously, it was not my intention to inquire about female circumcision. This information was offered by three of the women as "something your nurses should know about." They felt the topic was important enough to discuss, even though as noted in Chapter II it is a practice that can be subject to harsh judgment. They provided me with information to share with other nurses and nursing students.

Fowsio stated,

> "You should know that some women are a little bit cut. This was supposed to stop in 1991, but it still happens. Some people do small cut, but some a lot. They say is not safe when having your period or having babies, so please don't. A lot of women die, also the baby dies from infections. I tell my nurses and my doctors because I want them to know."

Amburo also shared,

> "You know how Somali woman have a cut at the bottom? It is already swollen and hard to the blood to come out because of what they did."

It is difficult to be a strong patient advocate and support a woman's spiritual practices when the practice could potentially cause great harm. Giddens (2021), relates this to conflict for healthcare providers stating, "if a patient understands the consequences of their health practices,

do we have the right to make a judgement regarding that individual's choice? Perhaps now is the time to accept this as a phenomenon of human nature with no one solution" (p. 49). The best course of action may be to provide accurate health information and allow patients to make their own decisions.

In summary, the Muslim specific birth practices and rituals are important for nurses to be aware of, however they were not critical to outcomes or satisfaction according to the study participants. The Somali Muslim women that participated in this study discussed a desire to be included in decisions regarding their care. One of the most critical obstacles to achieving this goal is the language barrier that may exist with providers that are not of the same culture. However, women from different cultures may experience the phenomena of childbirth based on previous experience, cultural beliefs and values, healthcare providers should be offering care that is individualized to them.

CHAPTER V

IMPLICATIONS FOR EDUCATION AND PRACTICE

In this Chapter I discuss potential implications of the research findings for nursing practice and education. I was very pleased to discover that research and nursing have some commonalities. For example, in the field of nursing we are led by something called the "nursing process". This process consists of five elements: assessment, diagnosis, planning, implementation, and evaluation. The acronym "ADPIE" is common in nursing literature. In nursing as in research, we first seek to assess or discover information. Data is collected to determine what factors are contributing to whatever issue or problem exists. In this case, the problem is that health disparities exist among people of color in the United States.

In the second portion of the process, we diagnose, or name the problem. The literature clearly identifies that outcome of care for Somali Muslim women in the United States are poorer that the outcomes for the White population. This is agreed upon by Johnson, Reed, Hitti & Batra (2005), Lightfoot, Blevins, Lum & Dube (2016) & Shahawy, Deshpande & Nour (2015). Satisfaction with care is also lower with this population. The next crucial piece is to plan for interventions that could potentially improve outcomes. Then the implementation of those interventions and finally evaluation. Did those interventions make a positive difference and therefore should be continued, or do we need to alter the plan of action? The following paragraphs will suggest interventions for care that are supported by the literature.

Supporting the Laboring Woman in Her Experience and Need for Community

The first step in meeting the needs of the laboring woman includes understanding her needs in a holistic way. That includes physically, emotionally, spiritually and any culturally influenced needs. Recognizing and supporting her as both an individual, and part of a cultural group with specific needs is imperative. This may be accomplished by first *asking* how we can support her. Showing a desire to be responsive opens the door to a therapeutic relationship. Developing trust will be optimized when nurses follow through with meeting the patient's needs. The National Academy of Medicine (2018) identifies six characteristics for quality health care: it must be safe, timely, effective, efficient, equitable and patient-centered. Patient-centered care is "responsive to individual patient preferences, needs and values. It requires partnering with the patient in every aspect of care" (Giddens, 2021, p. 456). Some examples of supporting the concept that her child is a gift from God might include using terms like "baby" as opposed to "fetus", supporting her emotionally as she learns the additional role of mother in addition to wife or woman.

Some strategies that might mitigate the risks of isolation during labor and delivery could include providing space for family members, encouraging the use of a doula, or being present with the laboring mother as much as possible. When resources are stretched thin, even having an unlicensed nurse's aide to be in the room might be helpful.

Interventions for Ineffective Communication due to Language Barriers

The primary language of the Somali people is Somali (Lewis, 2008). The literature supports the notion that language barriers contribute to less positive outcomes and decreased satisfaction for patients (Rose, 2011, Hudelson & Vilpert, 2009). The Department of Health and Human Services Office of Minority Health, (DHHSOMH, 2019) agree that language difficulties, or poor communication contributes to inequities in healthcare, but "are one of the most

modifiable risk factors" (p. 1). Some of the strategies that could be implemented to decrease the barrier of language differences include the use of interpreters, slower delivery of information, offering written information in the patient's native language and utilizing healthcare staff that speak the language. Healthcare workers could be taught basic phrases in Somali as well. Technology allows multiple avenues for language interpretation.

Squires, (2018) discusses the use of professional medical interpreters as a primary way of improving communication when patients and healthcare providers do not speak the same language; "Effective use of interpreter services or bilingual healthcare professionals has a significant impact on patient satisfaction" (p. 22). Squires also states that U.S. law requires that healthcare institutions provide this service to patients who may need it, or they will not be eligible for Federal funding. She cautions against having family members interpret due to inaccurate translation of medical or nursing terms. In the case of a woman that is laboring or delivering a baby it would be inappropriate to have a young child assisting with interpretation due to the sensitive nature of the event.

The DHHSOMH, (2019) has developed national standards for the use of medical interpreters. "Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (p. 1). The principal standard is that "effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred language, health literacy, and other communication needs" (p. 2). There are 15 total standards and 4 of those directly relate to communication and language assistance.

"Standard 5: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to

all health care services. Standard 6: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. Standard 7: Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals or minors as interpreters should be avoided. Standard 8: Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area" (DHHSOMH, 2019, p.2).

Technology is another tool that could be used to improve communication but should be appropriately vetted. Applications that are available on smart phones or electronic devices could "put an organization at legal risk if their accuracy is poor" (Squires, 2018, p. 24). Slowing down the delivery of information may also improve understanding. While it is not necessary to speak more loudly, it may be beneficial to use short statements and repeat as needed.

Often a patient will receive health related literature to guide their self-care after discharge from the hospital. This may include instructions regarding medications, complications to be aware of, when to call a provider, or other information related to their care. If this information is not in a form that is useful to the patient, it is not appropriate to document that this education was given. Pearson (2019) states that "educational materials should be written in the patient's primary language" (p. 1781) to achieve the goal of the patient understanding their role in their care.

Interventions for Meeting Culture Specific Needs

Meeting the culture specific needs must begin with a desire to increase cultural knowledge and awareness at the personal level. "Cultural desire is a personal choice; this interest is foundational to cultural competence and provides the means for overcoming one's biases and their effect on care" (Giddens, 2021, p. 32). Organizations must support ongoing cultural

sensitivity training and ensure that healthcare providers are completing that training satisfactorily. Curriculum in schools of nursing must also include cultural competency training as a requirement to achieve accreditation. Providing specific knowledge of the population of Somali Muslim women improves understanding and may improve satisfaction of care and promote positive outcomes for mother and baby.

As noted in Chapter II of this document, attention to culture is "an essential aspect to healthcare because of the increasing diversity of the population of the United States" (Giddens, 2021, p. 32). Repo, Vahlberg, Salminen, Papadopoulos & Leinko-Kilpi (2016) agree that it is "a legal and a moral obligation for nurses to be culturally competent in order to provide high-quality care to diverse patients" (p. 98). At the end of a nurse's training, there should be an assessment of their ability to demonstrate cultural competence. This is true regardless of the level of the nursing degree they are seeking. This is accomplished in a variety of ways. The Quality and Safety Education for Nurses (QSEN) competencies are incorporated into clinical evaluations; these competencies define the level of skill, attitudes, and behaviors the student must demonstrate to be successful in a specific nursing course and the overall curriculum. Prior to being licensed and allowed to practice independently, a student nurse must pass a licensure exam called the NCLEX-RN. A percentage of the content on the exam is dedicated to care of diverse patient populations. Throughout the coursework, there is ongoing education, assessment and evaluation of the skills and competencies of the student nurse. Creating presentations and learning experiences about the Somali population would increase the student's knowledge and understanding and could be evaluated via exam or project as the instructor deems appropriate.

Repo et al. (2016) mention multiple ways of integrating cultural competence into all levels of nursing curriculum in addition to course work and clinical experiences. They suggest

immersion type encounters. In the case of the Somali population, student nurses could perform outreach projects with the Somali women in our community. Offering blood pressure checks or other health screenings might be a way to allow students and community members to meet and dialog with one another. The authors also encourage students to travel and study abroad. While this may not be a feasible option for some students, it may be possible for some to experience this culture firsthand.

Other possibilities for having exchanges with Somali women might include inviting them to campus to speak on a panel, offering students a chance to ask respectful questions. Local organizations such as "Global Friends Coalition" or "Love in Action" might also present opportunities for interaction that is facilitated to provide assurance for both parties. Having students learn commonly used words or phrases in Somali might be beneficial. During the interview process for this study, I was taught simple phrases by Rose. When I greeted the other participants with a Somali greeting "As-salumu alaykum" which means "peace and blessing to you" and thanked them in their language, "mahadsanid" it was met with smiles.

Technology allows for nursing students to experience multiple encounters that may not naturally occur as well. The use of simulation is widely accepted in nursing curriculum as a satisfactory way to offer learning opportunities. The simulation could include patients from the Somali culture, or a standardized patient that has been instructed to act as a representation of a person from that population. In simulation, a very structured scenario is created by the instructor and the students must respond as if it were "real life". Giddens, North, Carlson-Sabelli, Rogers & Fogg (2012) also suggest the use of high-fidelity simulation, or the use of virtual communities to introduce students to diverse populations and situations.

In summary, the purpose of this work was to identify the lived experience of Somali Muslim women that had given birth in either Minnesota or North Dakota. These women were interviewed and shared information about that experience. As a nurse researcher, I can now add that information to the literature and inform others of the specific needs of this population during labor and delivery. Hopefully this will offer ongoing cultural knowledge, and potentially improve the birth outcomes for Somali women and their families. One final note, Fowsio gifted me with this, “Thank you for caring enough to give us a voice.” No greater reward needed.

APPENDICES

APPENDIX A

Interview Questions for Dissertation

Aims	**Primary Questions**	**Probing Questions**
1.) Please share your experience giving birth in the United States?	What do you feel went well during this experience?	Did you feel supported by the healthcare workers? Did you feel that you were listened to? Did you feel that your needs were taken into considerations? Did you feel that your pain was managed well?
	What did you feel went poorly during this experience?	Were you afraid to ask for what you needed? Did your care providers ignore your requests? Were you afraid at any time during this experience?
2.) What did you *want* your experience to be giving birth in the United States?	Were there cultural customs that you were able to participate in?	Did your healthcare providers ask for your input when making decisions about your delivery? Did they attempt to accommodate your wishes?
	Were there cultural customs that were ignored or advised against?	
3.) How do you feel that this experience has affected your thoughts/feelings about childbirth?	Did you feel that you were able to fulfill your desired role as a woman during this time? Did you feel that you were able to fulfill your desired roles as a mother during this time? Did you feel that you were able to fulfill your role as Muslim during this time?	

4.) How do you think/feel this experience changed your attitudes about health care in the United States?	Did you feel as if you could trust your health care providers? Were you given information and education that was appropriate?	
5. What is the primary language that you speak?	Was there an opportunity to speak with a care provider that spoke in your first language?	Did you feel that you were heard and understood?

What additional information do think is important for me to know?

APPENDIX B

THE UNIVERSITY OF NORTH DAKOTA
CONSENT TO PARTICIPATE IN RESEARCH

Project Title: Giving Birth on Foreign Soil: A Phenomenological Study of Somali Women Giving Birth in the Upper Midwestern United States.

Principal Investigator:	Tracy Enger, FNP-C
Phone/Email Address:	tracy.enger@ndus.edu
Department:	Teaching & Learning
Research Advisor:	Cheryl Hunter
Research Advisor Phone/Email Address:	701-777-3431 Cheryl.hunter@und.edu

What should I know about this research?

- Someone will explain this research to you.
- Taking part in this research is voluntary. Whether you take part is up to you.
- If you don't take part, it won't be held against you.
- You can take part now and later drop out, and it won't be held against you
- If you don't understand, ask questions.
- Ask all the questions you want before you decide.

How long will I be in this research?
We expect that your taking part in this research will last approximately 30 minutes for the initial interview. You may be contacted for one additional interview if further information is needed for clarification.

Why is this research being done?
The purpose of this research is to increase the body of knowledge about the culturally specific needs of Somali/Muslim women during labor and delivery. This study is designed to assist health care providers to be culturally sensitive and be able to deliver patient centered care.

What happens to me if I agree to take part in this research?
If you decide to take part in this research study, you will be asked to travel to the campus of the University of North Dakota and answer series of questions about your experiences giving birth in the United States. You will participate in one thirty-minute interview and possibly be contacted for a second interview. Your responses will be recorded with an audio device only.

Could being in this research hurt me?
The most important risks or discomforts that you may expect from taking part in this research include answering questions that may be uncomfortable. There is minimal risk to you from participating. You may decline to answer any interview questions you don't want to answer.

Will being in this research benefit me?
The most important benefits that you may expect from taking part in this research include having healthcare providers in the local area that have an increased understanding of your culturally specific needs during labor and delivery.

Possible benefits to others include culturally sensitive care for other Somali/Muslim women during labor and delivery.

How many people will participate in this research?
Approximately 10 people will take part in this study at the University of North Dakota.

Will it cost me money to take part in this research?
You may have transportation costs to the University of North Dakota campus for being in this research study. You will have no other costs to participate.

Will I be paid for taking part in this research?
You will receive a five-dollar Walmart gift card for your participation.

Who is funding this research?
The University of North Dakota and the research team are receiving no payments from other agencies, organizations, or companies to conduct this research study.

What happens to information collected for this research?
Your private information may be shared with individuals and organizations that conduct or watch over this research, including:
- The academic advisor of the research student.
- The Institutional Review Board (IRB) that reviewed this research

We may publish the results of this research. However, we will keep your name and other identifying information confidential. We protect your information from disclosure to others to the extent required by law. We cannot promise complete secrecy.

Data collected in this research will not be used or distributed for future research studies, even if identifiers are removed.
You should know, however, that there are some circumstances in which we may have to show to a court or to tell authorities if we believe you have abused a child, or you pose a danger to yourself or someone else.

The interview will be audio recorded. The recordings will be available to you if you wish to review. They will be stored in a locked office and will be destroyed after 3 years.

What if I agree to be in the research and then change my mind?
If you decide to leave the study early, we ask that you inform the researcher. There will be no penalty to you if you withdraw.

Who can answer my questions about this research?
If you have questions, concerns, or complaints, or think this research has hurt you or made you sick, talk to the research team at the phone number listed above on the first page.

This research is being overseen by an Institutional Review Board ("IRB"). An IRB is a group of people who perform independent review of research studies. You may talk to them at 701.777.4279 or UND.irb@UND.edu if:

- You have questions, concerns, or complaints that are not being answered by the research team.
- You are not getting answers from the research team.
- You cannot reach the research team.
- You want to talk to someone else about the research.
- You have questions about your rights as a research subject.
- You may also visit the UND IRB website for more information about being a research subject: http://und.edu/research/resources/human-subjects/research-participants.html

Your signature documents your consent to take part in this study. You will receive a copy of this form.

Subject's Name: _____

_____ _____
Signature of Subject Date

I have discussed the above points with the subject or, where appropriate, with the subject's legally authorized representative.

_____ _____
Signature of Person Who Obtained Consent Date

your information to other people. For example, the law may require us to show your information

APPENDIX C

Stamped Approval of Institutional Review Board

THE UNIVERSITY OF NORTH DAKOTA
CONSENT TO PARTICIPATE IN RESEARCH

Project Title: Giving Birth on Foreign Soil: A Phenomenological Study of Somali Women Giving Birth in the Upper Midwestern United States.

Principal Investigator: Tracy Enger, FNP-C

Phone/Email Address: 701-777-4511, tracy.enger@ndus.edu

Department: Teaching & Learning

Research Advisor: Cheryl Hunter
Research Advisor
Phone/Email Address: 701-777-3431
Cheryl.hunter@und.edu

What should I know about this research?

- Someone will explain this research to you.
- Taking part in this research is voluntary. Whether you take part is up to you.
- If you don't take part, it won't be held against you.
- You can take part now and later drop out, and it won't be held against you
- If you don't understand, ask questions.
- Ask all the questions you want before you decide.

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Could being in this research hurt me?

Approval Date: 5/2/2021
Expiration Date: 5/1/2022
University of North Dakota IRB

Date: _____
Subject Initials: _____

The most important risks or discomforts that you may expect from taking part in this research include answering questions that may be uncomfortable. There is minimal risk to you from participating. You may decline to answer any interview questions you don't want to answer.

Will being in this research benefit me?
The most important benefits that you may expect from taking part in this research include having healthcare providers in the local area that have an increased understanding of your culturally specific needs during labor and delivery.

Possible benefits to others include culturally sensitive care for other Somali/Muslim women during labor and delivery.

How many people will participate in this research?
Approximately 10 people will take part in this study at the University of North Dakota.

Will it cost me money to take part in this research?
You may have transportation costs to the University of North Dakota campus for being in this research study. You will have no other costs to participate.

Will I be paid for taking part in this research?
You will receive a five dollar Walmart gift card for your participation.

Who is funding this research?
The University of North Dakota and the research team are receiving no payments from other agencies, organizations, or companies to conduct this research study.

What happens to information collected for this research?
Your private information may be shared with individuals and organizations that conduct or watch over this research, including:
- The academic advisor of the research student.
- The Institutional Review Board (IRB) that reviewed this research

We may publish the results of this research. However, we will keep your name and other identifying information confidential. We protect your information from disclosure to others to the extent required by law. We cannot promise complete secrecy.

Data collected in this research will not be used or distributed for future research studies, even if identifiers are removed.

You should know, however, that there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information

Approval Date: 5/2/2021

Expiration Date: 5/1/2022

University of North Dakota IRB

Date: _____
Subject Initials: _____

to a court or to tell authorities if we believe you have abused a child, or you pose a danger to yourself or someone else.

The interview will be audio recorded. The recordings will be available to you if you wish to review. They will be stored in a locked office and will be destroyed after 3 years.

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If you decide to leave the study early, we ask that you inform the researcher. There will be no penalty to you if you withdraw.

Who can answer my questions about this research?
If you have questions, concerns, or complaints, or think this research has hurt you or made you sick, talk to the research team at the phone number listed above on the first page.

This research is being overseen by an Institutional Review Board ("IRB"). An IRB is a group of people who perform independent review of research studies. You may talk to them at 701.777.4279 or UND.irb@UND.edu if:

- You have questions, concerns, or complaints that are not being answered by the research team.
- You are not getting answers from the research team.
- You cannot reach the research team.
- You want to talk to someone else about the research.
- You have questions about your rights as a research subject.
- You may also visit the UND IRB website for more information about being a research subject: http://und.edu/research/resources/human-subjects/research-participants.html

Your signature documents your consent to take part in this study. You will receive a copy of this form.

Subject's Name: _____

_____ _____
Signature of Subject Date

I have discussed the above points with the subject or, where appropriate, with the subject's legally authorized representative.

_____ _____
Signature of Person Who Obtained Consent Date

Approval Date: 5/2/2021

Expiration Date: 5/1/2022

University of North Dakota IRB

Date: _____
Subject Initials: _____

APPENDIX D

Advertising Flyer for Participation

Are you a Somalian woman who has given birth in the United States?

Research Study Participants Needed

University of North Dakota | Grand Forks ND

We want to tell your story!

UND UNIVERSITY OF NORTH DAKOTA LEADERS IN ACTION

We are looking for women who are 18 years or older who have immigrated from Somali and have had a baby in the U.S.

Participants will be asked to consent to a recorded interview with a Family Nurse Practitioner about their labor and delivery experience.

Participants will receive snacks, refreshments and a gift card to Walmart.

For More information contact

Tracy Enger, FNP

at **701-777-4511**

or by email at **tracy.enger@UND.edu**

Somali Mothers Study
Tracy Enger 701-777-4511
tracy.enger@UND.edu

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